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Minister for Health
Chair of Health Ministers' Meeting
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Dear Minister,

I am pleased to provide the Report of the *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025*. The Review was commissioned by the Health Ministers of the Commonwealth and all States and Territories and is a requirement of Clause 21 of the Addendum.

The Review makes forty-five recommendations that respond to the Review's Terms of Reference. These recommendations seek to build on the strengths of the *National Health Reform Agreement*, while proposing reforms and initiatives to enable the health system to address current and future challenges.

The Review concludes that there are significant opportunities to broaden the scope of the Agreement to take a whole of health system view, to better manage the interface between care sectors, to embed innovation and reform into its operations, to incorporate the key system enablers of workforce and digital health and to establish priority actions in the areas of First Nations' people, mental health, prevention and rural and remote health.

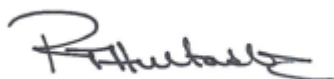
While progress has been made to improve transparency and efficiency of hospital funding, largely through activity-based funding, there is an opportunity to take this to the next level by developing and enabling optimal models of care that seek to deliver care in the right place at the right time, often in the community or through virtual settings. The implementation of a Health Funding and Payments Framework will embed financing models that are fit for purpose and that reward high value care to improve patient outcomes.

Establishing a robust performance framework that includes measurement of patient experience and outcomes across the health system will enable a more proactive approach to system management.

A thorough consultation process informed the Review and has been invaluable in developing its recommendations. I wish to acknowledge the open and collaborative way in which all stakeholders have participated and their willingness to test ideas and provide case studies and data.

I also wish to thank my initial co-Reviewer, Mr Michael Walsh PSM, who was a tireless contributor to the Review's consultation phase, policy framing and direction, prior to his appointment as Acting Director General of Queensland Health in late July 2023. The Review was supported by Deloitte and I thank them for their contribution throughout, in supporting consultations, reviewing submissions and collaborating on preparation of Review materials, report drafting and ideas.

Yours sincerely



Rosemary Huxtable AO PSM

24 October 2023

Copied to: Health Ministers' Meeting - All Members
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Executive summary

National Health Reform Agreement context

The *National Health Reform Agreement* (NHRA or Agreement) has its genesis in a substantial health reform agenda, dating back to 2011, that sought to improve and mature how the Commonwealth, States and Territories fund public hospitals, and provide a platform for broader collaboration that could achieve a connected, sustainable and equitable health system. In 2021-22, \$59.2 billion in Commonwealth, State and Territory funding was administered under the NHRA.

Designing a health system able to deliver continual improvement in outcomes, drive more integrated care and equity of access, in a context where more people have chronic and complex needs and there is inequity in health outcomes, was as fundamental to the 2011 NHRA as it is today. Many of the aspirations and objectives of the Agreement are as relevant now as they were then.

While the original NHRA sought to put aside historic Commonwealth-State and Territory differences on funding adequacy and share, improve patient outcomes and experience through innovative models of care and embed governance that would drive a ‘...nationally unified but locally controlled health system’, it has had mixed success and the level of enduring reform that was anticipated has not been achieved.

That is not to say that benefits have not accrued from the 2011 NHRA and its successor Addenda. The introduction of activity-based funding (ABF) as the predominant method of funding public hospitals has generated technical efficiency in the allocation of funding, as well as accountability and transparency through its classification systems, pricing determinations and funding flows. The establishment and operation of the Agreement’s independent national bodies has been key to this achievement, though not without challenges.

At the same time, the focus on the funding of acute activity through ABF has detracted from methods to allocate funds across the health system in the most efficient way: the capacity to deliver the right care in the right place at the right time. At its simplest, care delivered outside an acute setting that can reduce the likelihood of an acute presentation or mitigate its complexity is likely to be a more efficient way of allocating funding and improve patient outcomes. This is particularly the case in an environment of an ageing population and a rise in chronic and complex conditions.

The challenge for a future NHRA is to deliver models of care most likely to reduce the rate and complexity of acute hospital admissions and improve patient outcomes, using a variety of tools, and to be more adaptive and innovative in forecasting and planning for future challenges.

This Review was conducted against the requirements set out in Clause 21 of the Agreement and further directions from Health Ministers, notably to consider the impact of the COVID-19 pandemic which coincided with the commencement of the 2020-25 Addendum. Its findings were informed by a wide-ranging consultation process comprising workshops, interviews with key stakeholders, a targeted call for written submissions, and extensive data retrieval and analysis.

There was a level of unanimity that emerged through consultation about the key themes that needed attention. These themes became the organising principles for this Report and have guided the development of recommendations consistent with the Terms of Reference. An implementation Roadmap is provided to inform the most effective sequencing of recommendations, including where development work is required leading up to a new Agreement.

Whole of Health System Agreement

There was a general view that the NHRA did not operate as a health system agreement, but as a technical hospital financing agreement and, while it has had success in this area, its broader aspiration to take a system-wide approach and drive innovation and integration has not been realised in practice.

A future Agreement should be reshaped as a single collaborative health system Agreement that recognises that all elements of the health system need to work effectively together to improve patient outcomes, is performance-focused, predicts and prepares for future challenges and is clear on shared and individual accountabilities.

The governance of the Agreement needs to reflect its broader ambition, fully utilise the resources and expertise of the national bodies and dedicate resources to ensure innovation and reform remains at the forefront, establishing an innovation and reform entity. Relevant elements of related Agreements, including Closing the Gap, Preventive Health and Mental Health and Suicide Prevention need to be reflected in the NHRA with actions, accountabilities and milestones agreed.

The Medicare Principles, that provide equitable access on the basis of clinical need and free of charge to a public patient in a public hospital, remain fundamental to a future Agreement.

A focus and platform for intersectoral collaboration

Stakeholders considered that the NHRA fell short in encouraging intersectoral collaboration (for example between the acute, primary, disability and aged care systems) and enabling integrated patient care and that this has led to fragmented care pathways and bottlenecks and detracted from patient outcomes.

To improve coordination between sectors requires an integrating layer to operate at the local level and a proactive approach to improve care pathways for vulnerable groups. The role of local hospital networks (LHNs), primary health networks (PHNs) and Aboriginal Community Controlled Health Organisations (ACCHOs) needs to be reinvigorated and authorised with flexible funding to support local initiatives.

Reduced access to primary care puts pressure on State-based health services, often the provider of last resort for vulnerable communities. This is particularly the case where there are thin markets, often but not always in rural areas, and when the continued provision of primary care relies on a small number of providers. Models of care that can identify and respond to emerging gaps in service systems and that make the best use of scarce resources are needed, with equitable and sustainable funding attached. A further priority is to improve the acute-aged-disability care interface. The impact on hospital flow and poor outcomes for patients who are ready for discharge but unable to be placed safely back into the community was consistently raised. More proactive management of these patients, supported by data and appropriate funding from the point of admission is key, together with access to step-down and support services in the community or residential settings.

Optimal models of care

The NHRA, with its focus on the funding of activity, tends to drive care toward inpatient settings, while the health needs of the population increasingly require multidisciplinary integrated care that supports transitions across sectors. The NHRA has not enabled this patient-centred approach due to the split of roles and responsibilities, where service gaps emerge.

The way that funding is delivered through the NHRA, primarily through ABF, has tended to respond to demand rather than seek to shape demand. The next Agreement should take a proactive approach to shape demand and deliver higher value care by establishing shared incentives and payment streams that focus on early intervention in non-hospital settings and accelerate the adoption of agreed high value care pathways through bundling of payments, use of technology and incentives. How public hospital services are understood needs to be broadened to adapt to emerging models and digital tools, with virtual care incorporated into funding mechanisms. The Review proposes that the scale, pace and focus of new pricing arrangements should be mapped out in a new National Health Funding and Payments Framework.

Financing reform

The level of Commonwealth contribution to public hospital funding was seen as growing too slowly (currently 40.3%), with differences in the Commonwealth share for individual States and Territories remaining significant and an expectation that the Commonwealth share will remain relatively flat due to the operation of the 6.5% national growth cap. The capacity to respond to demand pressures in the system is further affected by the operation of a cap that covers both price and activity growth, which, in an environment of cost escalation, leaves insufficient room for new activity. Smaller jurisdictions remain concerned at the misalignment between their costs and the national efficient price (related to scale) and all jurisdictions were concerned that the three year time lag between incurring costs and their reflection in the NEP generated funding gaps.

While ABF is, and should continue to be, a foundational element of a new Agreement, issues such as calculation complexity, lags between costs and price, and impacts on smaller jurisdictions need to be reviewed by the Independent Hospital and Aged Care Pricing Authority (IHACPA) in consultation with jurisdictions. Consideration by all parties of a new methodology to determine the Commonwealth's funding share should seek to simplify the calculation, narrow the differences between individual States and Territories and accelerate the trajectory to a 45% Commonwealth contribution to nationally efficient public hospital activity. The national growth cap should be reframed as an activity only cap, with price growth removed, noting the considerable drivers on all parties to drive efficiency. There remains an important role for block funding where diseconomies of scale dictate, and for the transparency that has been a feature of ABF to be extended to other funding streams, such as Teaching and Training and Public Health.

Access to Pharmaceutical Benefits Scheme (PBS) subsidised medicines for patients at the point of discharge improves continuity of care at a time when patients and their families can be vulnerable. A nationally consistent approach in this regard should be a feature of a new Agreement, as should a uniform way to undertake health technology assessment for high-cost, highly specialised therapies (to date, cell and gene therapies), which are likely to increase in both number and diversity in the life of the next Agreement.

Progressing long-term health reforms

The NHRA Addendum identified six long term reform priorities that remain important, but progress in delivering against these has been slow, in part due to the COVID-19 pandemic as well as a lack of dedicated resources (workforce and funding), measurable outcomes and clear accountabilities.

While COVID-19 was a unique event that required extraordinary effort across all jurisdictions, it is difficult to advance a reform agenda without dedicated resources as there will always be pressing operational matters that take priority. A new Agreement

should establish a national innovation and reform entity, authorised and resourced to work with jurisdictions and the national bodies to establish priorities, develop innovative approaches and implement a long-term reform program driven by performance data and supported by an Innovation Fund. A new national body, the National Innovation and Reform Agency, is recommended to perform this task. Embedding a program of action focused on prevention and wellbeing should be a high priority, aligned with the objectives of the National Preventive Health Agreement and the emerging work of the Australian Centre for Disease Control.

Rural and remote service delivery

There remains evidence that people living in rural and remote communities experience poorer health outcomes, related in part to geographical distance and medical workforce distribution. Service systems in these areas can be fragile as they rely on a small number of providers and are vulnerable to any change, with State and Territory-run services needing to step in as providers of last resort.

The NHRA should establish a coordinated national approach to address health disparities in rural and remote communities, that encompass models of care able to function where workforce and infrastructure is limited, with health providers operating at a full scope of practice and greater integration across sectors to get the most from available resources.

A shared plan of action focused on equity of access in rural and remote areas should form a Schedule of a new Agreement with priority actions and milestone, national datasets and minimum access standards, appropriate regionality weightings in funding formulae and equitable distribution of Teaching, Training and Research funds. Some of the current mechanisms to improve access to services such as the Single Employer Model and access to the Medicare Benefits Schedule (MBS) by State and Territory managed services through section 19(2) *Health Insurance Act 1973* exemptions should be made more widely available across rural and remote settings and where ‘thin markets’ emerge.

Clear commitment to closing the gap for First Nations’ People

Access to necessary and culturally responsive health services is a key mechanism to close the gap in life expectancy and health outcomes for First Nations’ people. While the current Addendum acknowledges the Closing the Gap targets, it does not establish a national action plan to be delivered and enabled through the NHRA.

A new Agreement should have a specific Schedule that enunciates the shared commitment of the parties to improve the health of First Nations’ people through specific actions and accountabilities to be taken as part of the NHRA. This includes authorising the role of ACCHOs as key participants in the Agreement and its local commissioning, improving cultural safety in health service delivery, in consultation with communities, and establishing agreed measurement and reporting.

Embedding workforce and digital health as key enablers

A sufficient and skilled health workforce and an ability to provide the full range of digital and digitally informed health services are key enablers of effectiveness and efficiency across the health system. Neither of these have been strongly present in the NHRA to date, instead forming part of other bilateral agreements and processes.

There is value in bringing these elements into dedicated Schedules of a new Agreement, reflecting shared commitments and actions, accountabilities and performance milestones. Ensuring a sufficient and quality health workforce through a dedicated workforce planning body is part of this, as is collaborative work on enabling a full scope of practice across all professions consistent with safe practice standards. An explicit commitment of the parties to advance digital health solutions should acknowledge the role of the Australian Digital Health Agency (ADHA) and the related *Intergovernmental Agreement on National Digital Health*, with agreed priorities, roles and responsibilities and actions to progress digital health solutions and data sharing.

Measuring the success of the Agreement

Measuring the performance of the health system, understanding future pressures and the capacity of the system to respond to these pressures is essential to a well operating and responsive health system agreement. The health system is interconnected and so measuring its performance must also cross sectors and boundaries, seek to understand pain points for consumers and incorporate patient experience and outcome measures. While there has been an Australian Health Performance Framework as part of the Agreement, it is not widely accessible or understood, has not enabled reflection on system pressures nor development of shared solutions.

As part of the Review an Interim Quantitative Performance Framework was developed to better understand and track performance against the Agreement objectives of efficiency, effectiveness, sustainability and equity. This is intended as a starting point for a performance framework for a new Agreement and has identified gaps where collaborative development work is needed, for example, in patient reported outcome and experience measures, quality and safety indicators, the incidence and reasons for patients in hospital awaiting discharge, consistency of workforce data and measures of access to primary care.

Monitoring the performance of the health system and developing policy responses, working with jurisdictions and the national bodies, should be a key function of the innovation and reform function of the Agreement. It is also important to track the progress of the parties to the Agreement against their accountabilities (individual and shared) and those of the national bodies.

Learning from COVID-19 and preparing for future events

The Addendum came into effect at the same time as the emergence of COVID-19, and so has operated at a time of major and unprecedented disruption to the health system. There are lessons from this experience, many of which are emerging from the various inquiries that have been undertaken or are in train. A future NHRA should set out the principles and processes to establish time-limited funding arrangements in response to times of extreme national emergency, the circumstances in which these would be triggered and the path back to business-as-usual arrangements.

COVID-19 has brought long term consequences for the health system, with reported increases in demand and acuity, the impact of long COVID and backlogs in planned elective surgery procedures. The way in which NHRA funding operates, including how base funding is determined and a growth cap applied, mitigates against managing demand surges. A COVID-19 recovery plan should be put in place for the remaining period of the Agreement to address demand pressure.

Conclusion

The Agreement has been successful in improving the technical efficiency and transparency of public hospital funding through the operation of ABF with nationally consistent classification and pricing systems and funding flows. It has been less successful in delivering the right care in the right place at the right time (allocative efficiency) to respond to the needs of an ageing population and one with higher rates of chronic and complex conditions, to incentivise high value care and optimal patient outcomes.

The next stage of reform requires a single collaborative whole of health system Agreement, that incorporates a National Health Funding and Payments Framework that can deliver optimal models of care and increase the Commonwealth funding share over time. Critical system priorities and enablers need to be embedded into the Agreement, not just as aspirational statements, but with clear accountabilities and programs of action. A focus on innovation and reform and measurement of performance can better map and enable the system to respond to future pressures.

Recommendations

The Review includes forty-five recommendations intended both to inform and guide the remainder of the Addendum period as well as present options for future reform and Agreements, identified in Table 1.

Table 1: List of recommendations

Theme	Topic	Recommendation	Relevant Report section
A shared whole of Health System Agreement with the right architecture and governance	Single collaborative health system Agreement	<p>1. The NHRA should:</p> <p>a) Be framed as a single collaborative health system Agreement that acknowledges that health system performance is a function of the hospital, primary, disability, aged care and prevention sectors working effectively together, in the interests of the consumer and system sustainability and which clearly sets out roles and responsibilities, actions and accountabilities of the parties.</p> <p>b) Describe the shared vision, principles, objectives and reform goals for the health system, take a strategic view to health system challenges and drive innovation, with input from national bodies, system providers and consumers.</p> <p>c) Establish a health system performance framework, that is broadly-based and outcome-focused, to guide actions and actively monitor progress.</p> <p>d) Include individual Schedules, that are streamlined and updated to reflect shared goals, with outdated material removed, and key system enablers (such as digital health and workforce) added.</p>	5.1.1.4 - Agreement structure going forward
	Audit of existing health related agreements between the Commonwealth, States and Territories	<p>2. An audit of existing health related agreements between the Commonwealth, States and Territories should be undertaken to determine whether, and to what degree, they are suitable for inclusion in a new Australian Healthcare Agreement, with an agreed timeframe as to when any such inclusions would take effect. Future health related agreements that operate outside the NHRA should align with, and be guided by, the shared vision, principles, objectives and reform goals for the health system proposed at Recommendation 1(b).</p>	5.1.1.4 - Agreement structure going forward
	Mental health and the NHRA	<p>3. The NHRA should reaffirm the commitments to improving mental health outcomes through the separate <i>National Mental Health and Suicide Prevention Agreement</i>, utilising the mechanisms agreed through the NHRA, including models of care, financing, innovation and performance monitoring, to progress agreed actions in the area of mental health.</p>	5.1.1.4 - Agreement structure going forward
	Medicare principles – processes and reporting	<p>4. The Medicare Principles (that enable treatment to be provided free of charge to a public patient in a public hospital, access to public hospital services on the basis of clinical need and within a clinically appropriate period, and arrangements that ensure equitable access to services regardless of geographic location) should remain a core feature of the NHRA. The effective operation of the Medicare principles should be supported by:</p> <p>a) Processes to ensure the Medicare Principles are being delivered in practice through greater consistency within and across jurisdictions of the private patient election process, that is straightforward and understood by the patient and ensures accountability for the provider: for example, through rigorous informed financial consent processes, restricting multiple changes of election during an admission, making explicit a requirement for recording private patient election for non-admitted services and reporting data on out-of-pocket patient costs.</p> <p>b) Reporting of all Commonwealth, State and Territory funding provided to public hospitals, both through the NHRA and through Commonwealth programs such as MBS and PBS, to give a more complete picture and better map trends over time.</p>	5.1.2 - Medicare

Theme	Topic	Recommendation	Relevant Report section
	Reference to governance settings in NHRA	5. The NHRA should be updated to reflect current governance settings related to National Cabinet, with a check of roles and responsibilities of bodies referenced in the NHRA undertaken to ensure they remain relevant and have an appropriate place in a new Agreement.	5.1.3.1 - Governance evolution
	Architecture of national bodies	6. The general architecture of the national bodies should be retained , but with: <ol style="list-style-type: none"> National bodies better utilised to support reform directions, with their expertise and data insights integrated into national policy development processes. Roles/responsibilities of the national bodies revisited to ensure they are clear and appropriate, and strengthened to enable them to form part of a unified response to emerging healthcare challenges and evolving patient needs. Jurisdictional engagement with national bodies better balanced between strategic and technical issues (rather than the current technical focus). A new performance framework informed and delivered (Recommendation 41) with input from all jurisdictions and the national bodies, and that includes the progress of the national bodies in delivering their accountabilities. A new National Innovation and Reform Agency, responsible for identifying emerging system pressures and driving innovation and long-term reform, working closely with HCEF and Health Ministers (linked to Recommendation 34). Digital health and workforce recognised through dedicated bodies (existing or new) referenced in the Agreement, with relevant purpose, strategies and outcomes incorporated. Strategic engagement between national bodies, Health Ministers and Health Chief Executives to occur at least annually. 	5.1.3.3 - Governance for a future Agreement
A focus and platform for intersectoral collaboration	Intersectoral architecture (PHNs, LHNs and ACCHOs)	7. The intersectoral architecture set out in the NHRA should be reinforced and improved with a commitment to greater alignment and collaboration between PHNs, LHNs and ACCHOs. The future Agreement should: <ol style="list-style-type: none"> Establish a nationally consistent governance framework with formal governance structures, mechanisms, and roles and responsibilities that drive and enforce integration between LHNs, PHNs, and ACCHOs. This national governance framework should have the flexibility to accommodate jurisdictional variance and unique regional needs and reiterate current Agreement expectations of clinician and community engagement, particularly related to safety and quality of health care. Detail minimum requirements for how the Commonwealth and State and Territory health departments, PHNs, LHNs and ACCHOs will work together on joint planning and commissioning. These requirements should contain the following elements: <ul style="list-style-type: none"> Balanced representation in local governance. Local planning and co-commissioning focused on improving patient pathways and outcomes, with flexibility to innovate and design care models that are fit-for-purpose and support long-term health reform goals. Shared and, where possible, linked datasets on population and service utilisation at the local level. Agreed programs of work that address local health priorities, with greater funding flexibility for PHNs and ACCHOs to support local service needs. Shared reporting and accountability arrangements to measure progress against initiatives and the impact on health outcomes and the quality of health services. 	5.2.2 - The role of PHNs in commissioning and driving an integrated health service
	Primary care interface	8. Measures of primary care access , able to be monitored at the local level, should inform the operation of the NHRA, including: <ol style="list-style-type: none"> whether and when different models of care are mobilised to respond to serious service gaps that would otherwise result in avoidable hospital presentations 	5.2.3.1 - Primary care interface

Theme	Topic	Recommendation	Relevant Report section
		<p>b) collaborative planning at the local level that would underpin the need for action and the escalation pathways through which action would be taken</p> <p>c) a capacity to act quickly to use available resources to greatest effect with equitable funding arrangements agreed in advance. The triggers for this need to be negotiated as part of a new Agreement but should ensure there is every incentive for primary care to work effectively without intervention.</p>	
	Collaboration between Aged Care and public hospitals	<p>9. Collaboration between Aged Care and public hospitals should be strengthened through shared responsibility for supporting older patients to be discharged from hospital when clinically ready and to reduce avoidable ED presentations and hospital admissions. New strategies to address these long stay older patients (LSOP) include:</p> <p>a) A national data collection to assess number and acuity/needs of LSOP. This is an early foundation that should commence immediately.</p> <p>b) Greater availability and use of transition care places to support discharge from hospital to home, including step-down beds that are cost-shared and can bridge the gap between the hospital and a residential facility or community package.</p> <p>c) Creation of mechanisms (such as brokers, real time bed availability data, hospital liaison officers) to actively manage placement of older people, from the point of admission to discharge.</p> <p>d) New models within residential aged care and the community (mobile outreach or rapid response teams) to support placement of hard-to-place individuals (including role of specialist dementia units and dementia training programs).</p> <p>e) Financial incentives to better share risk where discharge is delayed and, for those with particularly complex needs, potential top-up payments to support placement with a RACF or community provider.</p>	5.2.3.4 - Increase capacity of timely and appropriate aged care and disability accommodation and support services
	Transition out of hospital to home of people with a disability	<p>10. The proactive approach being taken to support the transition out of hospital to home of people with a disability who are NDIS eligible and ready for discharge should continue, supported by its own national data collection along the lines of that at Recommendation 9(a), with a focus on delivery of joint and concurrent responses across sectors, and further review of the mechanisms to ensure continuity of care for NDIS participants during a hospital stay to ensure optimal patient outcomes.</p>	5.2.3.5 - Proactively facilitate NDIS participant discharge from public hospitals
Optimal models of care	Development of optimal models of care	<p>11. The NHRA should prioritise the development of optimal models of care, using agreed innovative financing mechanisms, through:</p> <p>a) Enhancements that both respond to, and shape demand for health services, with a priority focus on:</p> <ul style="list-style-type: none"> • Reducing rates of potentially preventable hospitalisations • Scaled adoption of the ACSQHC Clinical Standards and Pathways • Bundling care for certain agreed pathways (maternity care, hip and knee replacement, stroke) • Embedding digital and technology solutions, including by enabling virtual care • Improving access to quality services in rural and remote regions. <p>b) Establishing guidelines for the development of evidence based care models and pathways that consider:</p> <ul style="list-style-type: none"> • The needs of patients • Whole of system pathways • Model of care enablers including data sharing and governance, capacity for local tailoring and adoption, workforce, funding, infrastructure and technology. <p>c) An Innovation Funding Pathway that, from the outset, maps the transition from seed funding to operation at scale, subject to evaluation milestones being met (linked to Recommendation 34). The process by which innovative models of care will be</p>	5.3.2 - Priority areas of focus

Theme	Topic	Recommendation	Relevant Report section
		initially funded and then brought to scale should form part of the ten year National Health Funding and Payments Framework at Recommendation 16.	
Optimal models of care - Building on the foundations of ABF	Scope of public hospital services reviewed and broadened	12. The scope of public hospital services referenced in the NHRA should be reviewed , with a view to removing reference to what was deemed to be a hospital service in 2010 (Clause A22), and broadened to address current disparities between States and Territories and to incorporate those services that are provided beyond the hospital door, including virtual services and in-reach/out-reach services, where the primary purpose is to both respond to, and shape demand for acute care by replacing or avoiding a hospital admission, with an appropriate transition to ensure any impact on activity growth caps are managed.	5.3.4.2 - Setting of care
	Develop and implement bundled payments (initial focus on maternity care)	13. A structured program of work should be undertaken to develop and implement bundled payments within the NHRA for certain end to end episodes of care (before, during and after a planned hospital admission), with an initial focus on maternity care , and with additional priority areas identified early in the Agreement in consultation with the national bodies and relevant stakeholders. Bundled payments should be implemented across several priority areas within the period of the next Agreement.	5.3.4.3 - Bundled payments
	Pricing approaches that reward high value care and penalise low value care	14. A new Agreement should develop and implement pricing approaches that reward high value care and penalise low value care , providing incentives to accelerate changes in clinical practice and manage introduction of new technologies, supported by evidence, effectively accelerating the approach foreshadowed in the <i>NHRA 2020-2025 Addendum</i> .	5.3.4.4 - Paying for value/outcomes
	Retaining and strengthening safety and quality reforms	15. The safety and quality reforms introduced in the <i>NHRA 2017-2020 Addendum</i> should be retained and strengthened along the lines set out in Clause A162 of the Agreement, with continued scrutiny of the specific adjustment areas and their application to ensure they remain fit for purpose and are achieving their intended objective.	5.3.4.5 - Safety and quality
	Ten-year National Health Funding and Payments Framework	16. The scale, pace and focus of new pricing arrangements should be underpinned by a ten-year National Health Funding and Payments Framework , informed by the national bodies and agreed between the Commonwealth, States and Territories, which incorporates blended models of care, virtual care, bundled payments and paying for value and outcomes, with clear and measurable milestones and accountabilities and an agreed transition path.	5.3.4.5 - Safety and quality
Financing reform - Financing public hospitals and health care	Retaining activity-based funding	17. Activity based funding should be retained as a foundational element of a future Agreement . ABF has proven value in enabling transparency, accountability and consistency of funded episodic activity and provides a solid basis from which to enhance and evolve funding incentives to support system improvements.	5.4.1 - Financing public hospitals and health care
Financing reform - Reducing calculation complexity	Review NEP calculation to reduce calculation complexity	18. The IHACPA, in consultation with jurisdictions and the NHFB, should undertake a further review of the calculation of the NEP to seek to reduce calculation complexity and address the particular funding challenges for smaller jurisdictions unable to operate at the scale and without the cost base of larger jurisdictions. The impact of the NEP and the calculation of Indigenous, residential and treatment location adjustments should also be reviewed to ensure they are operating as intended.	5.4.2.1 - Impact on smaller jurisdictions

Theme	Topic	Recommendation	Relevant Report section
	(particularly smaller jurisdictions)		
	Identify options for use of more recent activity / cost data	19. A process should be undertaken that identifies and tests options, in consultation with jurisdictions, to calculate the NEP using more recent activity and cost data than the current three-year-old data, with an agreed option implemented in the course of the next Agreement.	5.4.2.2 - Timeliness of activity and cost data
	Cross-border principles augmented	20. The principles underpinning cross border arrangements as set out in the Agreement should be confirmed but augmented with guidelines that enable timely and fair outcomes applied on a consistent basis, including making allowance for capital and block components of funding, above certain thresholds of cross border activity.	5.4.2.3 - Cross-border arrangements
	Determining funding neutrality for private patients in public hospitals	21. A review should be undertaken by IHACPA, in consultation with jurisdictions and the NHFB, regarding the requirements and implementation of the arrangements for determining funding neutrality for private patients in public hospitals , particularly in the calculation of growth funding, to determine whether the policy intent of the parties is being achieved, and what if any adjustments are required.	5.4.2.4 - Methodology for funding neutrality for private patients in public hospitals
Financing reform - Commonwealth funding share and growth cap	New funding model to increase Commonwealth contribution to 45% of nationally efficient public hospital activity	22. A new Agreement should put in place a new and simpler funding model to gradually increase the Commonwealth contribution to 45% of nationally efficient public hospital activity through: <ul style="list-style-type: none"> a) An initial injection of Commonwealth funds into those States and Territories that sit below the current median contribution rate to bring them closer to the national average. b) Consideration of a new funding model that sets the Commonwealth contribution as a fixed percentage of the national efficient price of each State and Territory's total NWAU. c) A stepped transition to increasing the Commonwealth percentage contribution to 45% over the course of the Agreement. 	5.4.3.1 - Accelerate the Commonwealth contribution
	Increased Cwth contribution redirected to support new and blended models of care and innovation	23. State and Territories should maintain their level of contribution to health funding through the transition at Recommendation 22, noting that this would allow State and Territory funds displaced through an increased Commonwealth contribution to be directed to support new and innovative models of care consistent with the National Health Funding and Payments Framework at Recommendation 16.	5.4.3.1 - Accelerate the Commonwealth contribution
	Reframe 6.5% national funding cap to activity cap alone	24. Consideration should be given to reframe the 6.5% national funding cap to an activity cap alone (~4-5% activity growth), with price growth not subject to a cap but based on an efficient price calculation using contemporary activity and cost data.	5.4.3.2 - Reframe the 6.5% national funding cap

Theme	Topic	Recommendation	Relevant Report section
Financing reform - Block funding and public health funding	Retain block funding arrangements	25. Block funding arrangements should be retained as a feature of a future NHRA , recognising that certain services and functions, particularly in rural and remote areas, are more appropriately funded in this way.	5.4.4 - Block funding and public health funding
	Transparency in Teaching and Training funding and investments	26. There should be greater transparency in the funding and investment in Teaching and Training functions .	5.4.4.1 – Transparency in Teaching and Training funding
	Transparency and reporting on Public Health funding	27. A new Agreement should improve transparency and reporting on Public Health funding and investments . Funding through the NHRA should be harmonised with investments and priorities of the Australian Centre for Disease Control, once established, and align with the <i>National Preventive Health Strategy</i> (see Recommendation 44).	5.4.4.2 - Transparency of Public Health funding and prevention activities
Financing reform - PBS reform and high-cost, highly specialised therapies	Nationally consistent access to medicines across the care continuum	28. A new Agreement should deliver nationally consistent access to medicines across the care continuum , noting the benefits to patients of continuity of care on admission and discharge. <ul style="list-style-type: none"> a) This would replace Pharmaceutical Reform Arrangements (PRAs) and require negotiations with, and preparations by, New South Wales and Australian Capital Territory for access to PBS medicines in public hospitals for admitted patients on discharge, non-admitted patients and same day admitted patients. b) Interim PRA arrangements for New South Wales and the Australian Capital Territory in the lead-up to a new Agreement could be progressed, if supported by those jurisdictions. c) This change could be implemented either through a new Medicines Schedule added to the Agreement, or through amendments to current Clauses A9 and A10 which address access to the Pharmaceutical Benefits Scheme. 	5.4.5.1 – Pharmaceutical Reform Arrangements
	Horizon scanning process for high-cost, highly specialised therapies	29. A structured horizon scanning process should be established for high-cost, highly specialised therapies, with the involvement of all jurisdictions, and with input from relevant stakeholders, including but not limited to the National Blood Authority, Organ and Tissue Donation Authority, Pharmaceutical Benefits Advisory Committee and Medical Services Advisory Committee to support forward planning and priority setting.	5.4.5.2 - High-cost, highly specialised therapies
	Unified national HTA process for high-cost, highly specialised therapies	30. A unified national HTA process for the assessment and delivery of high-cost, highly specialised therapies under the NHRA should be progressed , that addresses issues of national consistency, risk sharing, access (including the potential for private sector delivery), affordability, timeliness and information sharing.	5.4.5.2 - High-cost, highly specialised therapies
	Cost consistency and cross-model approach for unified HTA framework	31. The unified HTA framework and methodology at Recommendation 30 should: <ul style="list-style-type: none"> a) Drive consistency in identification of all costs associated with delivery (Commonwealth, State and Territory funded), but also lifetime potential avoided health system costs, through strengthened data collection and analysis. b) Take a cross-modal approach that compares new high-cost, highly specialised therapies to the range of treatments/technologies for the same indication (e.g., medicines, devices, surgery). 	5.4.5.2 - High-cost, highly specialised therapies

Theme	Topic	Recommendation	Relevant Report section
Progressing long-term health reforms	Reinforce a shared national commitment and program of action on long-term health reform areas	32. A new Agreement should reinforce a shared national commitment and program of action on long-term health reform areas , with a collaborative process to confirm or vary the current long term reform areas and with governance structures, incentives, resources, and success measures to drive the implementation of the reforms.	5.5.1 - National commitment
	Renewed focus on prevention activities	33. A renewed focus on prevention activities should be set out in the Agreement which directly addresses the rising burden of chronic disease in the community, complements the <i>National Preventive Health Strategy 2021-2030</i> and work of the Australian Centre for Disease Control and provides a shared program of action, with clear accountabilities, funding and milestones.	5.5.2 - Prevention
	Innovation and reform supported by agency and Innovation Fund	34. A focus on innovation and reform in the Agreement should be supported by: <ul style="list-style-type: none"> a) A National Innovation and Reform Agency, authorised to develop and advise on long term system reforms and innovation, working with all jurisdictions and the national bodies, with strong reporting lines through HCEF to Health Ministers, and informed by performance data flowing from the Agreement (linked to Recommendation 6). b) An Innovation Fund, drawn from new and freed up monies delivered through the NHRA that can support short term activities, while working with jurisdictions and the national bodies on options to implement successful innovation and reform at scale using the 'Funding Innovation Pathway' at Recommendation 11. 	5.5.4 – Funding
Rural and remote service delivery that is fit for purpose	Roles and responsibilities of rural and remote health care provision	35. The NHRA should set out the roles and responsibilities in the governance of rural and remote health care provision and include provisions that: <ul style="list-style-type: none"> a) Outline the Commonwealth's stewardship role in ensuring the accessibility and sustainability of primary, aged and disability care in thin rural and remote markets. b) Establish clear accountability and escalation mechanisms to address market failures in rural and remote primary, aged and disability care. c) Establish governance and pathways to support the development of flexible models to improve access to primary care, aged care and disability care in rural and remote areas. 	5.6.1.1 -Strengthen the governance model for rural and remote service provision
	Rural and remote reflected in new Schedule	36. The importance of improving equitable access to health care services in rural and remote areas should be reflected in a new and dedicated Schedule in a future Agreement , with priority actions and milestones incorporated. The Schedule should include: <ul style="list-style-type: none"> a) Establishing consistent national datasets and minimum standards of access to primary, disability, aged, and hospital services to ensure maintenance of services across rural and remote areas. b) Implementing models of care within the infrastructure and workforce limitations in rural and remote areas. c) Developing a sustainable health workforce in rural and remote areas. d) Reviewing regionality weighting to ensure rural and remote hospitals are funded fairly. e) Ensuring an accountable and equitable distribution of the TTR funding pool to regional and rural hospitals to underpin sustainable health workforce training. 	5.6.1.6 - Ensure accountable and equitable TTR funding to rural hospitals

Theme	Topic	Recommendation	Relevant Report section
	Section 19(2) Exemptions simplified and expanded	<p>37. The process for the application and approval of exemptions from Section 19(2) Health Insurance Act 1973 should be reviewed, simplified and expanded to improve access to bulk-billed primary health care (MBS-eligible GP, nursing and allied health services) in rural and remote areas and where there are thin and failing markets. This work should:</p> <ol style="list-style-type: none"> Explore opportunities to include further sites and increase the number of exemptions for areas without access to primary health services (including thin and failing markets) within a reasonable distance. Simplify and streamline approval processes to enable timely establishment of services in areas where there is limited access to primary care. Ensure that doctors providing rural hospital emergency services are appropriately remunerated and patients who attend the ED are not charged out-of-pocket fees. 	5.6.2 - Expand 19(2) exemption arrangements to improve access to bulk-billed primary health care
Clear commitment to closing the gap for First Nations' people	First Nations' people through Closing the Gap reflected in new Schedule	<p>38. The critical importance of improving the health of First Nations' people through the National Agreement on Closing the Gap should be reflected in a future Agreement as an additional Schedule. The Schedule should reflect at least the following:</p> <ol style="list-style-type: none"> A shared commitment to Closing the Gap, working in partnership with First Nations' people. Specific actions to close the health gap with accountabilities assigned and performance assessed against agreed milestones, including cross-cutting targets. A shared commitment and requirement to work with ACCHOs and local communities in the design and commissioning of services and transitioning of services to community-control. A shared commitment to Cultural Safety in health service delivery with agreed measurement and reporting, including patient experience indicators. A shared commitment to embed appropriate governance of Indigenous data holdings held by all levels of government. 	5.7.3 - Focus of a future Agreement
Embedding workforce and digital health as key enablers of the health system	Role of the health workforce reflected in new Schedule	<p>39. A future Agreement should explicitly recognise the role of the health workforce in the delivery of quality health services as an additional Schedule. The Schedule should:</p> <ol style="list-style-type: none"> Align to relevant national workforce strategies by reflecting the current work being progressed to support, grow, shape, and deliver a health workforce to achieve the goals of the Agreement. Ensure a collaborative Commonwealth and State and Territory focus encompassing a concise set of strategic priorities and actions, including those related to operating at full scope of practice, to be delivered through the Agreement. Consider dedicated national health workforce planning governance oversight (either within the Agreement or as an adjunct to it) along the lines of the previous Health Workforce Australia. This, together with a shared Commonwealth and State and Territory commitment, would provide a vehicle to drive collaborative reform on workforce priorities. Include a commitment to the continued development of the national regulation scheme through the Australian Health Practitioner Regulation Authority (AHPRA). 	5.8.1 - Workforce
	Digital Health reflected in new Schedule	<p>40. A future Agreement should include an explicit commitment to progress digital health as a key enabler to improving the health system, as an additional Schedule. The Schedule should reflect:</p> <ol style="list-style-type: none"> Support and incentivisation for a digitally enabled healthcare system, including integrated funding for evolving models of care. The role of the Australian Digital Health Agency (ADHA) in progressing digital health. The <i>Intergovernmental Agreement (IGA) on National Digital Health 2023-27</i> and <i>Connecting Australian Healthcare - National Healthcare Interoperability Plan 2023-28</i>. 	5.8.2.3 - Shared commitment to progressing digital health and data sharing

Theme	Topic	Recommendation	Relevant Report section
		d) Agreed priorities, roles and responsibilities, and actions to progress digital health, data sharing and data linkage as a foundation to advance effective co-commissioning and optimal models of care.	
Measuring the success of the Agreement	Health System Performance Framework	41. A broadly based health system performance framework incorporating quantitative and qualitative indicators and outcome measures that accurately report against the objectives of the Agreement should be developed as a priority, with clear governance drawing on the expertise of the NHRA national bodies, and with at least annual reporting to Health Ministers on system performance and improvement strategies.	5.9.1 - The need for a health system performance framework
	Framework responsibility with AIHW and new Innovation and Reform Agency	42. The AIHW should be primarily responsible for the development of nationally consistent data standards, data collection and reporting for the health system performance framework, working with jurisdictions and the national bodies, with the new Innovation and Reform Agency to advise Ministers on potential innovation and reform responses to the system implications of reported data.	5.9.1 - The need for a health system performance framework
	Framework accompanied with shared commitment for development and indicators	43. The health system performance framework should be accompanied with a shared commitment to: <ol style="list-style-type: none"> Being developed as an immediate priority, in order to take effect from the start of a new Agreement, with an agreed timeframe to move to nationally consistent measurement and reporting as soon as possible. Include indicators that focus not only on quantitative and qualitative performance of public hospitals, but also on the outcomes that are achieved, the interface with the broader health system such as prevention/health promotion, primary care access, aged care transition, disability support transition, Closing the Gap indicators, rural and remote access, and adequacy and distribution of the health workforce as well as patient experience and reported outcome measures. 	5.9.2 - Elements of a Performance Framework
Learning from COVID-19 and preparing for future events	Future system disruption planning	44. In relation to future system disruptions , a future NHRA should: <ol style="list-style-type: none"> Set out the principles and processes to establish time-limited funding arrangements to respond to short-term national emergencies, the circumstances in which these would be triggered and map the transition back to usual arrangements. These principles, processes and transitions should be informed by coordinated Commonwealth, State and Territory consideration of the experience and lessons of the COVID-19 pandemic including the Independent Inquiry into Australia's Response to the COVID-19 Pandemic. Be informed by the Australian Centre for Disease Control and other related national bodies' advice and guidance regarding public health actions aimed at addressing disruptions to the health care system. 	5.10.1 - Increase flexibility in funding arrangements to enable rapid response to future system disruptions
	Recovery plan for ongoing impacts of COVID-19	45. A recovery plan should be agreed for the remainder of the 2020-25 Addendum to address the ongoing impacts of COVID-19 on workforce availability, cost escalation, increased disease burden and the backlog of delayed care. An option that should be considered is to exempt elective surgery activity (all or part) from the growth cap for the period to the end of the current Agreement, to reduce elective surgery backlogs.	5.10.2 - Support health system recovery from the ongoing impacts of COVID-19

1 About the Mid-Term Review

This chapter details the scope of the Mid-Term Review (Review) based on the Terms of Reference and the methodology for conducting the Review.

1.1 Commissioning of the Review

A Mid-Term Review (Review) of the *Addendum to the National Health Reform Agreement 2020-2025* (the Addendum) was commissioned by Commonwealth, State and Territory Health Ministers to report by December 2023. The Review was required to consider the extent to which the objectives of the Addendum are being met, and whether the Addendum's health funding, planning and governance architecture remains fit-for-purpose, given the shared priorities for better integrated care and more seamless interfaces between the health, disability and aged care sectors.

The Review was asked to consider potential options for future reforms and Agreements, as well as to consider and complement other work between Health Ministers that make it easier for Australians to access healthcare and relieve pressure on public hospitals. This included the unanticipated and ongoing context of the COVID-19 pandemic. The Review has also considered the national governance arrangements referenced in the Addendum that have changed since the Agreement was signed.

1.2 Scope of the Review

The Review is a requirement of Clause 21 of the Preliminaries to the Addendum, which sets out the following seven matters to be considered at the midpoint of the Addendum:

- Implementation of the long-term reforms and other governance and funding arrangements, and whether practice and policy in place delivers on the objectives of the *National Health Reform Agreement* and the Addendum
- The impact of external factors on the demand for hospital services and the flow-on effects on Addendum parameters
- For small rural and small regional hospitals, whether they continue to meet the block funding criteria determined by the Independent Hospital and Aged Care Pricing Authority (IHACPA)
- Whether any unintended consequences such as cost-shifting, perverse incentives or other inefficiencies that impact on patient outcomes have arisen, and the capacity of Parties to adopt and deliver innovative models, as a result of financial or other arrangements in the Addendum
- The performance of the national bodies against their functions, roles and responsibilities
- Arrangements for approval and funding of high-cost therapies offered in public hospitals, as outlined in the Addendum Schedule C (Clauses C11 and C12) and Appendix B
- Any additional matters as agreed by the Health Ministers' Meeting (HMM) or National Cabinet.

HMM also asked the Review to consider any impacts on the above matters from factors arising since the Addendum came into effect, including:

- Policy changes and adjustments to the mechanics of the national funding model
- The COVID-19 pandemic including both the response to the pandemic and its ongoing implications for health services
- The restructure of national governance arrangements as they apply to the operation and oversight of the Addendum
- Reform in the primary care, aged care, disability and mental health systems as they relate to the operation of the Addendum
- Function/role changes of national bodies.

Based on the evidence gathered, the Review was asked to propose options for future reforms and agreements that may better meet the objectives of the Addendum and address emerging issues in the health system, including changes that may be recommended for the national funding model, the roles and responsibilities of national bodies, or for priorities for healthcare reforms.

Further detail on the Review's Terms of Reference (ToR) is at Appendix B.

1.3 Independent Reviewers

The Review was commissioned through the Commonwealth Department of Health and Aged Care, on behalf of the Commonwealth and all State and Territory Health Ministers. The Review was initially co-led by two independent Reviewers (Ms Rosemary Huxtable AO PSM and Mr Michael Walsh PSM) with responsibility for convening the Review process, making final decisions on review approach, conducting the Review and making recommendations. The Reviewers were supported by Deloitte to maintain transparency and independence in conducting consultations, analysing inputs and developing recommendations.

From 24 July 2023, Ms Huxtable became the sole Reviewer as Mr Walsh took up the role of Acting Director-General of Queensland Health. Mr Walsh continued as an advisor to Ms Huxtable on the Review after that date, together with the Chair and Deputy Chairs of the Health Chief Executives Forum (HCEF), Dr David Russell-Weisz PSM, Ms Kathrine Morgan-Wicks and Professor Euan Wallace AM, and the Commonwealth Department of Health and Aged Care Secretary, Mr Blair Comley PSM.

1.4 Review methodology

The Review was conducted over an eight-month period and across 11 key tranches of activities, beginning in February 2023 and concluding at the end of October 2023.

These activities are illustrated in Figure 1 and described further in the sections that follow.

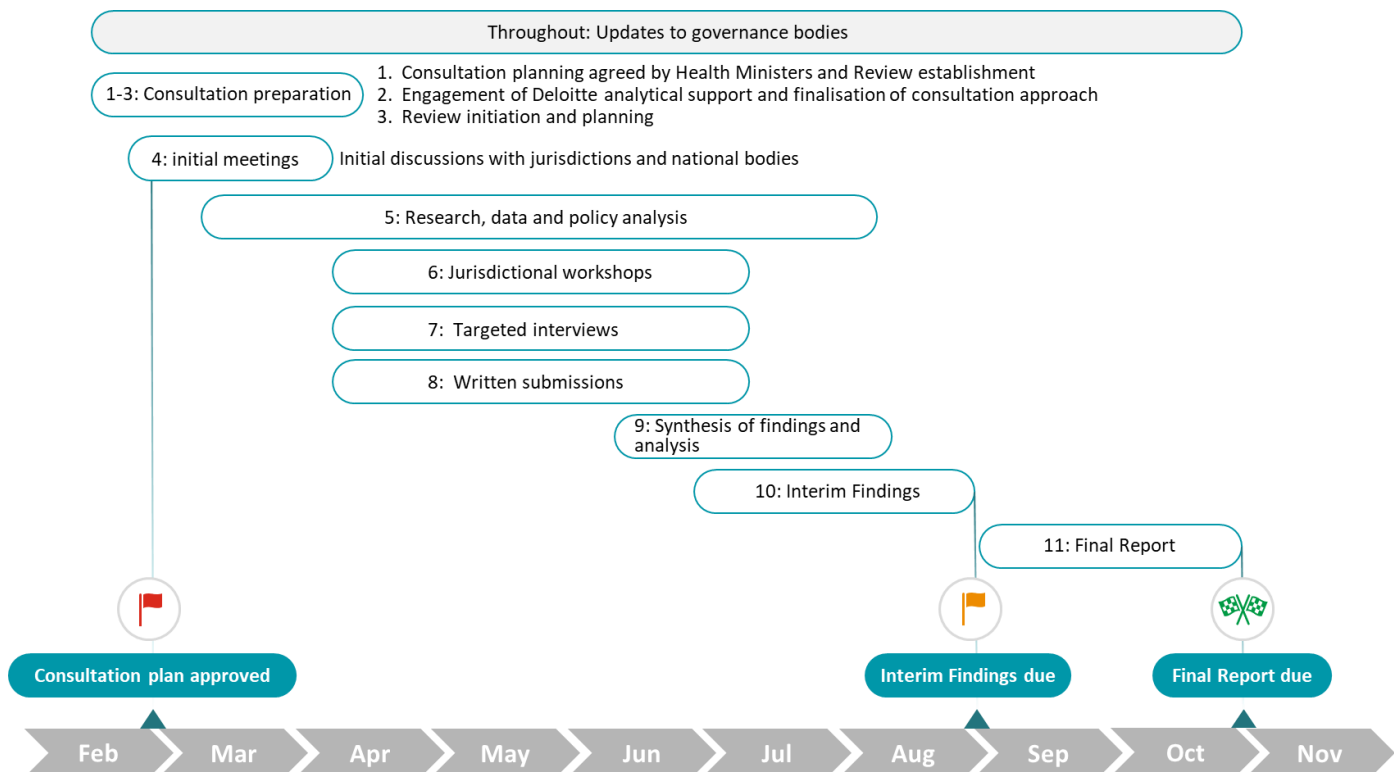


Figure 1: Review timeline

1.4.1 Document review

Relevant documents including the *National Health Reform Agreement* and related Addenda (2017 and 2020), the *National Health Reform Act 2011*, *National Healthcare Agreement 2012*, the *National Partnership Agreement on COVID-19 Response* (COVID-19 NPA), the *National Agreement on Closing the Gap* (Closing the Gap) and other relevant documents, were reviewed to establish an understanding of relevant issues and inform findings. A full list of reference documents is at Appendix C.

1.4.2 Jurisdictional workshops

Two days of workshops with each of the nine jurisdictions were conducted to discuss their perspectives on whether the objectives of the Addendum are being met, any identified improvements, presentation of case studies and relevant data on system challenges and performance, and to help inform future directions.

The structure of the workshops, including the individual workshop sessions and workshop attendees were defined by each jurisdiction to best reflect their areas of interest.

Attendees in these sessions spanned the following:

- Health Ministers
- Health Department Chief Executive Officers (CEOs)
- Health Department senior executive and key staff
- Senior representatives of First Minister, Treasury and Finance Departments
- Health service CEOs
- Peak body and community health organisation CEOs
- CEOs, Presidents, Board chairs and clinical staff from various jurisdictional health organisations
- Primary Health Network (PHN) representatives
- Consumer representatives

- Aboriginal and Torres Strait Islander health organisations.

In total, there were 62 individual jurisdictional workshop sessions conducted across Australia over a three-month period (May to June 2023). Jurisdictional workshop dates are at Appendix D.

1.4.3 Targeted interviews

A targeted process of stakeholder interviews was conducted to obtain perspectives on current challenges and opportunities for the NHRA. 31 organisations participated in virtual or face-to-face interviews with one or both Reviewers and there were multiple engagements with the five national bodies that perform key functions in the NHRA (refer to section 2.4). Those who participated in virtual and face-to-face interviews are listed at Appendix D.

1.4.4 Written submissions

Over 70 organisations were invited to make a written submission to the Review.

65 written submissions were received, both solicited and unsolicited, from a wide range of stakeholders including Commonwealth, State and Territory health departments, government related entities, NHRA national bodies, PHNs, representative stakeholder organisations, consumer organisations, academics and think tanks. A list of organisations that provided submissions is at Appendix E.

1.4.5 Data analysis

An extensive data analysis exercise was undertaken comprising 87 data downloads and 31 data series sourced from seven different data custodians, covering data since the commencement of the NHRA, focused on population health indicators, system performance and NHRA objectives. This established part of the evidence base to support the Review findings and recommendations.

This data analysis was also used to identify key measures in support of the proposed NHRA Interim Quantitative Performance Framework (refer to section 5.9 for further information). The NHRA Interim Quantitative Performance Framework provides a reference point against which to measure whether the intent and principles of the NHRA are being met.

1.4.6 Global input

Deloitte’s global network of international experts in public hospital and health system governance, funding models and operations was accessed to provide perspectives on the current state of health systems in international jurisdictions (United Kingdom, Canada, Denmark and United States).

Specific insights were sought on the different approaches being taken in other countries, relevant to the Review areas, to assess their potential application in the Australian context.

1.4.7 Governance body updates

Progress reports and Review update presentations were provided to relevant governance bodies throughout the course of the Review, including the Reform Implementation Group (RIG)¹, HCEF and HMM.

Review oversight was provided by a sub-group of the RIG as the cross-jurisdictional Review Steering Committee.

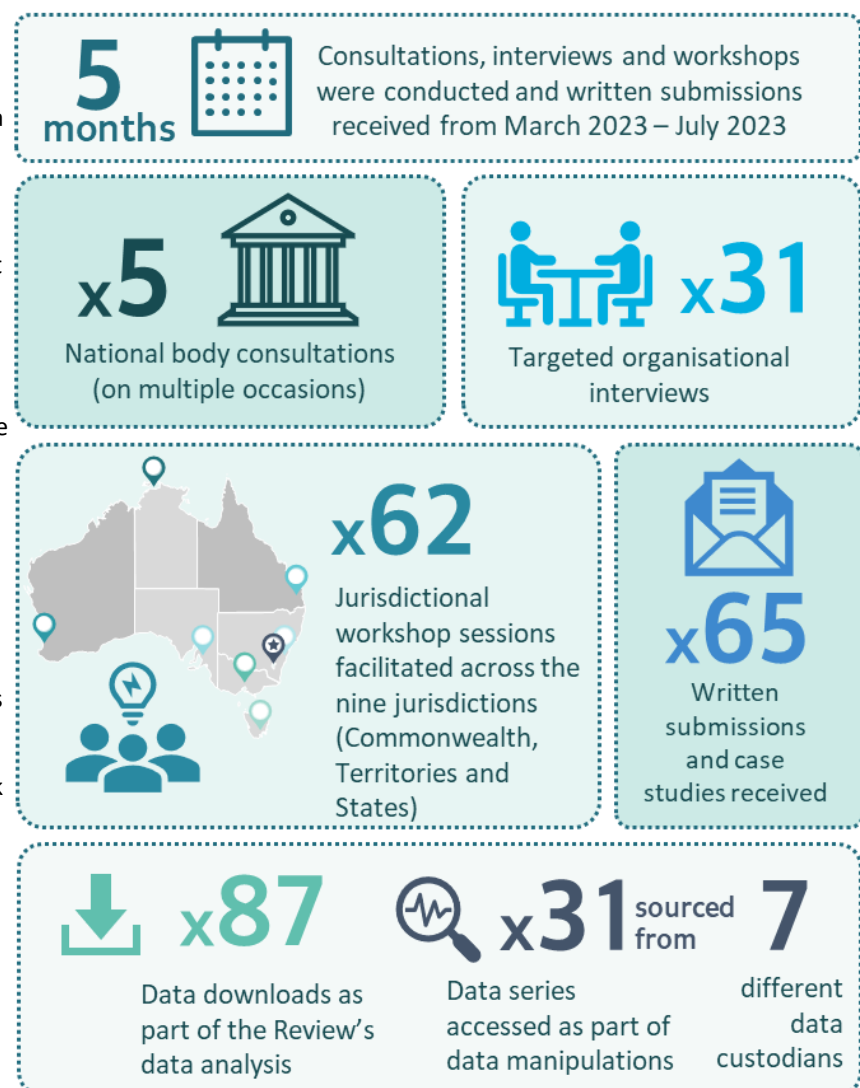


Figure 2: Review methodology infographic

¹ The RIG oversees NHRA reform implementation and reports to the HCEF. RIG members are health department deputies from the Commonwealth and each State and Territory, with responsibility for system performance and strategy.

2 NHRA Addendum context

This chapter provides information about the Addendum and the overarching hospital and healthcare environment in which the Addendum operates.

2.1 About the NHRA and the 2020-2025 Addendum

The NHRA came into effect on 2 August 2011. It is an enduring Agreement, amended from time to time, which aims to establish a unified framework for healthcare. The NHRA builds on, and complements, the policy and reform directions and outcomes, performance measures and outputs outlined in the *National Healthcare Agreement 2012*.

The primary purpose of the NHRA is for the Commonwealth, States and Territories to describe how they will fund public hospitals and cooperate to achieve a sustainable, connected and equitable health system that delivers the best outcomes for Australians.

During 2021-22, \$59.2 billion of Commonwealth, State and Territory funding was administered under the NHRA², with a further \$14.7 billion in Commonwealth funding provided to States and Territories since March 2020 (and generally matched by them on a 50:50 basis) related to the COVID-19 NPA³.

The *NHRA Addendum 2020-2025* makes amendments to the NHRA 2011 for the period 1 July 2020 to 30 June 2025. Prior to this, the *NHRA Addendum 2017* varied the NHRA for the period 1 July 2017 to 30 June 2020.

Key objectives of the 2020-2025 Addendum are described below.

Improve health outcomes and equity of access

- Delivers safe, high-quality care in the right place at the right time, and in turn improves patient outcomes, patient experience and access to services.
- Affirms the Medicare Principles of access to public hospital services free of charge, based on clinical need, within a clinically appropriate period, regardless of geographic location.

Improve efficiency and ensure financial sustainability

- Adjusts the way public hospitals are funded, through a combination of activity-based funding (ABF) and block funding.
- Establishes cost and activity classification systems, and independent annual setting of the National Efficient Price (NEP) and National Efficient Cost (NEC) for hospital activity and transparent funding flows.
- Retains a funding cap to constrain the growth in the Commonwealth’s contribution at an aggregate national level.

Focus on transparency and accountability

- Utilises five independent national bodies to support the funding, performance reporting and safe operation of public hospitals.
- Enables transparency through performance reporting, utilising data sources, benchmarks and performance indicators.



Figure 3: Key objectives of the Addendum

² Administrator National Health Funding Pool. National Health Funding Pool Annual Report, 2022. Available from: https://www.publichospitalfunding.gov.au/sites/default/files/images/documents/nhfp_annual_report_2021-22.pdf, page 35

³ Administrator National Health Funding Pool. Annual Report 2021-22 Maintenance of Effort, 2022. Available from: <https://www.publichospitalfunding.gov.au/publications/annual-report-2021-22-maintenance-effort>

National agreement of individual and shared responsibilities

- Outlines both primary and joint responsibilities for the Commonwealth, States and Territories (refer to section 2.4.1 for detailed stakeholder responsibilities).

Local accountability and responsiveness

- Commits to a decentralised model of delivery for public hospital and health services that supports local accountability and drives improvements in performance through the creation of local hospital networks (LHNs) and PHNs and supports the provision of General Practice (GP) and primary health care services.

Committed to six long-term health reforms (LTRs)

- Prioritises the commitment for the Commonwealth, States and Territories to collaborate on six LTRs, framed around four strategic priorities of financial efficiency and sustainability, safe and high-quality care, prioritising prevention and best practice through data and research. These are:
 - Health technology - a nationally cohesive assessment
 - Paying for value and outcomes
 - Joint planning and funding at a local level
 - Empowering people through health literacy
 - Prevention and wellbeing
 - Enhanced health data.

2.2 Components of the NHRA Addendum

Figure 4 depicts the ten areas presented in the NHRA. The purpose, principles and processes underpinning each are described in separate Addendum Schedules. Further detail on Schedule contents is at Appendix F.

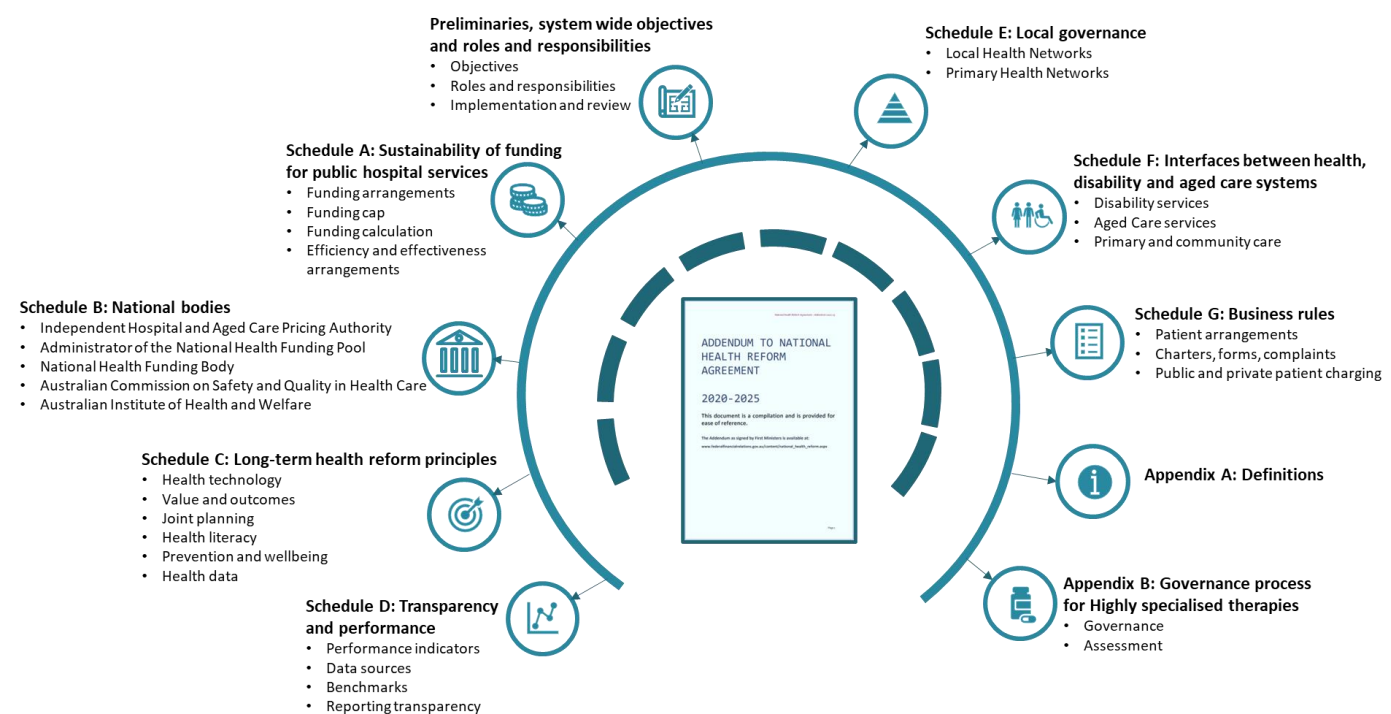


Figure 4: Components of the NHRA Addendum

2.3 NHRA road to date

The NHRA reflected very significant reform at the time of its inception and implementation in 2011.

At its essence, the NHRA, together with the *National Healthcare Agreement*, sought to establish an enduring foundation for the shared commitment of the Commonwealth, States and Territories to improve health outcomes and the sustainability of the health system while putting in place an architecture for health reform and sustainable funding.

The Agreement, and the related *National Health Reform Act 2011*:

- established Agreement architecture
- set out principles, roles and responsibilities
- introduced ABF on a national basis
- established, through legislation, new national bodies and embedded powers in some existing bodies
- designated LHNs and PHNs as local governance and delivery mechanisms within the Agreement



- established a process of performance monitoring and reporting
- anticipated the need for a system view through local commissioning, interface and LTRs.

A fundamental change introduced through the NHRA was to implement ABF as the predominant means of funding public hospital services. The NHRA put in place classification systems, independent pricing mechanisms and transparent funding flows through the (then) Independent Hospital Pricing Authority (IHPA), the Administrator of the National Health Funding Pool (Administrator) and the National Health Funding Body (NHFB). At its inception the Agreement committed to increase the Commonwealth contribution to the funding of public hospital services to 45% of efficient growth from 2014-15 to 2016-17, and to 50% of efficient growth from 2017-18 onwards.

Since 2012, the NHRA has undergone several changes (including through the two Addenda introduced in 2017 and 2020). Some of these relate to funding share, with the Commonwealth extending its commitment to 45% of efficient growth for the period beyond 2016-17, rather than increasing it to 50% of efficient growth. In addition, a 6.5% national funding cap was introduced on the Commonwealth contribution to public hospital services from 2017-18 (discussed further in section 2.5), and a level of safety and quality pricing was introduced.

While the 2020-2025 Addendum reflects much of the structure and content of the earlier Agreement and Addendum, it also introduced new content, particularly focused on:

- new arrangements for assessing and funding high-cost, highly specialised therapies
- changes to financial incentives for the treatment of private patients in public hospitals
- improved collection, sharing and matching of data and performance reporting
- further clarification on the role of the national bodies
- a focus on innovation and LTRs
- stronger reference to aged care, disability and primary care interface issues and equity of access in rural and remote settings
- commitments to Closing the Gap and to improving mental health outcomes.

These changes, and precursor arrangements, are summarised in Figure 5. Further detail regarding the changes introduced as part of the 2020-2025 Addendum is at Appendix F.

	Pre-NHRA	Development of the NHRA	NHRA Addendum 2017	NHRA Addendum 2020-2025
Overview	<ul style="list-style-type: none"> • National Healthcare Specific Purpose Payments (SPP) were used in the form of 'block grants' • Calculated based on historical costs, negotiation and government decisions 	<ul style="list-style-type: none"> • In August 2011, COAG introduced the NHRA as an enduring agreement between the federal government and states/territories • The NHRA established key principles and objectives for healthcare funding, governance and service delivery • Read in conjunction with the National Healthcare Agreement 2012 	<ul style="list-style-type: none"> • Focused on reducing unnecessary hospitalisations and improving patient safety and service quality • Aimed to strengthen the accountability and governance arrangements with changes to governance framework, reporting and performance indicators • Focused on improving the efficiency and sustainability of healthcare funding with: <ul style="list-style-type: none"> – modifications to the funding formula – streamlining of funding arrangements • Increased emphasis on patient outcomes, with introduction of additional reforms 	<ul style="list-style-type: none"> • Focused on advancing six long term reforms: <ul style="list-style-type: none"> ○ Looked to trial, evaluate and scale new models of care ○ Improve health data and streamline health technology assessment ○ Focus on prevention and improved local level planning • Shared aspirations to improve the interface between sectors • Improved compliance and data matching
Governance changes	<p>1987</p> <ul style="list-style-type: none"> • Australian Institute of Health and Welfare (AIHW) established under <i>Australian Institute of Health and Welfare Act 1987</i> <p>2006</p> <ul style="list-style-type: none"> • Australian Commission on Safety and Quality in Health Care (ACSQHC) first established by Council of Australian Governments (COAG) - within the Department of Health and Ageing (as agreed by Health Ministers) 	<p>2011 (in NHRA)</p> <ul style="list-style-type: none"> • ACSQHC – commenced as independent statutory authority • IHPA established as independent government agency (now IHACPA) • National Health Performance Authority (NHPA) established for performance reporting • AIHW play a supportive role to NHPA • Administrator and NHFB established to improve transparency of public hospital funding arrangements <p>2015</p> <ul style="list-style-type: none"> • Medicare Locals ceased and PHNs established in their place 	<p>2016</p> <ul style="list-style-type: none"> • NHPA ceased operations with performance reporting function transferred to the AIHW • IHPA governance structure adjusted. Performance indicators updated <p>2017 (in Addendum)</p> <ul style="list-style-type: none"> • Administrator role to incorporate changes to funding formula e.g., funding cap • States/Territories need to provide IHPA with a Statement of Assurance • National bodies responsibilities adjusted to reflect 2016 changes 	<p>2020 (in Addendum)</p> <ul style="list-style-type: none"> • Reaffirms role of Administrator and the NHFB, adding Administrator responsibility for monitoring maintenance of effort <p>2020</p> <ul style="list-style-type: none"> • COAG replaced by the National Cabinet • COAG Health Council (CHC) replaced with HMM • Australian Health Ministers Advisory Committee (AHMAC) replaced with HCEF • HCEF established a RIG <p>2021</p> <ul style="list-style-type: none"> • NHRA Long Term Reforms Roadmap endorsed by all Australian Health Ministers <p>2022</p> <ul style="list-style-type: none"> • IHPA became the IHACPA as its role expanded to include the provision of costing and pricing advice on aged care
Impacts	<ul style="list-style-type: none"> • Limited transparency in how the SPPs were used 	<ul style="list-style-type: none"> • ABF replaced majority of block grants • Independent national bodies were established to improve transparency and accountability • PHNs replaced Medicare Locals to improve patient care and efficiency and effectiveness of health care 	<ul style="list-style-type: none"> • Increasing requirements/processes, independent national body changes and updated performance indicators improved transparency and accountability • Funding changes made to improve equity and transparency of funding distribution, reinforcing ABF approach 	<ul style="list-style-type: none"> • Additional responsibilities added to help all Parties work towards consistency and transparency of reporting • RIG established to lead the implementation of NHRA, with endorsement of Roadmap creating a push for implementing the reforms

Figure 5: NHRA timeline

2.4 NHRA governance

Improved governance and transparency are at the heart of the NHRA through the establishment and evolution of national governance bodies and local governance arrangements.

The NHRA, through the *National Health Reform Act 2011*, established four national bodies to facilitate the funding of public hospitals using a combination of ABF and block funding to lead and coordinate improvements to safety and quality of health services, and collect and report on health and hospital performance. The fifth national body, the Australian Institute of Health and Welfare (AIHW), is established and has its functions determined by the *Australian Institute of Health and Welfare Act 1987*. Working together, these five bodies support the funding, safe operation and reporting of public hospitals, with each having the responsibilities identified in Figure 6.



Figure 6: NHRA national bodies

While there have been changes to the national bodies and their overarching governance through the course of the Agreement, the fundamental principle of dedicated national entities with clear roles and responsibilities, together with a network of LHNs and PHNs to improve local accountability and responsiveness is largely unchanged.

In 2020, the Council of Australian Governments (COAG) and associated sub-Committees were replaced by National Cabinet.

The NHRA governance bodies and the major changes that have occurred since the inception of the NHRA are shown in Figure 7.

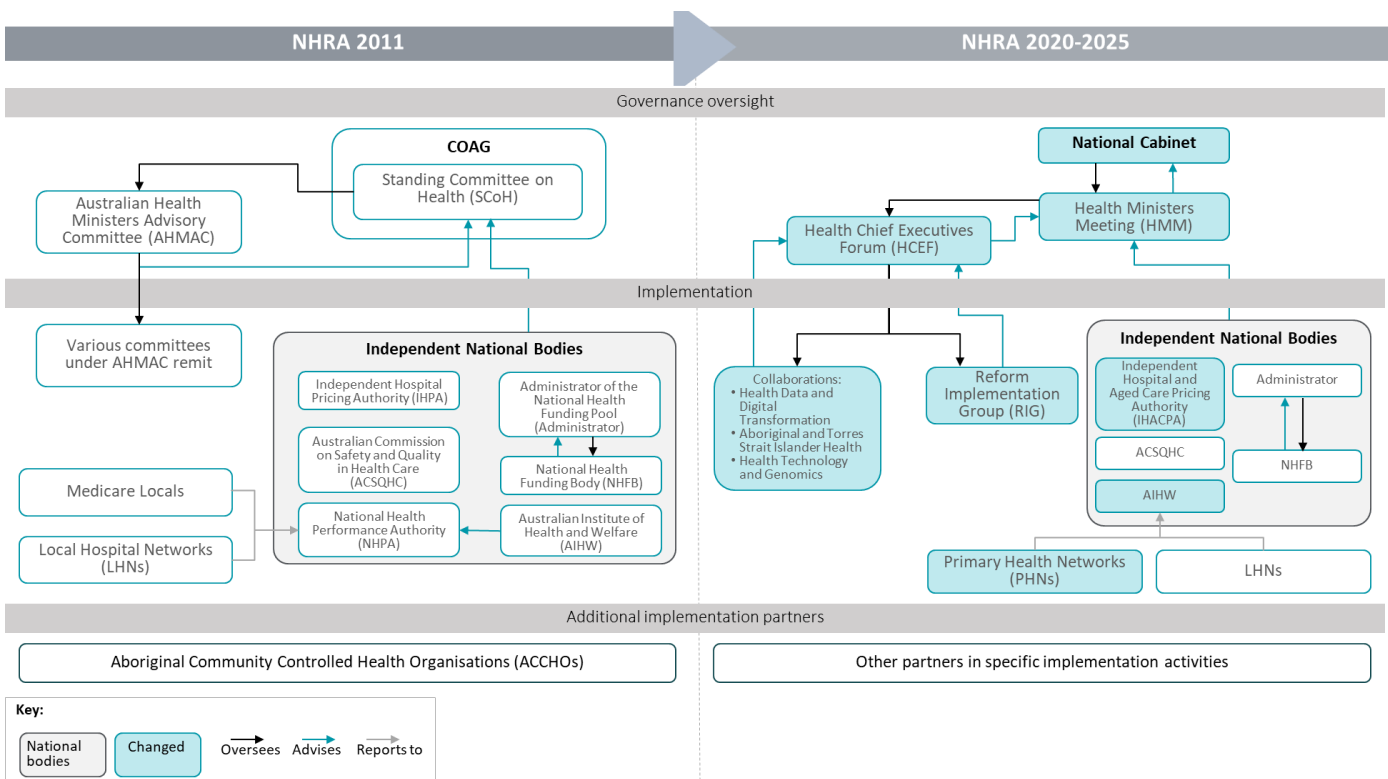


Figure 7: NHRA governance body changes since the inception

2.4.1 Commonwealth, State and Territory responsibilities

The NHRA describes areas of primary and joint responsibility for the Commonwealth, States and Territories, seeking to clearly delineate respective roles and identify shared commitments:

The Commonwealth is responsible for:

- Maintaining the legislation and other arrangements to support the operation of the independent National Bodies
- Policy and funding of GP and primary healthcare services
- Policy and funding of PHNs
- Policy and funding of the Aged Care sector
- Operation of the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS).

States and Territories are responsible for:

- Providing health and emergency services through the public hospital system
- Maintaining the legislation and governance arrangements for LHNs
- System-wide public hospital service planning and performance
- Planning, funding and delivering public hospital capital
- Taking a lead role in managing public health activities

The Commonwealth, States and Territories are jointly responsible for:

- Funding public hospital services using ABF, where appropriate, and block funding in other cases
- Funding activity and cost growth in public hospital services
- Establishing, maintaining and reporting on nationally consistent care standards in healthcare
- Determining funding policy and exploring innovative models of care in the national funding model
- Working to close the gap in First Nations' people disadvantage and life expectancy.

2.5 NHRA funding types

In 2021-22, \$59.2 billion of Commonwealth, State and Territory funding was administered under the NHRA.⁴

Around a sixth of Commonwealth Government expenses occur in Health, including payments to the States and Territories to deliver essential health services (including public hospitals), and expenses relating to medical services that are funded through the MBS and PBS (total 2023-24 estimate of \$106.5b).⁵

The NHRA includes the following funding types⁶:

- **Activity Based Funding** (\$50.0b funding in 2021-22): Hospitals are paid based on the number and complexity of treated patients, underpinned by the NEP, covering:
 - Acute admitted
 - Non-admitted
 - Admitted mental health services
 - Sub-acute and non-acute services
 - Emergency department (ED) services
- **Block Funding** (\$8.7b funding in 2021-22): For services not suitable for ABF, mainly for smaller hospitals or for services where pricing and funding based on activity is not yet undertaken, underpinned by the NEC, covering:
 - Teaching, training and research
 - Small rural hospitals
 - Non-admitted mental health and non-admitted Child and Adolescent Mental Health Services
 - Other non-admitted services (e.g., chronic disease management, home ventilation)
 - Highly specialised therapies
- **Other Funding Types** (\$0.5b in 2021-22):
 - Public Health Funding
 - Cross Border Funding
 - Interest
 - Over Deposit.

The NEP and NEC are major determinants of the level of Commonwealth Government funding for public hospital services and provide a price signal or benchmark for the efficient cost of providing public hospital services. Commonwealth funding is

⁴ Administrator National Health Funding Pool. National Health Funding Pool Annual Report, 2022. Available from: https://www.publichospitalfunding.gov.au/sites/default/files/images/documents/nhfp_annual_report_2021-22.pdf, page 35

⁵ Australian Commonwealth Government. Budget Strategy and Outlook, Budget Paper No. 1, 2023. Available from: https://budget.gov.au/content/bp1/download/bp1_2023-24_230727.pdf, page 201 and 210

⁶ Administrator National Health Funding Pool. Public Hospital Funding, Funding Types. Available from: <https://www.publichospitalfunding.gov.au/public-hospital-funding/funding-types>

calculated using the Commonwealth Contribution Model (CCM). The NEP, NEC and public hospital activity estimated from States and Territories are key inputs to this model, which is independently reviewed each year.

Under the NHRA, the Commonwealth has committed to provide base funding plus 45% of the annual national efficient growth up to a national funding cap of 6.5% growth. National efficient growth includes activity, price and cost increases. The funding cap, introduced to the funding formula in the 2017 Addendum, where the growth in annual Commonwealth NHR funding will not exceed 6.5% a year, includes the National Funding Cap and a State and Territory based soft Cap.⁷

Other factors that underpin the funding formula include reconciliation of actual hospital activity provided by States and Territories, Funding Integrity (data matching program), Safety and Quality Adjustment, and Data Conditional Payment.

2.6 NHRA funding flows

NHRA funding mechanisms seek to promote accountability, transparency with consistency in funding, independent oversight and collaboration between the Commonwealth and State and Territory governments. The NHRA funding flow and mechanisms have remained consistent, reaffirmed in each Addendum. The implementation of the National Health Funding Pool (Pool) and State Managed Fund (SMF) for each State and Territory provide a line-of-sight to track each jurisdiction’s contribution to LHNs and third parties.

There are two main funding mechanisms:

- **National Health Funding Pool (Pool)**, which comprises:
 - Commonwealth funding (ABF and Block)
 - State and Territory funding (ABF only)
 - Other funding types contributing to the Pool including Public Health funding, cross border, Interest and over deposits.
- **State Managed Fund (SMF)**, which comprises:
 - Each State and Territory has a SMF to manage Block funding (from both the Commonwealth, and State or Territory).

In 2021-22, \$59.2 billion of Commonwealth, State and Territory funding was administered under the NHRA.⁷

The NHRA allows for additional streams of funding to be paid through the Pool if agreed by governments (e.g., response to COVID-19). Pool accounts are audited each year and have transparent accounting and reporting.

Monthly reports on funding and payments are published on www.publichospitalfunding.gov.au.

National funding and payment flows by type for 2021-22⁸ are illustrated in Figure 8.

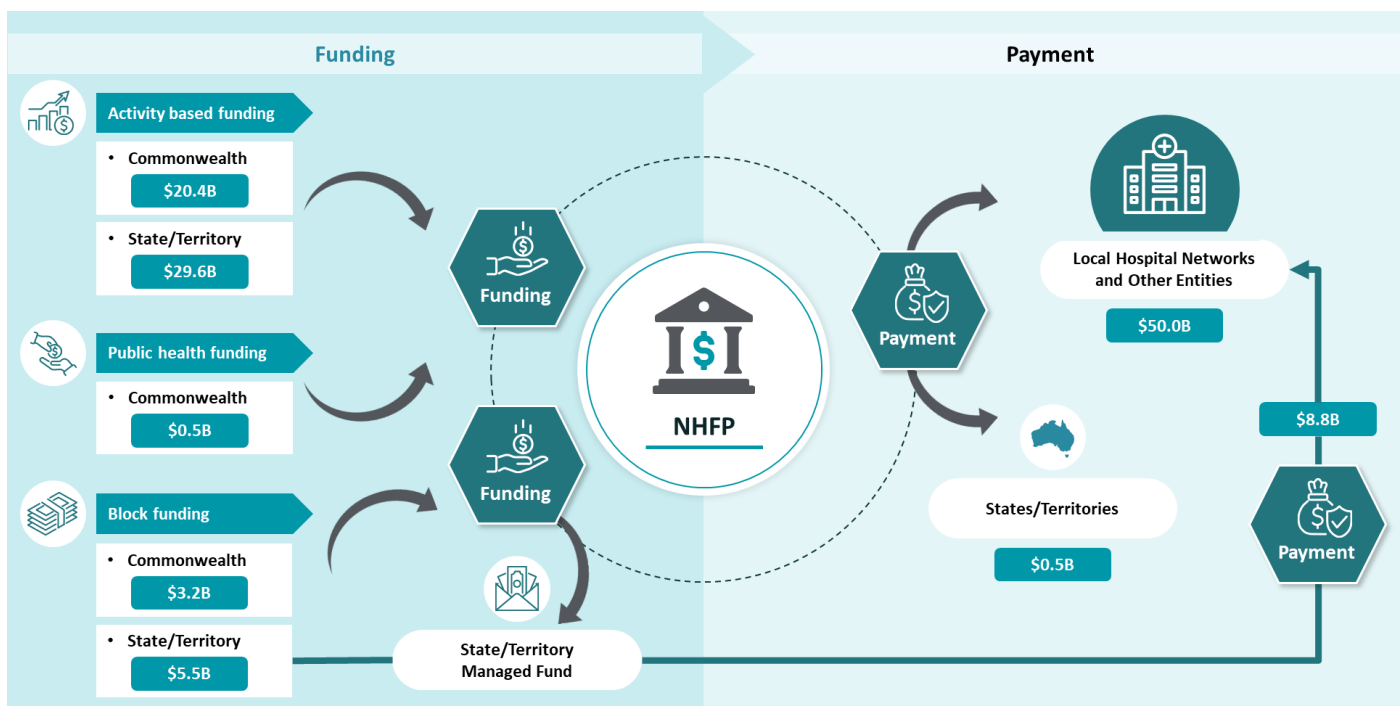


Figure 8: NHRA funding and payment flows

⁷ Administrator National Health Funding Pool. Public Hospital Funding, Funding Formula. Available from: <https://www.publichospitalfunding.gov.au/public-hospital-funding/funding-formula>

⁸ Administrator National Health Funding Pool. National Health Funding Pool Annual Report 2021-22, 2022. Available from: https://www.publichospitalfunding.gov.au/sites/default/files/images/documents/nhfp_annual_report_2021-22.pdf, pages 24 and 35

2.7 Reinforcing and building on existing priority work

In recent years there have been dynamic changes to broader political and governance settings, health delivery and policy environments, in part related to COVID-19 as well as the impact of other program reforms. These reforms have occurred, and continue to occur, in and around the NHRA at Commonwealth, State and Territory levels, with constant attention (reactive and proactive) for reform and improvement.

Some of these related priority areas include:

- National Disability Insurance Scheme (NDIS) – substantial and growing investment in providing reasonable and necessary support to people with disability, in turn creating competition for the care workforce and markets and interface risk. The NDIS Reform Review is examining two key areas: NDIS’ design, operations and sustainability; and ways to build a more responsive, supportive and sustainable market and workforce. Recommendations are due in October 2023.
- Changes to aged care funding and structures flowing from the Royal Commission on Aged Care Quality and Safety and related Commonwealth budget decisions. The Royal Commission’s recommendations included minimum staff time standards, a change in governance, and creating a more experienced aged care workforce, enhancing working conditions and career growth opportunities.
- Investment in primary care through bulk billing incentives, voluntary enrolment, aged care incentives and scope of practice changes. The Strengthening Medicare Taskforce has recommended significant changes to how primary care is funded and delivered.
- Agreements that sit outside the NHRA, but enable or complement NHRA objectives – digital health, mental health, workforce, and shared commitments such as Closing the Gap. The Australian Digital Health Agency (ADHA) is the primary agency for national digital health in Australia with a direct responsibility to act collaboratively with the Commonwealth and States and Territories for the delivery of national digital health services. The Health Workforce Taskforce was established to develop options to address the workforce shortages and distribution issues across specialisations and geographical location.
- Development of models of care that aim to fill gaps in the current service system. For example, single employer model, hospital in the home, and virtual care that aim to provide care in the community or in residential aged care. Attempts at inter-sectoral reform have tended to be piecemeal, as well as time and scale limited. Translating these to systemic sustainable reform is a key challenge of a future Agreement.

While not exhaustive, some of these reforms are summarised in Figure 9.

SECTORS	PRIMARY CARE	AGED CARE	DISABILITY SUPPORT	PUBLIC HOSPITALS	ENABLERS
CURRENT REFORMS (SAMPLE)	<ul style="list-style-type: none"> • Strengthening Medicare • MBS & PBS reviews 	<ul style="list-style-type: none"> • Aged Care Royal Commission recommendations 	<ul style="list-style-type: none"> • NDIS rollout • NDIS Reform Review • Disability Royal Commission recommendations 	<ul style="list-style-type: none"> • 2011 National Health Reform Agreement • 2012 National Healthcare Agreement • 2020 – 2025 NHRA Addendum • NHRA Addendum Mid-Term Review 	<ul style="list-style-type: none"> • Australian Digital Health Agency (ADHA) Initiatives • Health Workforce Taskforce • Productivity Inquiry Report (2023) - Productivity Commission
EXAMPLES OF LOCAL STATE AND TERRITORY INITIATIVES (SAMPLE)	<ul style="list-style-type: none"> • Aboriginal Health Practitioner led Primary Health Care Model (NT) • Rural Generalist telehealth support (NT) • Primary Care Outreach Clinic (ACT) • Integrated diabetes management programs (VIC, NSW) • Single Employer Model (Various) • Urgent Care Centres (Various) 	<ul style="list-style-type: none"> • Older Person’s Oncology Clinic (ACT) • From Hospital to Home (WA) • Real time bed availability portal (WA) • ACCHO-led Transition Care Programs (WA) • Multi-Purpose Services (TAS) • Residential Aged Care District Assessment and Referral Service (RADAR) Rapid Response (QLD) 	<ul style="list-style-type: none"> • Long Stay Patient Fund (WA) • Long Stay Rapid Response (QLD) 	<ul style="list-style-type: none"> • COVID@homeplus (TAS) • HealthPathways (NSW) • The HOPE platform (NSW) • In-reach services into Residential Aged Care Facilities (RACFs) (Various) • Palliative care in the home (Various) • Virtual Emergency Service (Various) • Regional Virtual Service (Various) 	<ul style="list-style-type: none"> • Queensland Ambulance Service (QAS) - Paramedic lead fever clinics; Paramedic Immunisers; Virtual Care Services; and Prison and Watch House Support • Single Employer Model for GP trainees in regional areas

Figure 9: Current reforms within health and care sectors (sample)

2.8 Operation of the Agreement during the COVID-19 pandemic

The NHRA continued to operate during the COVID-19 pandemic. However, due to changes in hospital activity related to the pandemic and COVID-19 response costs, it was supplemented with new arrangements⁹:

- The COVID-19 NPA (\$14.7 billion¹⁰) provided States and Territories with additional funding to respond to the COVID-19 outbreak, generally matched on a 50:50 basis, and
- A Commonwealth Minimum Funding Guarantee (separate to the Addendum) for 2019-20, 2020-21 and 2021-22 totalling \$1.23 billion recognised the impact of the COVID-19 outbreak on public hospital activity.

The COVID-19 NPA was amended several times and ended in December 2022. In summary it comprised:

- A one-off upfront payment of \$100 million by the Commonwealth to the States and Territories, shared on a population basis
- A commitment to equal (50:50) funding of COVID-19 public hospital services and other COVID-19 public health activities delivered by the States and Territories
- A Commonwealth payment to States and Territories to ensure the viability of private hospitals
- Commonwealth funding support for the roll-out of the COVID-19 vaccination program by States and Territories.

⁹ Administrator National Health Funding Pool. Annual Report 2021-22 Maintenance of Effort, 2022. Available from: <https://www.publichospitalfunding.gov.au/publications/annual-report-2021-22-maintenance-effort>

¹⁰ Estimated – final funding subject to reconciliation.

3 Consultation outcomes

This chapter provides insights from the jurisdictional workshops, interviews and written submissions.

A key requirement of the Review was a comprehensive stakeholder consultation process – encompassing two-days of workshops within each jurisdiction, targeted virtual or face-to-face interviews with key organisations and written submissions from stakeholders. This wide-ranging process gathered stakeholder perspectives on whether the objectives of the NHRA Addendum are being met, current challenges, any identified improvements or opportunities, presentation of case studies, data on system challenges and performance, and potential future directions.

The areas of improvement identified through consultation group into 10 themes as listed below and illustrated in Figure 10.

1. Whole of system Agreement

Establishing the NHRA as a strategic reform Agreement, with the remit and governance to take a whole of health system view and to respond to current and future system pressures, rather than as a hospital financing agreement that is narrow and technical in focus.

2. Intersectoral collaboration

Delivering integrated, coordinated and responsive patient-centred care that reduces fragmented patient care pathways, suboptimal patient experiences and outcomes, and bottlenecks in hospital flows.

3. Optimal blended models of care

Providing sustainable, innovative and scalable public hospital funding and holistic, blended models of care that can deliver the right care in the right place at the right time.

4. Financing reform

Ensuring a transparent and accountable funding model that generates the right incentives and is fit for purpose for future challenges.

5. Long-term health reforms

Building innovation and options for future reform and associated governance.

6. Rural and remote service delivery

Ensuring equitable access to healthcare that meets rural and remote community needs and service delivery.

7. First Nations' people

Strengthening and addressing culturally responsive support, access and equity of services provided to First Nations' people within the health system.

8. Workforce and digital health

Enabling and incentivising a sufficient and skilled health professional workforce (including relevant strategies), providing digital health services, and accessing comprehensive health information about patients across the health sector at the point of care.

9. Measuring success

Embedding a performance framework as a proactive monitoring and planning tool to measure the performance of the health system, understand future pressures, and the capacity of the system to respond to these pressures.

10. COVID-19

Providing flexibility in the Agreement to respond to large external shocks and major disruptions to the system, such as COVID-19.

Consultation outcomes are mapped to these 10 themes in sections 3.1 to 3.10, covering a summary of what was heard in consultations, specific key issues raised, strengths and case studies where relevant.



Figure 10: Consistent themes identified in the Review

3.1 Whole of system Agreement



Summary of what we heard:



Stakeholders generally considered that the NHRA did not operate as a health reform agreement, but as a technical hospital financing agreement. While its objectives and schedules aspired to a broadly based approach to engagement and reform, this did not happen in practice. There was no place where a holistic health system view could be taken, including to identify and respond to current and future system pressures, or to incorporate the views and responsibilities of different sectors and players.

The objectives and goals of the NHRA tended to operate in isolation from other bilateral agreements that interact with, or are related to it, for example those seeking to address access to health care for high priority groups such as mental health or First Nations people. In a similar vein, some of the key Agreement enablers (digital health and workforce) are not widely referenced.

It was apparent from stakeholder comments that, while the national bodies had performed essential functions in implementing elements of the Agreement, there was a mixed understanding of their role and functions and, in some instances, momentum had been lost when functions transferred and the level of national governance reduced, particularly following changes to COAG arrangements. There was a tension expressed between the independence of the key national bodies and a desire from jurisdictions for greater responsiveness in addressing technical issues and immediate pressures.

Reform aspirations are clear throughout the Addendum. Stakeholders noted that, while there are pockets of innovation, they have not been systemic and are stifled by lack of dedicated funding and bureaucratic process. There has been insufficient use of the data and expertise held by the national bodies in mapping out reform opportunities and solutions.

3.1.1 Identified issues

The key issues identified by stakeholders as part of this theme were:

- The NHRA was seen as operating narrowly as a hospital financing agreement, driving a focus on technical efficiency and at times preventing progress towards the shared objective of delivering safe, quality care in the right place.
- The NHRA does not operate in partnership with broader system stakeholders, including consumers and there are no channels for consumers and consumer organisations to raise issues.
- The NHRA principles and objectives aim to provide a pathway to improve the interface between sectors, however progress has tended to be fragmented, uncoordinated and supported by limited additional funding to support new models of care. Stakeholders indicated the NHRA often lacks sufficient detail, or the wording is too ambiguous, with few processes or measures to assess if the Agreement is delivering on the NHRA intent.
- Considering the ongoing implications of COVID-19, changes to national governance and new priorities, a holistic approach to the management of the health system was needed, recognising the interplay between different parts of the care continuum and between healthcare and adjacent sectors such as primary care, aged care and disability.
- The objectives and goals of the NHRA tend to be considered in isolation from other bilateral agreements that interact with, or are related to, the NHRA. While its objectives and schedules aspired to a broadly based approach to engagement and reform, this does not happen in practice. Particular examples cited in consultations included the *National Agreement on Closing the Gap*, the *National Mental Health and Suicide Prevention Agreement*, the *National Preventive Health Strategy* and health workforce initiatives.
- Stakeholder understanding of the roles, functions and performance of national bodies varied. In some instances, national bodies were perceived as having lost momentum or there was confusion about lines of responsibility, notably with the dissolution of some bodies e.g., those related to COAG.
- There was a perceived tension between the independent nature of the key pricing and funding national bodies and the development of shared goals and actions. Stakeholders indicated a desire for increased responsiveness to individual jurisdictional concerns, and to foster more effective and collaborative decision-making.
- Some stakeholders commented that the Addendum does not hold parties accountable when they fail to implement their elements of the Agreement. A stronger mechanism to drive greater accountability for all governments was seen as required.
- Limited progress was identified in implementing the Agreement's LTR agenda due to insufficient coordination between the Commonwealth, States, Territories and national bodies. Stronger incentives, additional resources and oversight at a national level to drive action and improve outcomes was seen as necessary (see Observation: Reform Implementation Group).

3.1.2 Strengths

Some of the strengths identified by stakeholders include:

- The Agreement has brought improved technical efficiency and greater transparency to the flow of Commonwealth, State and Territory monies to LHNs and the relationship of those monies to activity, enabled through regular reporting and the operation of the national bodies independently of government.
- There is shared commitment across jurisdictional health authorities towards the NHRA's objectives and LTRs, focused on a health system that is more patient-centric, outcomes focused and financially sustainable. The shared commitment brings a platform of national dialogue for health operations, collaboration between jurisdictions and a greater level of consistency in data collection and reporting.



Observation: Reform Implementation Group (RIG)

RIG was established under the HCEF to lead implementation of the NHRA including the LTRs. However, without dedicated and additional resourcing to drive implementation, RIG members have had to progress this work alongside their usual and demanding roles as senior health executives. While support for some of the LTR work has been sought and provided through other national processes (e.g., via the HCEF cost shared budget), the activities required to implement the LTRs are insufficiently resourced and progress has been slow.

3.2 Intersectoral collaboration



Summary of what we heard:



Stakeholders considered that the NHRA fell short in encouraging intersectoral collaboration and enabling integrated patient-centred care. While all jurisdictions are making progress within their respective sectors, insufficient collaboration between sectors and tension around roles and responsibilities, has led to fragmented patient care pathways, suboptimal patient experiences and outcomes, and bottlenecks in hospital flows. A particular area of concern was the number of disability and aged care patients who remain in public hospitals after their clinical episode is complete, contributing to hospital access block.

Recognising the pressing need for a more cohesive approach, stakeholders are actively advocating for enhanced intersectoral coordination and cooperation to address these challenges and create a more seamless healthcare system that prioritises the needs and well-being of patients throughout their healthcare journey. There was particular concern that, when primary care struggles to meet demand, avoidable hospital presentations result, that this is neither cost nor clinically effective and that States and Territories need to step in as providers of last resort.

While the architecture for integrated and locally responsive services is in the Agreement, through the requirements on LHNs and PHNs, the track record of delivery at the local level has been patchy, in part due to a lack of flexible funding and an imbalance in the power and influence of the two sectors.

3.2.1 Identified issues

The key issues identified by stakeholders as part of this theme were:

- There is insufficient cross-portfolio and cross-government collaboration to address system interface issues. There is a risk of poor patient experience and outcomes, as well as cost shifting between systems, in the absence of a shared understanding and contribution to responsibilities at the interface and how transitions are managed.
- Current funding mechanisms and the delineation of roles and responsibilities, particularly between hospital care, and aged, disability and primary care discourage a continuum of healthcare service delivery across multiple settings, which hinders the capacity to deliver the right care in the right place at the right time, detracting from allocative efficiency and patient experience. There are deficiencies in referral networks, patient transfer and transition support to and from the aged care and disability sectors that impact on patient outcomes.
- Insufficient step-down care and service constraints to meet the demand from NDIS participants and elderly people in hospital who require community or residential aged care, lead to longer hospital stays despite patients having completed their clinical episode and being ready for discharge, which results in poorer health outcomes and access blockages (see Observation: hospital discharge barriers).
- The current architecture lacks support for joint commissioning, collaboration and planning between PHN/LHNs, hindering the development of locally responsive person-centred services and resulting in duplication. There is too little involvement of Aboriginal Community Controlled Health Organisations (ACCHOs) in local planning.
- Identifying needs at the local level and jointly commissioning services between PHNs and LHNs is patchy. PHNs do not have access to sufficient flexible funding to enable them to respond to local needs and, in some cases, the relationship between LHNs and PHNs is more competitive than collaborative, contrary to the expectations of the Agreement.
- Equitable access to primary care is constrained by available workforce, care models and service affordability, especially in areas where there are thin markets, which puts demand on hospital activity, affects patient outcomes and shifts a service delivery burden to States and Territories as providers of last resort.
- Inadequate data systems and data sharing and linking processes fail to provide comprehensive patient journey data that can support a cohesive and integrated health system.

3.2.2 Strengths

Some of the strengths identified by stakeholders include:

- There are examples where PHNs have had success in localised joint planning and program design working closely with jurisdictions, LHNs and local stakeholders to drive positive health outcomes (e.g., Joint Mental Health System Planning and Redesign in Tasmania, Collaborative Commissioning between the Western Sydney LHN and PHN).
- The collaborative and proactive approach taken in recent months for NDIS participants in public hospitals experiencing discharge delay from hospital was acknowledged nationwide as a positive step that is supporting NDIS participants to transition back to their usual place of care.
- The Lumos program (a collaboration with New South Wales Health and PHNs) was viewed as a key enabler of integrated care by providing a more comprehensive view of the patient journey across different care settings.



Observation: Hospital discharge barriers

Issues of thin markets affecting access to providers, availability of suitable accommodation and response timeliness nationwide have resulted in older patients and NDIS participants remaining in acute care beds when clinically ready for discharge. This unnecessary extended length of stay can cause poorer patient outcomes and experiences, while limiting the availability of beds for those who clinically require them. Anecdotal evidence presented to the Review stated that around 4%-5% of beds nationwide are filled by older patients clinically ready for discharge, with up to 25% of ED accessible beds impacted in some regions.

As of 31 May 2023, a total of 1,331 NDIS participants were medically ready for discharge, with an average wait time of 26 days to discharge. *Report on Government Services 2023* data indicated there were a total of over 286,000 hospital patient days across Australia for those eligible and waiting for residential aged care in 2020-21 (with anecdotal evidence this has grown substantially since). This equated to 9.2 hospital patient days per 1000 patient days. When assessing this figure based on remoteness there was a significant variation compared to major cities (7 hospital patient days per 1000 patient days) and those in regional and remote settings (for example, 47.6 hospital patient days per 1000 patient days for the remote setting).

3.3 Optimal blended models of care



Summary of what we heard:



A widespread view expressed in consultations is that NHRA funding with its focus on activity drives care to the inpatient setting when, increasingly, the health needs of the population (ageing and increase in chronic and complex conditions) require integrated care that is multidisciplinary and supports transitions between sectors. The capacity to develop these blended models and implement them in a systematic and scalable way is not seen as enabled by the NHRA nor is there sufficient differentiation between low and high value care. While the NHRA references the exploration and trial of innovative models of care, progress has been slow, impacted both by COVID-19 and a lack of ongoing funding support.

3.3.1 Identified issues

The key issues identified by stakeholders as part of this theme were:

- The NHRA funding model with its focus on activity drives care towards inpatient settings and does not enable integrated care that is multidisciplinary and coordinated across various care settings. This includes hospital, primary and community care, and aged care where an integrated approach to care is needed, particularly for the management of patients with chronic and complex conditions and for system efficiency.
- Alternative blended funding arrangements, such as bundled payments that bring together the in-hospital and out of hospital elements of an episode of care, have not been developed under the current Addendum, nor has there been systemic progress on identifying and intervening in high-risk populations to avoid expensive hospital admissions.
- The NHRA does not fund patient services that are funded, in any part, through another benefit program to avoid duplicate funding. However, with the increasing complexity and interconnectedness in the delivery of health care services, there is a wider issue as to whether funding arrangements are keeping up with cross-sector clinical practice and technology.
- The ABF model can financially penalise innovation by not applying the Commonwealth funding contribution to new models of care that are deemed out-of-scope even if they have the effect of reducing in-scope activity. While there have been initiatives using technology to provide virtual care these are not always supported through the NHRA, creating the need for workarounds or unnecessary hospital admissions.



Case study: Virtual Care – Remote Patient Monitoring Program

New South Wales Health identified that residents of regional New South Wales have poorer health outcomes and face significant challenges in accessing health and hospital services compared to people living in metropolitan areas. Diabetes was identified as a major risk factor to hospitalisation and death. To address this, New South Wales Health are piloting a Virtual Care – Remote Patient Monitoring (VC-RPM) Program, focusing on patients with type 2 diabetes, type 2 diabetes with chronic heart failure, and chronic obstructive pulmonary disease (COPD). The VC-RPM Program allows participating patients to be cared for conveniently and safely in the comfort of their home, at work, or Country or in community settings. The program aims to help reduce pressures on the hospital system by reducing admissions, presentations to ED as well as wait and travel time for patients.

The VC-RPM is funded by New South Wales Health as the current ABF model does not accurately identify, cost and price the digital costs of service delivery. As the patient is typically not physically present, under the current counting methodologies these activities do not generate National Weighted Activity Unit (NWAU). However, staff are spending considerable time reviewing patient results and interpreting these in the medical record. Remote monitoring improves patients care through more frequent monitoring and detection of issues earlier in patients, particularly with chronic diseases. The number of remote monitoring consults can range from one to four, can be resource intensive and may happen on the same day, depending on patient needs.

This case study demonstrates the need for the funding model to be flexible and responsive to innovative models of care. For remote monitoring models of care, the entire episode of care could be defined by a specified period so that it can be costed and priced for an agreed amount of time. This may mean remote monitoring activity is bundled and counted as one admitted patient service event per patient per calendar month regardless of the number of occasions of service delivered.

- The NHRA has aspired to promote more integrated models of care, with a stronger focus on higher value interventions and patient outcomes and to improve safety and quality. However, to date, there has been little progress at a system level, though some of the building blocks exist with work undertaken by the national bodies.
- The process of adding new services or procedures to the NEP and NEC to be funded through the ABF and Block funding system is slow and infrequent. In addition, it is a complex process which means there is additional financial strain on States and Territories as they may need to assume the responsibility of funding the initiative in the meantime (without

the Commonwealth contributing ongoing financial assistance). This has been a brake on the willingness of system managers to test new ideas.

3.3.2 Strengths

Some of the strengths identified by stakeholders include:

- There are pockets of successful innovation piloted across Australia, such as virtual ED services, psychosocial step-down care facilities, and integrated patient-centred models that involve specialist and hospital services playing a role to strengthen the capacity of community-based services.
- Public hospital services have embraced technology to provide virtual care where clinically appropriate, together with hospital avoidance and hospital length of stay minimisation models; and are increasingly networking and integrating services to improve equity of access to patients, in line with Clauses 5a-5d and Clause 19a of the Addendum.
- All jurisdictions have consistently identified paying for value and outcomes as a priority reform, in alignment with the recommendation from the Productivity Commission's *Advancing Prosperity* report.

3.4 Financing reform



Summary of what we heard:

Stakeholders acknowledged the significant reform that ABF represented at the time of its introduction and considered that its objectives to improve technical efficiency, transparency and accountability have largely been met. However, the NHRA's funding arrangements were generally criticised as putting too great a pressure on State and Territory budgets, with the Commonwealth share of public hospital funding seen as growing too slowly and the operation of the 6.5% funding cap impacting both the rate of growth and the capacity of hospitals to respond to demand pressures.

The ABF system and efficient growth formula were seen as overly complex and becoming more so, and it was unclear whether increasingly technical adjustments were delivering intended outcomes, while other elements of the funding system (such as public health and teaching, training and research (TTR)) lacked transparency and accountability.

A summary of the key issues raised include:

- While the rationale for the Commonwealth's 45% contribution to efficient growth and 6.5% growth cap is understood, perceived inequity in the Commonwealth share of public hospital expenditure and the operation of the cap was seen as impacting the ability to meet real demand growth, particularly when cost pressures and the impact of an ageing population is taken into account, and as putting unsustainable pressure on State and Territory budgets.
- The current funding model has improved technical efficiency and accountability, but is considered too restrictive and inflexible to adapt to the increasingly complex needs of patients and to enable those interactions with different providers required to support the entire care pathway. This creates a barrier to delivering a more seamless approach to care and disincentivises design, development and implementation of innovative models.
- The ABF price determination process, predominantly based on average unit costs derived at a national level, were seen to disadvantage smaller jurisdictions and rural and remote services that did not have the economies of scale to realise efficiencies. Furthermore, the basis for determining block funding through the NEC was seen as not adequately meeting the service costs of rural hospitals, particularly relating to workforce and supply chain. There are elements of block funding arrangements that continue to lack transparency and accountability.
- The approach to drive efficiency through the case weight classification framework is complex and is impacted by technical deficiencies and data shortcomings. The most notable concern is the time lag between when costs are incurred by jurisdictions and when they are reflected in the NEP. While this relates to the time that it takes to collect and assure the quality of data at the jurisdictional level, at a time of high price growth, it results in a gap between the level of funding and the cost of service delivery and adds pressure to State and Territory budgets.
- Current funding arrangements that cater for cross-border patient flows are not consistent across jurisdictions. The ABF approach between jurisdictions does not adequately account for the underlying non-recurrent, infrastructure and technology costs incurred by host jurisdictions when cross-border services are delivered at scale.
- An overarching theme on accessing and paying for high-cost, highly specialised therapies were the inefficiencies in the governance mechanisms to approve the use of these therapies and funding schemes. The challenges to access and maintaining financial sustainability will only intensify as more of these therapies come to market in the coming years.
- Stakeholders acknowledged that progress had been made in implementing more neutral funding arrangements between public and private patients being treated in public hospitals; however, considered that incentives remained for public hospitals to admit a patient as a private patient.

3.4.1 Identified issues

The key issues identified by stakeholders as part of this theme were:

Commonwealth Contribution Rate (CCR), growth cap and funding share

The current level of Commonwealth contribution to public hospital expenditure was seen as not representing an equitable share and as growing too slowly, limiting the capacity of health services to meet community needs.

- While the commitment in the Agreement is that the Commonwealth will contribute 45% of the efficient growth of ABF service delivery and block funding, the operation of the calculation system has seen the relative Commonwealth share grow to only 40.3% by 2022-23. This makes it challenging for States and Territories to budget and plan the purchase of additional activity to meet strong demand growth and address the backlog in elective surgery and specialist outpatient services.
- For historical reasons, there remains a wide discrepancy between the CCR in each State and Territory – 32.9% for the lowest through to 41.9% for the highest in 2022-23. While this discrepancy has narrowed over the course of the Agreement, progress has been slow and is likely to remain so.

The 6.5% growth cap incorporates both price and activity growth, which are affected by external factors of inflation and the impact on hospital activity from the ageing population and increased incidence of chronic disease.



- Within the calculation of the 6.5% cap, a key issue in the current climate of cost escalation is the proportion of funding growth that is driven by price variables rather than activity. This significantly limits the ability to grow service capacity to address projected demand, as it leaves little headroom for activity growth.
- The issue has significant ramifications for jurisdictions that are facing longer term planning challenges in their ability to make the necessary decisions to build health service capacity to meet growing community health needs, particularly as Australia faces the ongoing demands from an ageing population and increased incidence of chronic disease. The issue is made more challenging by the fact that the determination of whether jurisdictions have exceeded the cap is made well past the end of the financial year.

The efficient growth formula is complex and has technical deficiencies.

- The basis for determining a jurisdiction's growth cap was seen as overly complex both in terms of what it represents (price and growth) and how the final yearly determination is confirmed, as well as difficult to plan and administer by States and Territories. This complexity is added to through the way in which yearly back-casting processes are conducted which is effectively the only way that the funding mechanism adjusts for the change in events between years and does not address the impact on the absolute number of events that occur each year.

Potential impact of funding activity through ABF

The funding model was considered to have insufficient flexibility to adapt to the complex needs of patients across the care pathway.

- The focus on setting and meeting NWAU/ABF targets to attract Commonwealth funding was seen as driving care to the inpatient setting, rather than preventing hospitalisations through individualised health interventions and early disease management, usually delivered in primary and community-based care settings.
- In some situations, the ABF approach was seen as a significant barrier to introducing integrated care models. A number of examples have been identified including hospital activities incurring high cost/low volume activity, programs aimed at hospital avoidance, community or at-home non-admitted programs aimed at reducing or replacing the reliance on admitted activity, which were effective but could not be sustained within the provisions of the NHRA.

NHRA's ABF approach (including NEP) tends to disadvantage smaller jurisdictions.

- For smaller jurisdictions with smaller and fewer hospitals, lack of scale, and sparse populations, the NEP and NEC were seen by many as providing neither a realistic price signal nor an achievable benchmark. Larger jurisdictions, and larger metropolitan hospitals' costs, strongly influence the calculation of the NEP and NEC by the sheer volume of cost data impacting price and cost weight parameters. This issue is further compounded by other additional cost imposts incurred by smaller hospitals (e.g., the higher wage burden to attract specialist and technical skills to smaller jurisdictions and remote health services).

There is ambiguity in ABF shadow pricing parameters.

- The Addendum does not provide leverage around the often significant changes arising from the introduction of new ABF classifications or resulting changes in costing methodologies, even in situations where transitional arrangements such as shadow pricing are introduced. There is ambiguity in the Addendum about what constitutes full participation in shadow pricing (clause A42a), which significantly influences the applicability of these provisions. The lack of specificity around these provisions has seen pressure to shadow price all new classifications regardless of the significance of the impact of the new classification on the national pricing model, constraining the ability to be responsive in reflecting changes in clinical practice.

Cost and price data

The lag in cost data and NEP calculation makes it difficult for LHNs to use the NEP for activity and capacity planning.

- The NEP is based on hospital data collections that are prepared from the three years prior which fails to realise the more immediate real time cost and efficiency effects impacted, for example, by workforce shortages and jurisdictional Enterprise Bargaining Agreement outcomes, cost inflation on supplies/consumables and related supply chain distribution and the downstream impacts of COVID-19.
- The lag between the cost data submission and the NEP means that States and Territories face a liquidity risk if health service costs escalate at a more rapid rate, having to find ways to address the immediate higher cost of healthcare provision while they wait for equivalent Commonwealth funding contributions.

Some adjustments are not effective in achieving the objectives of the Addendum and promoting innovations based on evidentiary requirements.

- Stakeholders noted that the most common barriers to the introduction of new adjustments, or perceived inadequacy of existing adjustments, is a lack of evidence available in reported cost and activity data, including due to jurisdictional limitations in allocating costs accurately at the patient level or limitations in the collection of patient characteristics data. Others may be rejected due to low materiality and/or misalignment with the Pricing Guidelines, such as State and



Territory-based adjustments that have been proposed by some jurisdictions but are inconsistent with a national pricing approach and a preference for patient-based adjustments.

There is limited jurisdictional capacity and capability for continuous improvement in clinical costing and cost data capture.

- While the intention of the ABF model framework was expected to drive improvements in quality and efficiency in the preparation of episodic cost data, it is no longer clear that this aspect remains a focus. This is largely due to ongoing limitations in data sources and in the technical costing capability across States and Territories.
- Accuracy, timeliness and administrative burden for preparing episodic cost data is also limited by the lack of skills and capacity of LHNs to adequately drive the collection of more contemporary data, particularly as the complexity of the patient classification systems used to base the pricing parameters increases. This limitation is commonly impacted by highly manual costing and collection processes, poor source data systems, highly administrative quality assurance requirements and workforce challenges in attracting technical skills and episodic costing capability.

Block funding allocations

Stakeholders noted the limited transparency of the block funding allocation.

- There is a lack of visibility of activities delivered by States and Territories where block funding is allocated to the State Managed Fund for allocation rather than through the Pool to the relevant LHN. This method of funding small and rural hospitals results in a lack of transparency over how States and Territories address efficiency improvements for the serviced populations.

Block funding does not adequately fund regional and rural hospitals for the higher costs of health delivery.

- Rural hospitals face higher costs in delivering their services for a multitude of reasons, such as a greater incidence of natural disasters, fewer doctors, and the impact of distance. In addition, TTR funding is perceived as largely consumed by large tertiary/quaternary services with a lack of rural and regional recognition.

Public health, cross-border and other funding

Current funding of public health programs is based on a legacy indexation model with no national mechanism for funding the implementation and ongoing support for preventative health initiatives.

- Currently, the Addendum maintains that public health programs and associated activity growth is based on the historical Specific Purpose Payment (SPP) growth factor which does not account for the underlying shortfall in providing public health services nor does it reflect the growing need and resource drivers for maintaining public health intervention. This further disadvantages jurisdictions with slower population growth.
- As a consequence of the expiration of COVID-19 NPA, there is no specific Commonwealth funding for the enduring impact of COVID-19 for LHNs or public health programs. States and Territories have noted that the backlog in planned care will be funded through the NHRA at the lower 45% growth rate and within the 6.5% cap, leaving them to fund the additional costs of this demand within existing growth calculation caps.

Cross-border arrangements do not appropriately allocate incentives between jurisdictions.

- The lack of clear and consistent procedural requirements or national guidelines for funding cross-border flows means that inter-jurisdictional funding agreements are negotiated individually between affected States and Territories, creating disparities in the way costs are recovered by the host jurisdictions to support the services provided.
- It was noted that the basis for negotiating cross border funding is mainly based on the NEP (or proportion thereof) which does not recognise the host jurisdiction's ongoing non-recurrent costs to support infrastructure and technology or the impact of block grant allocations such as TTR that are funded outside the NEP. While this issue may not be as great a concern for larger jurisdictions, smaller jurisdictions which support a higher proportional number of interstate patients are considerably more affected.

Pharmaceutical Reform and high-cost, highly specialised therapies

A lack of access to PBS medicines for admitted patients on discharge, non-admitted and same day patients was seen as potentially impacting access and continuity of care, noting that New South Wales and Australian Capital Territory do not participate in the Pharmaceutical Reform Arrangements which enable public hospitals to dispense PBS subsidised medicines in certain circumstances. This lack of national consistency was seen as introducing distortions to the NEP.

High-cost, highly specialised therapies are hampered by fragmented approval and implementation processes, with access to high-cost medications and therapy restricted under the funding agreements due to cost considerations and administrative hurdles. There was a perception that Australia, once a leader in introduction of new therapies, was beginning to lag behind.



- An overarching ambition noted in consultation was to enable equitable access to high-cost, highly specialised therapies regardless of geographic location and to take stronger steps toward a national unified framework for the assessment and introduction of new therapies.
- Access to high-cost, highly specialised therapies was seen as impacted by a lack of forward planning across all levels of government to support budgeting for these therapies and to do the horizon scanning to identify potential new therapies and prepare for their funding and implementation.
- There has been a lack of agreement between jurisdictions as to which services are eligible for the NHRA-established Health Technology Assessment (HTA) process. These compounding factors are resulting in barriers which reduce equitable access and referral, even for approved therapies. As a result, eligible patients were seen as missing out on trials/therapy.
- Further, when new therapies were introduced the HTA processes failed to fully recognise the impact on health service costs of introducing these therapies at the time of approval, such as the attendant staffing and patient support costs which can be significant. This acts as a brake on health service willingness to offer these technologies until the lag in cost capture is addressed.

Private patients and private providers

Stakeholders acknowledged that progress had been made in implementing more neutral funding arrangements between public and private patients being treated in public hospitals; however, considered that incentives remained for public hospitals to admit a patient as a private patient.

- Some LHNs see private health insurance (PHI) income as an important source of own source revenue, potentially at the expense of public patient admissions. Instances were noted of patients feeling pressured to use their private insurance following an admission from the ED and/or public hospital stay, and then facing out-of-pocket costs. The extent of those costs was not always clear at the point of private patient election.
- Concerns have also been raised by States and Territories that any material shifts away from treating patients as privately insured towards public patient activity will not be recognised by the Commonwealth with respect to growth funding contributions.

There is a perception by private hospital providers that the NHRA enables the public sector a competitive advantage in radiology services.

- Private providers report that they are unfairly disadvantaged because public hospitals receive government funding for the infrastructure and workforce used to deliver radiology services (i.e., subsidised by public funding). There are reports of some hospitals providing higher value radiology services like CT, MRI and PET as a revenue generation initiative and avoiding/limiting provision of Ultrasound, breast imaging and interventional procedures to outpatients because of lower rebates.
- There is a perception by private providers that public hospitals claim Medicare rebates for radiology services where the costs are covered by NHRA funding. The Commonwealth Government has sought to address this issue through compliance initiatives such as data-matching to identify duplicate payments and relevant audits. There is concern from the private sector that these actions may also lead to significant out-of-pocket costs for patients, which may be inconsistent with Clause A9 of the NHRA (not funding patient services if the same service, or any part of the same service, is funded through any other Commonwealth program). From a health service perspective, this could also create a risk that the IHACPA costing and pricing processes may have incomplete information.

There are inappropriate arrangements in some small rural hospital EDs to bill patients privately and claim Medicare.

- There are reports of current arrangements in small rural hospitals where EDs are billing patients privately, subsidised by Medicare. The Medicare rebate is significantly less than the remuneration a senior medical officer in a regional hospital would receive on salary and is seen as an unfair rate of pay. This disparity has contributed to a continued trend of local GPs no longer providing 24/7 emergency coverage at the local hospital.

3.4.2 Strengths

Some of the strengths identified by stakeholders include:

- The NHRA funding model has been successful in achieving its intention to promote accountability, transparency and consistency in funding, including through the use of the independent Funding Pool and Administrator. While progress in growing the Commonwealth contribution to public hospital services has been slower than anticipated, it has still grown both in absolute and percentage terms and the discrepancies between individual States and Territories has narrowed.
- There is evidence that technical efficiency in the delivery of public hospital services has improved over the life of the Agreement.
- The NHRA promotes a clearer independent oversight process in pricing determination and generates greater inter-jurisdictional collaboration between the Commonwealth and State and Territory governments on the principles for advancing the funding model on a nationally consistent basis.



- The Addendum provides a nationally consistent approach and clear process for how ABF and block funding should be calculated including explicit guidance on the principles that should underpin the development of the NEP. Previous agreements had grant values determined on a relatively rudimentary basis, generally being based on some historically agreed amount adjusted by population and cost growth rates.
- The funding model and approach to pricing that has been adopted by Australian jurisdictions under the NHRA is recognised internationally as one of the more technically advanced models for funding hospital services.

3.5 Long-term health reforms



Summary of what we heard:

Stakeholders reported that, while many of the Addendum's six LTRs remained important, there had been limited progress to date, partly due to the urgent focus on addressing the COVID-19 pandemic and a lack of appropriate governance, resourcing, incentives and success measures to drive implementation. It was further noted that there was a lack of agreement on the highest priority reforms, inadequate information sharing on what was being trialled where, and no clear pathway to integrate reform outcomes into NHRA funding.

Coming out of COVID-19, jurisdictions reported a commitment to deliver on the LTRs, but noted that the NHRA was not well positioned to sustainably drive and foster innovation, prevention and value-based care across the health system. Investment in innovations tend to be tactical and not sustained beyond pilot projects.

3.5.1 Identified issues

The key issues identified by stakeholders as part of this theme were:

- Progress in implementing LTRs have been relatively slow, in part due to the pandemic response and resulting capacity constraints across jurisdictions.
- Appropriate governance structures, incentives, resources and measures of success to drive and embed LTRs are lacking or obscure. Understanding at the outset what the long-term funding arrangement may be for a specific reform initiative was seen as important as, in its absence, there was concern that the commissioning State would end up solely bearing the long-term cost. This acted as a brake on reform.
- Insufficient resources and mechanisms supporting collaboration between PHNs and LHNs hindered genuine collaboration and responsiveness to local needs. PHN funding tended to be tied to specific areas, detracting from their capacity to support local commissioning.
- The NHRA does not provide sustainable funding for preventive care, hindering initiatives for healthier communities and addressing health inequity gaps. Limited progress has been made on achieving the objectives of the LTR area of prevention and wellbeing.
- The NHRA does not provide direct funding for investment in digital infrastructure, despite its importance for better data linkage and connectivity. Advances across the spectrum of LTR areas and to improve patient outcomes require digitally enabled sharing of patient level information, particularly at transition points between sectors.

3.5.2 Strengths

Some of the strengths identified by stakeholders include:

- There is a shared and genuine commitment to deliver LTRs. The long-term priorities have been used to inform jurisdictional health reform strategies, such as *HealthQ32* in Queensland and the *Long-Term Plan for Healthcare in Tasmania 2040*.
- There are some notable reform developments. For example, Queensland has committed to the Torres and Cape Health Care (TORCH) Commissioning Fund (Case Study below). Queensland and Victoria have also undertaken a review of the health data landscape and lessons from COVID-19 data sharing to inform national health data priorities.



Case study: Torres and Cape Health Care (TORCH) Commissioning Fund¹¹

The TORCH project is a joint commitment by the Australian and Queensland Governments in partnership with community leaders and the Queensland Aboriginal and Islander Health Council (QAIHC), for health system reform for the Torres and Cape region. The project will establish an independent regional health care commissioner (the TORCH entity), which will plan and buy health services based on evidence and local input. The TORCH Entity will be backed by pooled funding from both Commonwealth and State healthcare funding for healthcare services. The initiative is a ten-year journey to shift the way healthcare is commissioned, which will drive improved health system effectiveness, efficiency, equity and whole of population health and wellbeing outcomes.

The initiative will progress implementation at a regional level of the Paying for Value and Outcomes and Joint Planning and Funding LTR priorities. \$4.56 million was provided for the project through the Health Innovation Fund. The TORCH project will drive health system reform to allow regional community-controlled commissioning – in community, for community.

¹¹ Queensland Aboriginal Islander Health Council. Torres & Cape Health Care (TORCH) Commissioning Fund, 2023. Available from: https://www.tsra.gov.au/_data/assets/pdf_file/0003/34590/TSRA-HCF-Guest-speaker--Matt-Cooke-QAIHC.pdf

3.6 Rural and remote service delivery



Summary of what we heard:

Rural and remote residents experience inequitable access to healthcare, resulting in poorer health outcomes. Scarcity of health services and inadequate health workforce prevents people from accessing the right care at the right time and place, while limited step-down care results in delayed discharge and longer hospital stays. The NHRA lacks provision for addressing market failures in rural and remote areas and limited digital health literacy and unreliable internet access further hinder access to care.



3.6.1 Identified issues

The key issues identified by stakeholders as part of this theme were:

- The lack of health services to step-down care and accommodation in rural and remote areas detracts from the capacity for people to access the healthcare services they need at the right time and place, resulting in poorer patient outcomes, discharge delays and longer lengths of stay.
- Lack of access to primary care in rural areas has a significant impact on health outcomes and increases reliance on local public hospitals and ED utilisation.
- The NHRA does not safeguard against market failure in rural and remote areas. Some stakeholders noted that jurisdictional health services are required to deliver primary and aged care services in remote and rural communities when there is a market failure. There are no accountability and escalation mechanisms in the NHRA that mitigates this, despite responsibility for primary care and aged care resting with the Commonwealth.
- The distribution of teaching, training, and research funding through the NHRA lacks transparency and accountability, hindering the development of rural and remote health service capacity.
- The NEP is a national average model that does not provide sufficient flexibility for regional and rural variation, disadvantaging remote locations with higher service delivery costs. Although there are adjustments for rurality and remoteness, these are outweighed by the impact of larger populations in larger rural centres.
- Lower digital health literacy and restricted internet access in rural and remote areas hinder access to virtual health services.

“Rural, regional and remote patients have significantly poorer health outcomes, greater incidence of chronic disease and greater premature deaths when compared to their counterparts in metropolitan areas.”

- NSW Parliamentary Inquiry Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote NSW

3.6.2 Strengths

Some of the strengths identified by stakeholders include:

- The Single Employer Model for GP Registrars is being successfully piloted in several jurisdictions to increase the regional medical workforce in both hospital and primary care. While an evaluation of the program is currently being commissioned, initial feedback from stakeholders has been favourable.
- Initiatives to support expansion of the recruitment pipeline through the National Cabinet and HMM have been well received (e.g., Strengthening Medicare, Innovative Models of Care, Primary Health care Rural and Remote Innovative Multidisciplinary Models of care). However, these initiatives operate external to the processes of the NHRA.



Case study: Primary Health Care (PHC) clinics in the Northern Territory

Due to market failure, Northern Territory Health funds PHC clinics in remote and very remote areas. These clinics provide a range of services including general medical care, maternal and child health services, mental health care and chronic disease management. Patients with chronic diseases who reside in remote communities need to travel to a PHC clinic to receive care required under their multidisciplinary plans. There are often underlying health and social risk factors which place patients at a higher risk of acute deterioration and can result in multi-day visits to the PHC clinic. As Northern Territory PHC clinics are largely staffed by nurses, most health service interactions are not eligible for Commonwealth funding through MBS.

3.7 First Nations' people



Summary of what we heard:

Stakeholders noted that, while there is a reference to Closing the Gap in the NHRA, priority actions are not specifically identified or driven through the NHRA, with little evidence that current funding and governance mechanisms are addressing the issues of access and equity for First Nations' people. This is disproportionately felt in rural and regional settings, where access to necessary and culturally responsive health services is impacted by often insufficient access to primary care.

The absence of culturally relevant indicators in the Australian Health Performance Framework (AHPF) fails to capture the experience of First Nations' people within the health system. A reported lack of collaboration between the broader health sector and ACCHOs, along with the unclear articulation of their role in NHRA governance, contributes to a lack of coordination and sense of mistrust in the Agreement's capacity to deliver for First Nations' communities.

3.7.1 Identified issues

The key issues identified by stakeholders as part of this theme were:

- Institutional racism and a lack of cultural safety in hospitals affect both treatment outcomes and the likelihood of accessing care when it is needed. As a proxy indicator for cultural safety in hospitals, the proportion of First Nations' people who left or were discharged from hospital against medical advice in 2020-21 was 4.4 times higher than for non-Indigenous Australians. Additionally, the difference in median waiting time in elective surgery between First Nations' people compared to non-Indigenous Australians has increased from 4 days in 2012-13 to 11 days in 2021-22.
- The role of ACCHOs is not articulated or embedded within local and broader governance arrangements within the NHRA, detracting from the ability of community-controlled organisations to participate in local commissioning and service design.
- There was a perception that the current pricing framework did not adequately reflect the challenge, especially in remote settings, of delivering sufficient, quality and culturally responsive services, and existing adjustments are outweighed by the impact of urban populations where there is readier access to services.
- It was noted that the Indigenous adjustment in the national funding model accounts for legitimate and unavoidable costs, reflected in the data after the service has been delivered. The adjustment does not adequately reflect the cost of care that objectively should have been sought or provided, and funds entities in arrears rather than front-loading appropriate investment in health, including prevention services. The same applies for the remoteness adjustment.
- Stakeholders noted that the AHPF data does not include culturally relevant indicators that capture First Nations' people's experiences of the health system and that culturally appropriate models of health tracking may be required.
- Poor levels of access to care by First Nations people across the broader health system was identified. A particular area of concern was appropriate primary care for those with long-term health challenges who also interact with the prison system and juvenile detention, an issue currently being considered by the Commonwealth, States and Territories through the *National Aboriginal and Torres Strait Islander Health Collaboration*.

3.7.2 Strengths

Some of the strengths identified by stakeholders include:

- The Addendum recognises ongoing barriers to improving health equity for priority population groups, however there is opportunity to further strengthen the focus on First Nations' perspectives (see Case Study: South Australian Aboriginal Mental Health and Wellbeing Centre).
- The pricing and funding model includes adjustments relating to Indigeneity and remoteness (both residence and place of service) however the nature of the NEP as an average diminishes the impact in remote service settings.



Case study: South Australian Aboriginal Mental Health and Wellbeing Centre

The South Australian Aboriginal Mental Health and Wellbeing Centre aims to enhance its presence by becoming a member of the main organisation for South Australian Aboriginal Community Controlled Health Services within the South Australian Joint Health Planning and Commissioning Committee. This move is expected to amplify the visibility of various initiatives and lead to the creation and testing of innovative reforms. These changes are designed to ensure they effectively address the specific requirements of First Nations' people.

To support the establishment and operation of a new Aboriginal Mental Health and Wellbeing Centre, co-funding totalling \$5.4 million from both South Australia and the Commonwealth has been allocated. The Centre is projected to become operational in 2023-24. Its primary objective is to enhance access to mental health and wellbeing services that are culturally sensitive and interdisciplinary in nature. This effort aims to foster better integration of services and to cater to the needs of First Nations' people.

Collaboration between the Commonwealth and South Australia will play a key role in shaping these coordinated and culturally appropriate mental health and wellbeing services for First Nations' people. This collaborative process will involve consultation with Aboriginal Community Controlled Health Services, members of First Nations' communities, and other Indigenous health organisations.

3.8 Workforce and Digital Health as an enabler

Part a) Workforce



Summary of what we heard:

Access to a sufficient and skilled workforce is a critical enabler of health outcomes. At the time of the initial NHRA there was a national workforce agency with its own legislative basis, governance and functions. As a result, the NHRA does not strongly reference workforce challenges and strategies, to its detriment.

Workforce pressures are multifaceted, with maldistribution across specialities and geographies, and barriers to clinicians working to the top of their scope of practice and across care systems. Coordinated national leadership and governance is needed to manage the impacts on services and public hospital financial sustainability and to ensure an integrated, multidisciplinary approach that gets the most out of the available workforce to improve patient outcomes.

3.8.1 Identified issues

The key issues identified by stakeholders as part of this theme were:

- Australia is experiencing workforce shortages and maldistribution in some professions and specialties (including Aboriginal Health Workers, Primary Care, Aged Care, Allied Health, Mental Health). Shortages occur for a variety of reasons, including COVID-19 increasing demand, the absence of a national approach to workforce supply, retention and training, and clinician burnout. The shortages in turn result in poorer patient outcomes, impact safety and quality, and result in long wait times and reduced service access.
- The shortage is compounded in rural and remote locations where recruitment and retention are impacted by location. Challenges in achieving and maintaining an appropriate geographical distribution and specialty mix within the healthcare workforce results in disproportionate service demands, service gaps and inefficiencies, affecting the quality of patient care and career satisfaction of healthcare providers. Higher wages are often necessary to attract a workforce in remote locations, resulting in upward cost pressure through competition across jurisdictions.
- Ageing populations and increased rates of chronic disease have seen an increasing demand for primary care. At the same time, there is a fall in the proportion of doctors training as GPs and an ageing GP workforce. Nationally, the proportion of final-year medical students listing GP as their first preference speciality was only 13.1% in 2022¹².
 - The Western New South Wales PHN has estimated that 41 towns across the PHN footprint were at risk of not having a GP by 2030.
 - Tasmania's *Health Workforce 2040 Strategy* notes that over 27% of GPs in Tasmania are over the age of 60 years, with the average age of a GP being ~54 years, which foreshadows an imminent worsening of workforce challenges in that State.
- More broadly, the decline in GPs nationally is resulting in a medical staff shortfall in primary care, with up to 70% of primary healthcare positions occupied by agency nursing and visiting medical officers. Workforce pressures are contributing to high system costs despite increased vacancies and leave utilisation, with increased reliance on agency and locum staff to fill vacancies and cover leave.
- There are barriers to enabling clinicians to work to the top of scope and across care systems due to restrictive regulations, resistance to diverting from existing/current traditional roles, funding arrangements and training gaps. In addition, regulatory requirements and immigration processes inhibit the timely and effective employment of overseas-trained professionals, and there is an increase in the number of people leaving the public sector workforce due to labour market competition.

3.8.2 Strengths

Some of the strengths identified by stakeholders include:

- All jurisdictions have acknowledged significant challenges related to their workforce and are implementing health workforce strategies, including:
 - Addressing the geographic maldistribution of health professionals: by providing financial incentives for health professionals to work in these areas, and developing new models of care that can be delivered more efficiently in rural and remote settings.
 - Improving the diversity of the health workforce: by increasing the number of First Nations' health professionals and recruiting more health workers from culturally and linguistically diverse (CALD) backgrounds.

¹² Medical Deans Australia and New Zealand – Medical Schools Outcomes Database National Data Report, July 2023



- Attracting and retaining health professionals: by improving working conditions, providing more flexible work arrangements and addressing the issue of burnout.
- Upskilling and reskilling the health workforce: by providing financial assistance for training and developing new training programs that are tailored to the needs of the health workforce.
- Strengthening the health workforce planning process: by developing long-term workforce plans and coordinating the planning efforts of different stakeholders.
- The HCEF Health Workforce Taskforce and the *Independent Review of Overseas Health Practitioner Regulatory Settings* are considering domestic and international workforce supply respectively. This is likely to identify new options to address workforce shortages and distribution issues across specialisations and geographical location.
- The Single Employer Model trials for GP registrars is an innovative approach to address the ongoing recruitment and retention issues of Australia's GP Registrar workforce which is a major challenge for regional, rural and remote communities. Further information is provided in the Case Study in section 5.8.
- The Strengthening Medicare reforms are investing in systems that increase support for the primary care workforce to meet evolving needs as the population ages and rates of chronic disease and mental illness rise, encouraging multidisciplinary team-based care and empowering staff to work to their full of scope of practice.

Part b) Digital health as an enabler



Summary of what we heard:

8. WORKFORCE AND DIGITAL HEALTH

There is broad agreement on the value of having ready access to comprehensive patient health information at the point of care, with digital health viewed as integral to delivering patient centred care.

The health system is experiencing increasing expectations from patients and providers, with Australians displaying a higher desire to utilise digital health tools to access their personal health information. However, the current ability to draw together a 'single view' of a patient and their experience is hampered by the lack of system interoperability across the health system, and there is little within the NHRA to incentivise the health sector to commit to supporting digital health solutions.

3.8.3 Identified issues

The key issues identified by stakeholders as part of this theme were:

- The NHRA lacks adequate funding mechanisms to enable and incentivise digital care services. Digital health technologies are redefining care pathways, but the costs are not adequately known and captured in the current funding model. Initiatives such as digital Front Door, virtual acute care services, Hospital in the Home and Remote Patient Monitoring, will all require information and communications technology (ICT) and digital infrastructure (including information management and cyber security) to support delivery.
- Digital health plays a crucial role in providing patient-centred care. Both patients and providers are increasingly expecting more from the health system, and there is broad agreement on the value of accessing comprehensive health information about patients across the health sector at the point of care, to support more personalised care and better clinical decision making. Inflexibility of funding hinders the full potential of this integration.
- Healthcare data remains siloed, largely driven by the lack of connected digital infrastructure, with data processing in rural and remote services often highly manual and paper based. This is limiting the ability to view and track the full patient journey across the system, and between services, due to a lack of interoperability, the absence of cohesive standards for electronic health records, and low public trust in data collection and sharing. The inability to access and use accurate and timely data to inform clinical decisions impacts on outcomes and causes inefficiencies.
- The *National Digital Health Strategy, Inter-governmental Agreement 2023-2027 (IGA on National Digital Health)* and *Connecting Australian Healthcare - National Healthcare Interoperability Plan 2023-2028 (the Interoperability Plan)* reflect the intended objectives and priorities of the NHRA. However, the objective and actions of these Agreements and Plans are not embedded in the NHRA, impeding the development of incentives for the health sector to commit to supporting digital health solutions within hospitals and at transition points.
- The increasing costs of evolving requirements for healthcare to be digitally enabled, such as Artificial Intelligence and machine learning to support real time patient care and virtual healthcare provision are not adequately reflected in funding arrangements. Given this is a complex area involving rapid implementation of ICT solutions, the cost data used for pricing may not reflect the ongoing and enduring costs associated with contemporary ICT infrastructure.
- The NHRA does not include information about digital health literacy which is a determinant of health and required for communities, patients and clinicians to understand why and how care can be digitally enhanced.

3.8.4 Strengths

Some of the strengths identified by stakeholders include:

- Schedule F (Interfaces between Health, Disability and Aged Care Systems) of the NHRA Addendum sets out all governments' commitment to improve patient outcomes at transition points of care. This provides a practical launch point to introduce and integrate digital health solutions in a future NHRA.
- The COVID-19 pandemic response provided opportunities to innovate, accelerating the use of digital health and telehealth which are now being embedded systematically by governments (see Case Study: Western Australia Virtual Emergency Department).
- The former *2017-22 National Digital Health Strategy* set the foundations to fundamentally shift Australia towards greater use of digital systems. Building on those achievements, the *2023-28 strategy* sets the roadmap for the Commonwealth, State and Territory governments and other partners to collaboratively harness the unprecedented availability of digital technology and data to ensure people have the right information at the right time.
- The ADHA plays a key role in connecting Australians to a modern healthcare system that ensure they can access the care they need, when and where they need it. The *IGA on National Digital Health*, a shared investment commitment between the Commonwealth and the States and Territories, has been renewed for four years from 2023-24. The IGA ensures funding to the ADHA to enable interoperability and the flow of health information across care settings to support high quality care and the efficiency, effectiveness, and sustainability of the health system. The IGA also funds the ADHA to

deliver a range of national digital services that contribute to minimising the pressure on hospitals and supporting Australia's health reform objectives.



Case study: Western Australia Virtual Emergency Department (WAVED)

The Western Australia Virtual Emergency Department will give patients the option of being seen virtually in the comfort of their own home when safe and appropriate to do so, rather than waiting in an ED. The partnership between the Western Australia Department of Health, Health Service Providers (HSPs) and St John Western Australia will provide patients with clinically appropriate alternative care options within their community using virtual specialist emergency medical care and help reduce physical ED presentations and hospital admissions, easing the pressure on hospitals.

The next phase of this initiative, aiming to be operational before the end of 2023, will require rapid development of a new platform to connect HSP-based virtual medicine pathways and support a centralised secondary triage service.

3.9 Measuring success



Summary of what we heard:

Measuring the performance of the health system, understanding future pressures, and the capacity of the system to respond to these pressures, is essential to a well operating NHRA. While there are mechanisms in the Agreement to track performance, there is insufficient understanding and ownership of these performance mechanisms and they are not used as a proactive monitoring and planning tool. The NHRA lacks an overarching governing body, robust business rules and a shared understanding of performance that can guide future planning, the design and implementation of highest priority healthcare interventions and immediate responses.

There was limited evidence of regular assessment against key performance measures to monitor progress against NHRA objectives.



3.9.1 Identified issues

The key issues identified by stakeholders as part of this theme were:

- There is a lack of an overarching governing body, robust business rules and principles to support a shared vision and understanding of the performance of the health system, drive implementation of highest priority healthcare interventions, and conduct regular assessment against key performance measures to monitor progress against reform objectives.
- The Australian Commission on Safety and Quality in Health Care (ACSQHC) and IHACPA have data, expertise and capabilities that are critical to the development, monitoring, and evaluation of the performance of the health system. However, the current governance arrangements do not encourage active and regular involvement of the ACSQHC or IHACPA in national health policy issues.
- A nationally consistent framework and underpinning dataset to measure performance is a known gap (see Observation: Australian Health Performance Framework). The absence of the quantification of benefits constrains the ability to make informed investment decisions.
- Current performance metrics in the AHPF are largely focused on activity, with insufficient reporting on the consumer experience or outcome measures including for vulnerable populations.
- Available data does not provide full visibility of the operation of the current health system, with limited visibility of the drivers or barriers to health system performance and efficiency (see Observation: Hospital Acquired Complication reforms). For example, stakeholders reported that the impact and value from public health and prevention is not prioritised and does not include the wider determinants of health, health improvement, health protection, public health and premature mortality factors.
- There is a perception that data-sharing is one-way, with jurisdictions reporting a lack of access to Commonwealth record-level data including MBS and PBS data, NDIS, Australian Immunisation Register (AIR) and aged care bed availability information to drive greater insights, clinical service planning, data linkage and joint commissioning.
- There is insufficient incentive to prioritise improvements in digital health infrastructure to support data collection and national reporting, despite the potential for this to inform evidence-based decision making and support person-centric healthcare.



Observation: Australian health performance framework

Although reporting requirements and indicator specifications introduced in 2011 have been reviewed over the decade since their development, the reasons why the data should be collected and reported, and whether the indicators remain contemporary in the current digital environment, have not been evaluated. As a result, the current AHPF may not prove to be useful in tracking the overall progress of the system and as a tool for planning and performance monitoring.

Reporting tends to focus on activity and outputs and does not talk to patient experience or outcomes. For example, reported data on access to EDs is not always a reflection of what is happening in practice, with patients transferred from the ED to a Short Stay Unit reported as seen within the recommended period, when their time in ED is in effect continuing. In addition, indicators tend to be lag rather than lead indicators. Reform indicators need to connect to clinical behaviour and decision-making.

3.9.2 Strengths

Some of the strengths identified by stakeholders include:

- The Addendum provides for “a consolidated set of whole of system performance indicators that are drawn from the Australian Health Performance Framework”, to enable system-wide reporting. The continued inclusion of this in the

Addendum indicates the need/relevance across all jurisdictions, as a foundational basis from which to work. This includes to “develop health, primary care, aged care and disability interface performance indicators and an associated data collection”.

- There are initiatives underway to close the gap on access to Commonwealth record-level data, such as the Multi-Agency Data Integration Project (MADIP) through the Australian Bureau of Statistics (ABS).
- IHACPA has developed significant technical expertise and a large repository of activity and cost data for Australian public hospitals over the last decade that can be leveraged to identify system and service performance improvements and efficiencies.
- ACSQHC has developed key capabilities and expertise in safety and quality measures, clinical governance, integrated care, and transitions of care. There is significant potential to leverage the ACSQHC’s capabilities and expertise in the development, monitoring and reporting of health care safety and quality performance and outcomes.



Observation: Hospital Acquired Complication (HAC) reforms

ACSQHC was tasked with measuring sentinel events, HACs and Avoidable Hospital Readmissions (AHRs) as part of the *NHRA 2017-2020 Addendum*. Since implementation, there has been a decrease across HAC (-20%) and AHR (-11%).

These HAC reforms are working toward national consistency and transparency of reporting and benchmarking, but overall, have not had a significant impact on quality and safety outcomes. Most of the measured improvement in HAC rates is due to improvements in data collection and the heightened profile of this indicator within health service clinical governance areas (all hospitals have established processes to review HACs). The HAC reforms do not connect to clinical behaviour and decision-making nor acknowledge the immediate impacts of strong demand growth and workforce pressures.

3.10 COVID-19



Summary of what we heard:

While COVID-19 highlighted some inflexibility in the NHRA when dealing with major disruptions, it also showed the capacity for the Commonwealth, States and Territories to come together quickly to develop new financing arrangements able to immediately respond to a system crisis. Some of the features of the arrangements put in place may provide a model in the event of future disruption.

A key theme in consultation was the significant and enduring increases in health service costs as a result of COVID-19, predominantly felt after the period of the COVID-19 NPA, which expired in December 2022. Stakeholders expressed concern that jurisdictions have borne significant additional costs, not yet included in the NEP, across the supply chain, higher acuity presentations due to deferred care during lockdowns, a backlog of elective surgery and workforce issues exacerbated by border closures and the high demands placed on health professionals. There was limited confidence that these pressures would reduce, and concern that there was a step change in acute care demand and workforce costs that would endure.

3.10.1 Identified issues

The key issues identified by stakeholders as part of this theme were:

- COVID-19 showed a lack of flexibility and agility in the NHRA to manage major disruptions to the health system (see Observation: responding to COVID-19).
- COVID-19 has fundamentally changed the way hospital services operate to accommodate elevated infection prevention and control measures, with changes to the space utilisation, consumable management, and patient pathway design. These have contributed to substantial and enduring increases in health service delivery costs. The cessation of the COVID-19 NPA on 31 December 2022 means that the increased service delivery costs which have not been, or not yet been, incorporated, into the NEP are borne by jurisdictions.
- Hospitals have experienced increased acuity of presentations due to deferred care caused by COVID-19 lock down measures, including elective surgery backlogs.
- Workforce issues were exacerbated by the closing of national, State and Territory borders, impacting access to overseas trained medical providers. Many health professionals experienced burnout caused by the high demands of the pandemic and left the workforce. Rural and remote communities had reduced access to health services as visiting specialists withdrew or reduced services.

“COVID-19 has exposed the inadequacy of the NHRA to manage major health system disruption beyond business-as-usual activity.”

3.10.2 Strengths

Some of the strengths identified by stakeholders include:

- COVID-19 created an impetus to innovate, particularly in care approaches and data sharing. The adoption of digital health and telehealth care has been accelerated and is now being embedded systematically by governments.
- The COVID-19 NPA enabled provider agility and flexibility that supported innovation across the health sector. It was able to capture activities from a broader range of health services, including community health, and accelerated the development of integrated and collaborative care models across hospital and primary care.



Observation: Responding to COVID-19

Governments swiftly established the COVID-19 NPA, in which the Commonwealth funded 50% of COVID-19 related hospital and public health costs. The COVID-19 NPA has expired and been replaced by a new National Partnership Agreement to cover ongoing vaccination and testing needs. However, certain public health costs are excluded from the national funding model as they are not covered through the NHRA. The backlog in planned care will be funded at a 45% growth rate within the 6.5% cap, potentially leaving jurisdictions with additional costs. The need for a separate funding agreement alongside the NHRA revealed a lack of flexibility to adapt to major health system shocks.

4 Understanding the Health environment

This chapter presents the context in which the Australian health system operates. It notes societal and demographic changes and pressures since the NHRA was introduced and anticipates some future trends and challenges.

Australia's health sector at a glance

Health services in Australia are delivered by public and private providers in a range of care settings. Universal access to health care, delivered through MBS, PBS and public hospitals are features of the Australian health care system, complemented by privately provided services and private health insurance (PHI).

As well as managing the MBS and PBS, the Commonwealth Government leads the development of national health policy, contributing funds to States and Territories to support public hospital services, regulating private health insurance, providing oversight of PHNs, funding community-controlled Indigenous primary health care, funding and organising health services for veterans, and funding health and medical research.

State and Territory governments have responsibility for managing public hospitals within their jurisdictions. They regulate and license private hospitals, provide oversight of LHNs and deliver a range of community-based and primary health services. Additionally, they deliver preventive services such as cancer screening and immunisation programs, ambulance services, and handle health-related complaints.

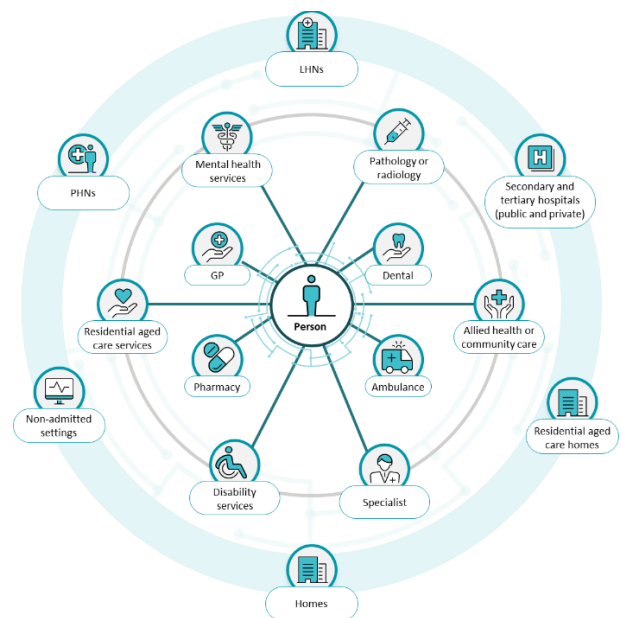


Figure 11: Australian health care landscape (adapted from Report on Government Services 2023 Report – Figure E.1)

Despite these distinct responsibilities, there are areas of shared responsibility between Commonwealth, State and Territory governments, including funding public hospital services, the education and training of health professionals, regulating health workforces, and improving the safety and quality of healthcare.

While governments lay the overarching framework for the healthcare system, the private sector significantly contributes by operating certain health services. This includes managing the operations of private hospitals, pharmacies, and many medical practices, as well as providing funding through PHI. There are 32 PHI providers registered with the Australian Prudential Regulation Authority (APRA)¹³. In 2020-21, the ratio of total health spending in Australia in the public and private sectors was around 70% to 30%, respectively¹⁴.

In 2020-21, total health spending in Australia was distributed across the various health services in the following ratios¹⁵:

- 40.6% on hospitals
- 33.2% on primary health care
- 10.9% on referred medical services
- 15.3% on other services, research and capital spending.

Hospital care

Both public and private hospitals provide admitted, ED and non-admitted services. The most recent data show that there were 640 private hospitals as at 11 October 2023¹⁶. In 2021-22, 697 public hospitals in Australia handled¹⁷:

- 8.8 million ED presentations
- 6.8 million hospitalisations across 21.7 million days of patient care
- 55.4 million non-admitted patient care service events for public patients.

¹³ Australian Prudential Regulatory Authority. Register of private health insurers, 2023. Available from: <https://www.apra.gov.au/register-of-private-health-insurers>

¹⁴ <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2020-21/contents/spending-trends-by-sources>

¹⁵ <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2020-21/contents/spending-trends-by-areas-of-spending>

¹⁶ Declared Hospitals List of the Commonwealth. <https://www.health.gov.au/resources/publications/list-of-declared-hospitals?language=en>

¹⁷ Australian Institute of Health and Welfare. Australia's hospitals at a glance: Hospital activity, 2022. Available from: <https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance/contents/hospital-activity>

In 2020–21, \$70.5 billion was spent on public hospitals¹⁸ (\$2750 per capita) – public hospital spending by source of funds is illustrated in Figure 12. Over the 10-year period to 2020-21, overall public hospital spending increased in real terms by 3.6% on average per year¹⁹.

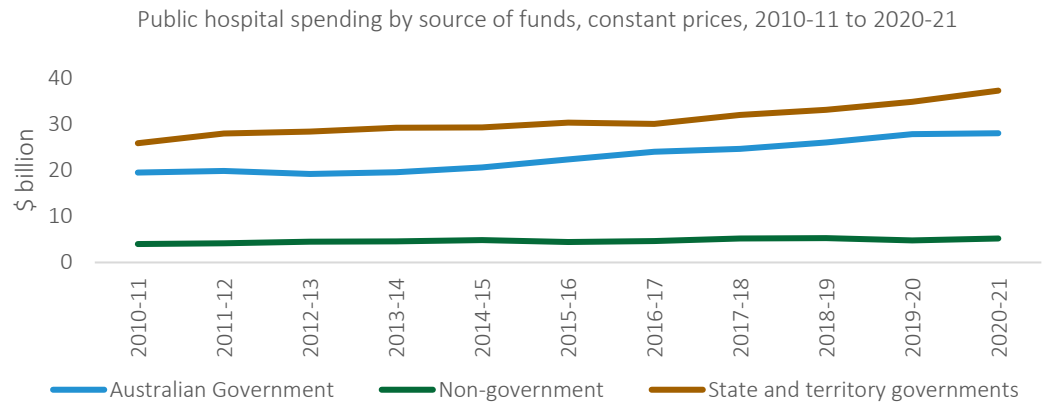


Figure 12: Public hospital spending by source of funds, constant prices, 2010-11 to 2020-21

Primary health care, specialist, and diagnostic services

Primary care is generally accepted as the cornerstone of a well-functioning healthcare system. By focusing on proactive measures and addressing health concerns at their initial stages, primary care (delivered by GPs, nurses, Aboriginal and Torres Strait Islander Health services, and allied health providers) can prevent the escalation of illnesses and the need for more costly interventions that are typically performed in hospitals. Primary health care may be delivered in a range of settings, including aged care, disability support and the community. In 2021-22, around 90% of Australians saw a GP and there were approximately 270 million MBS-subsidised primary care services, including 189 million GP attendances and 25 million allied health attendances²⁰.

One average hospital admission is over \$1000 more expensive than a patient seeing their GP for 20 minutes twice a week for an entire year.

Specialists typically engage with patients who have received a referral from a primary healthcare practitioner. They provide diagnostic and treatment services in a specific area of medicine both within and outside hospital settings. In 2021-22, a total of 25.6 million MBS-subsidised referred medical specialist consultations were provided to 8.1 million Australians²¹.

Pathology, diagnostic imaging and other diagnostic services are essential to assist health practitioners to diagnose and monitor a patient’s illness or injury. In 2020–21, a total of 204.1 million MBS-subsidised pathology tests, imaging scans and a range of diagnostic services were delivered to 69% of Australians²².

Primary care is a more cost-effective form of intervention than hospital care, with one average hospital admission around \$1000 more expensive than a patient seeing their GP for 20 minutes twice a week for an entire year^{23,24}. In a similar vein, managing more complex patients in the community for some or all of an acute episode can reduce costs and improve outcomes²⁵.

Australia’s health expenditure

In 2020-21, \$73.4 billion was spent on primary health care and \$89.7 billion was spent on hospitals²⁶, across private and public settings.

¹⁸ <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2020-21/contents/spending-trends-by-areas-of-spending/hospitals>

¹⁹ <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2020-21/contents/spending-trends-by-areas-of-spending/hospitals>

²⁰ Australian Institute of Health and Welfare. Medicare-subsidised GP, allied health and specialist health care across local areas: 2021-22, 2022. Available from: <https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-gp-allied-health-and-specialis/contents/about>

²¹ Australian Institute of Health and Welfare (2022a). Medicare-subsidised GP, allied health and specialist health care across local areas: 2021-22. Available from: <https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-gp-allied-health-and-specialis/contents/about>

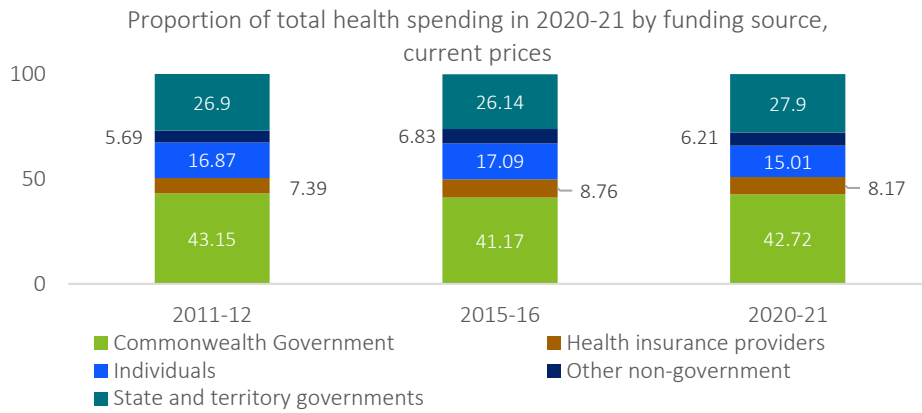
²² Australian Institute of Health and Welfare. Pathology, imaging and other diagnostic services, 2022. Available from: <https://www.aihw.gov.au/reports/diagnostic-services/pathology-imaging-and-other-diagnostic-services>

²³ MBS Online. Item 23, Medicare Benefits Schedule. Available from: <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=23>

²⁴ Steering Committee for the Review of Government Service Provision. Report on government services, 2019. Available from: <https://www.pc.gov.au/ongoing/report-on-government-services/2019/health/public-hospitals>

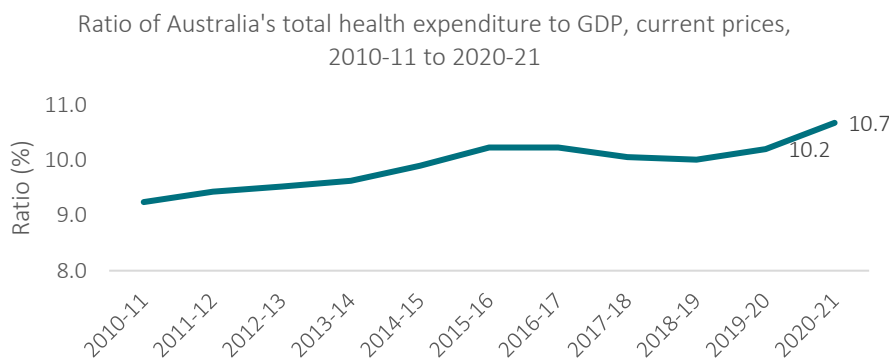
²⁵ Board N, Brennan N, and Caplan G. A randomised controlled trial of the costs of hospital as compared with hospital in the home for acute medical patients. Australian and New Zealand Journal of Public Health 24(3): 305-311, 2000.

²⁶ <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2020-21/contents/spending-trends-by-areas-of-spending>



Australia spent an estimated \$220.9 billion on health goods and services in 2020-21, equivalent to \$8617 per capita²⁷, comprising \$156 billion from government sources and \$64.9 billion from non-government sources. Figure 13 shows the proportion of total health spending in 2020-21 by the various funding sources.

Figure 13: Proportion of total health spending in 2020-21 by funding source, current prices



In 2020-21, total health spending (from government and non-government sources) represented 10.7% of Australia's gross domestic product (GDP), an 0.5 percentage point increase from 2019-20²⁸ (see Figure 14).

Figure 14: Ratio of Australia's total health expenditure to GDP, current prices, 2010-11 to 2020-21

Australia's overall government health spending accounts for 8.2% of the country's GDP, placing Australia thirteenth among Organisation for Economic Co-operation and Development (OECD) countries (see Figure 15)²⁹.

Government health expenditure as a proportion of GDP across OECD countries

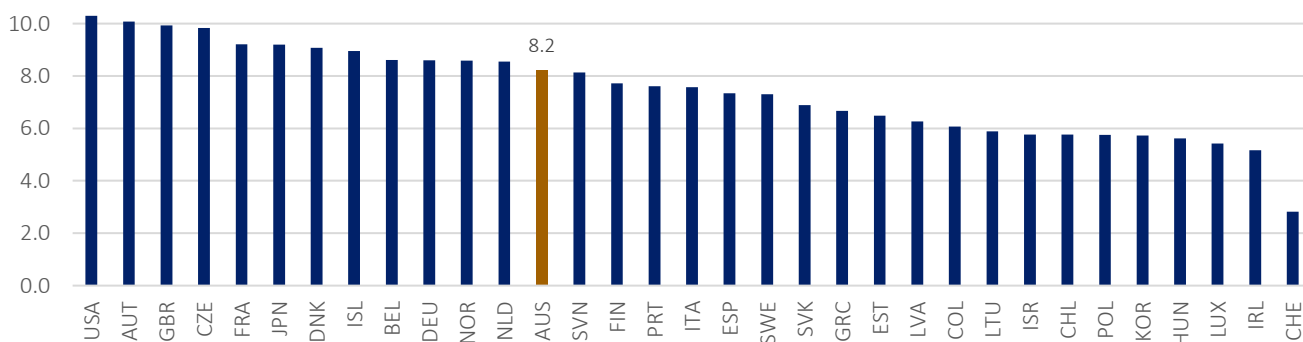


Figure 15 : Government health expenditure across OECD countries, 2021

Commonwealth, State and Territory health expenditure

In 2020-21, the Commonwealth Government's \$94.4 billion in health spending represented 14.3% of its expenses³⁰. Decreases in health expenditure as a proportion of all Commonwealth Government expenses over the two years 2019 to 2021 has seen a drop in this ratio to well below pre-pandemic levels, which indicates that the growth in health spending has been slower than other areas of Commonwealth Government spending, noting the significant impact on spending of COVID-19 related initiatives

²⁷ Australian Institute of Health and Welfare. Health Expenditure Australia 2020-21, 2022. Available from: <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2020-21/contents/about>

²⁸ <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2020-21/contents/overview/the-health-sector-relative-to-the-economy>

²⁹ OECD Data. General Government Spending, 2023. Available from: <https://data.oecd.org/gga/general-government-spending.htm>

³⁰ <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2020-21/contents/spending-trends-by-sources/government-sources>



such as JobKeeper. By contrast, the ratio of State and Territory government health spending to total government expenses was 17.4%, approximately 0.4 percentage points higher than in 2019–20³¹.

The recently released *2023 Intergenerational Report*³² has highlighted pressure on the sustainability of Australian Government health spending. Sustainability concerns are shared by States and Territories in terms of the pressures on their own budgets.

The Commonwealth Government’s health spending is projected to increase by 2 percentage points of GDP in the next 40 years from 4.2% of GDP in 2022-23 to 6.2% of GDP in 2062-63³³. This projected growth is primarily attributed to a growing and ageing population, and the cost of new technologies, treatments and improvements in care quality. Over the medium term, hospital expenditure is projected to be the fastest growing component of Commonwealth government health expenditure, increasing by 35% from \$950 per capita in 2022-23 to \$1300 per capita in 2033-34. MBS expenditure is also expected to grow significantly, increasing by 25% from around \$1050 per capita in 2022-23 to \$1300 per capita in 2033-34.

Under the NHRA, the Commonwealth Government contributes to the cost of operating public hospitals. An explicit goal of the national funding model is to increase the Commonwealth’s share of public hospital funding for the purpose of ensuring a more financially sustainable public health system. In 2022-23, the Commonwealth Government contributed \$25.8 billion under the NHRA, a 97% increase from the \$13.1 billion contribution in 2012-13 (See Figure 16)³⁴.

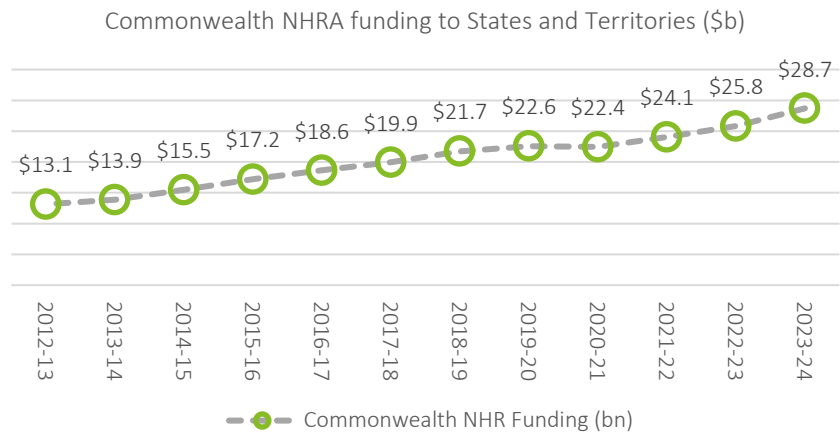


Figure 16: Commonwealth NHRA funding to States and Territories 2012-13 to 2022-23

The national Commonwealth Contribution Rate (CCR), a metric defined in the NHRA that measures the value of the Commonwealth’s NHRA funding as a proportion of total efficient hospital prices, has increased from 33.7% in 2013-14 to 40.3% in 2022-23 across all States and Territories. Significant variation between individual States and Territories’ CCRs have narrowed but are still present as shown in the whisker plots (Figure 17).

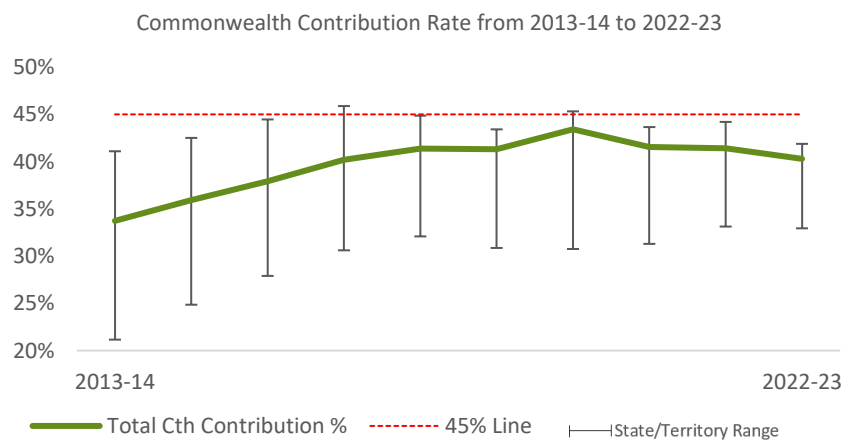


Figure 17: Commonwealth Contribution Rate from 2013-14 to 2022-23

Life expectancy

Australia’s healthcare system performs well compared to international counterparts, as evidenced by its low infant mortality rate (3.3 deaths per 1000 live births) and high life expectancy³⁵. Australia has one of the highest life expectancies globally, reaching 83.2 years in 2021, ranking fifth among 38 other OECD countries³⁶. Australia’s life expectancy can be attributed to advances in medical knowledge and technology, health care accessibility, enhanced living conditions and quality of life³⁷.

³¹ <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2020-21/contents/spending-trends-by-sources/government-sources-state-and-territory-government>
³² <https://treasury.gov.au/sites/default/files/2023-08/p2023-435150.pdf>
³³ <https://treasury.gov.au/sites/default/files/2023-08/p2023-435150.pdf>
³⁴ National Health Funding Body funding reports 2012-22. Available from: <https://www.publichospitalfunding.gov.au/public-hospital-funding-reports>
³⁵ The Commonwealth Fund. Mirror, Mirror, 2021: Reflecting Poorly. Available from: <https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly>
³⁶ Organisation for Economic Co-operation and Development. OECD Better Life Index, 2021. Available from: <https://www.oecdbetterlifeindex.org/topics/health/>
³⁷ Productivity Commission, “Why a better health system matters”, 2015. Available from: <https://www.pc.gov.au/inquiries/completed/productivity-review/report/productivity-reviewsupporting4.pdf>

Chronic and complex diseases

Almost half of Australians (47%, or 11.6 million people) were estimated to have one or more chronic health conditions in 2020-21.

While the average Australian is living longer and spending more years in full health without disease or injury, more Australians are living with chronic disease, impacting their quality of life and capacity to participate in society³⁸. Australians spend an average of nearly eleven years in poor health, roughly equating to 13% of the typical lifespan³⁹. The past 50 years has seen a rise in chronic disease prevalence across Australia, with 62% of Australia’s total disease burden in 2022 attributed to cancer, musculoskeletal conditions, cardiovascular disease, mental health conditions and substance use disorders and neurological conditions⁴⁰. Almost half of Australians (47%, or 11.6 million people) were estimated to have one or more chronic health conditions in 2020-21⁴¹. Figure 18 shows the prevalence of chronic conditions across age groups in 2020-21. The escalating prevalence of chronic conditions has elevated the rate of multimorbidity, where individuals have two or more chronic health conditions, requiring more specialised and coordinated care across the health system. Consequently, health care services face heightened demand and expenditure. In 2015-16, nearly half of all potentially preventable hospitalisations were attributed to chronic health conditions, with the impact of these potentially preventable hospitalisations estimated to cost the health system over \$2.3 billion dollars⁴². Over the next 40 years, the number of people aged 65 and over is projected to more than double and the number aged 85 and over more than triple, creating an ongoing economic and fiscal challenge⁴³.

In 2015-16, nearly half of all potentially preventable hospitalisations were attributed to chronic health conditions and were estimated to cost the health system over \$2.3b.

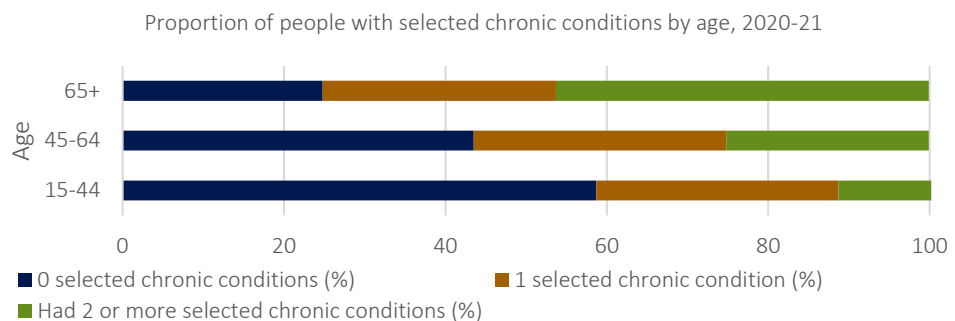


Figure 18: Proportion of people with selected chronic conditions by age

Health equity for under-served populations

Reductions in mortality rates have not been equitably shared across population groups. Persistent disparities remain for First Nations, rural and remote, and migrant populations. Notably, a considerable gap in life expectancy remains between Indigenous and non-Indigenous Australians (refer Figure 19), with mortality rates consistently higher among Indigenous Australians across most causes of death. Recent data spanning 2016 to 2020, reveal an age-standardised mortality rate for Indigenous Australians nearly twice that of their non-Indigenous counterparts (960 versus 522 deaths per 100,000 population respectively)⁴⁴. The health-adjusted life expectancy for males and females in 2015 in *Remote and very remote* areas was 5.2 and 5.8 years shorter, respectively, than those in *Major cities*⁴⁵. During the COVID-19 pandemic, people who died of COVID-19 with an overseas country of birth had an age-standardised death rate close to three times higher than that of people born in Australia (6.8 versus 2.3 deaths per 100,000 population)⁴⁶.

³⁸ Australian Institute of Health and Welfare. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015, 2019. Available from: <https://www.aihw.gov.au/getmedia/c076f42f-61ea-4348-9c0a-d996353e838f/aihw-bod-22.pdf?inline=true>

³⁹ Productivity Commission. Impacts of Health Recommendations, Shifting the Dial: 5 year Productivity Review, Supporting Paper No. 6., 2017 Available from: <https://www.pc.gov.au/inquiries/completed/productivity-review/report/productivity-review-supporting6.pdf>

⁴⁰ Australian Institute of Health and Welfare. Australian Burden of Disease Study, 2022. <https://www.aihw.gov.au/getmedia/d9ae4bfa-df27-4e3c-9846-ba452bef6ac5/aihw-bod-37.pdf.aspx?inline=true>

⁴¹ Australian Bureau of Statistics. Health Conditions Prevalence, 2021. Available from: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/health-conditions-prevalence/2020-21>

⁴² Australian Institute of Health and Welfare. Australia’s health 2020 data insights, 2020. Available from: <https://www.aihw.gov.au/getmedia/be95235d-fd4d-4824-9ade-34b7491dd66f/aihw-aus-231.pdf?inline=true>

⁴³ Commonwealth of Australia. Intergenerational Report, 2023. Available from: <https://treasury.gov.au/sites/default/files/2023-08/p2023-435150.pdf>

⁴⁴ Australian Institute of Health and Welfare. Deaths in Australia, 2023. Available from: <https://www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia/contents/summary>

⁴⁵ <https://www.aihw.gov.au/getmedia/c076f42f-61ea-4348-9c0a-d996353e838f/aihw-bod-22.pdf?inline=true>

⁴⁶ Australian Bureau of Statistics. COVID-19 Mortality by wave, 2022. Available from: <https://www.abs.gov.au/articles/covid-19-mortality-wave>

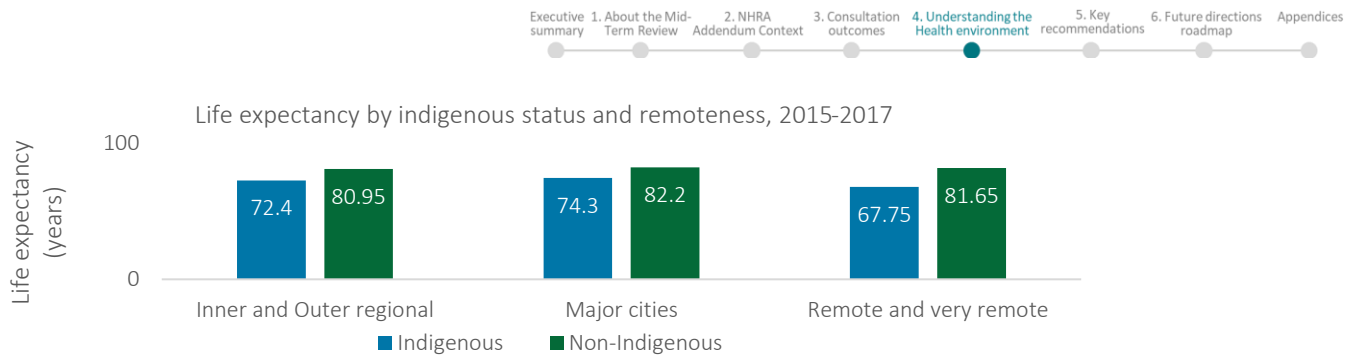


Figure 19: Life expectancy by Indigenous status and remoteness, 2015-2017

While the reasons for health inequity are multifactorial, the lack of access to health care services has been identified as a contributing factor⁴⁷. There is concern around future supply of rural, regional and remote primary care providers. For most health professionals including specialists, dentists, pharmacists, and other allied health professionals, there is a marked decline in the rate of clinical full-time equivalent practitioners per 100,000 population once outside major cities, with the notable exception of nurses and midwives⁴⁸. Data shows that people living in rural and remote areas have higher rates of hospitalisations, deaths, injury and have poorer access to, and use of, primary healthcare services, than people living in major cities⁴⁹. In 2020, the potentially avoidable death rate for people living in very remote areas was more than double the rate of people living in major cities⁴⁴. Although three-quarters of First Nations’ populations live in major cities and regional areas with access to mainstream health care services, there are several areas in Australia where the Indigenous population has very limited access to both Indigenous-specific services and GP services in general⁵⁰.

Access to primary care and community health services

Accessible primary care is essential, both to enable access to early diagnosis, intervention, and management of health conditions and to support timely hospital discharge and outpatient management. Providing access to comprehensive care within the community, enables more expensive hospital settings to focus on those in genuine need of specialised treatment.

Data suggests that the affordability of primary care services has been declining. In 2022-23, the proportion of patients attending non-referred GP appointments who reported that they were always or usually bulk billed decreased from 89.0% to 77.3%, while the proportion who reported they were never bulk billed increased from 4.2% to 10.5%⁵¹. Refer to Figure 20.

How often do patients report they are bulk billed for GP non-referred attendances?

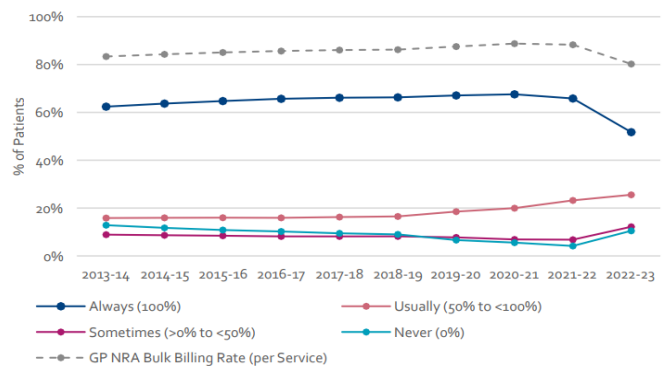


Figure 20: Proportion of patients who report they are bulk billed for GP non-referred attendances⁵¹

In addition, Australians reported barriers to accessing primary care, predominantly related to timely availability of services and cost. According to a survey conducted by the ABS in 2021-22⁵²:

- 24.8% of people delayed seeing a GP for reasons such as service availability or waiting time, an increase from 23.4% in 2017-18.
- 3.5% of people who needed to see a GP delayed or did not see a GP due to cost, a decrease from 4.0% in 2017-18.
- 23% of people felt they waited longer than acceptable for a GP appointment, an increase from 19.2% in 2017-18.
- 3.9% of people with a long-term health condition who needed to see a GP delayed or did not see a GP due to cost. This was higher in regional and remote areas compared to those in major cities (5% and 3.1%, respectively).

⁴⁷ Queensland University of Technology and the Australian Institute of Health and Welfare (2006). Health inequalities in Australia: morbidity, health behaviours, risk factors and health service use. Available from: <https://www.aihw.gov.au/getmedia/0cbc6c45-b97a-44f7-ad1f-2517a1f0378c/hiamhbrfhsu.pdf?inline=true>

⁴⁸ Australian Institute of Health and Welfare. Health workforce, 2022. Available from: <https://www.aihw.gov.au/reports/workforce/health-workforce>

⁴⁹ Australian Institute of Health and Welfare. Rural and remote health, 2022. Available from: <https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health#Access>

⁵⁰ Australian Institute of Health and Welfare. Australia’s health, 2016. Available from: <https://www.aihw.gov.au/getmedia/01d88043-31ba-424a-a682-98673783072e/ah16-6-6-indigenous-australians-access-health-services.pdf.aspx>

⁵¹ Australian Government Department of Health and Aged Care. MBS Quarterly Statistics Dashboard, 2023. Available from: <https://www.health.gov.au/sites/default/files/2023-08/medicare-statistics-per-patient-bulk-billing-dashboard-2022-23.pdf>

⁵² Australian Bureau of Statistics. Patient experiences in Australia: summary of findings, 2021-22. Available from: <https://www.abs.gov.au/statistics/health/health-services/patient-experiences/2021-22>

The Commonwealth made a \$6.1 billion investment in the 2023-24 Federal Budget⁵³ to improve access to GP and broader primary care services through increased bulk billing incentives, raising the Medicare indexation rate, support for longer telehealth items, and greater access to after-hours care as well as introducing a range of initiatives to improve management of chronic disease in the community.

Access and capacity of public hospital services

Population aged 65 or over

The number of available hospital beds per 1000 people aged 65 years or more is an important measure of public hospital capacity. People aged 65 and over account for 50% of total admitted bed days⁵⁴ and are admitted for 33% longer compared to all other age cohorts⁵⁵. The number of available public hospital beds per 1000 population aged 65 or over has declined from 18.6 to 14.8 between 2011-12 to 2020-21 (Figure 21). From 2016-17 to 2020-21 the number of ED presentations per 1000 population (for all age groups) requiring hospital admission increased by 3%. Over the same period the number of hospital beds per 1000 population decreased by 4%^{56,57}.

People aged 65+ account for 50% of total admitted bed days and are admitted for 33% longer compared to all other age cohorts.

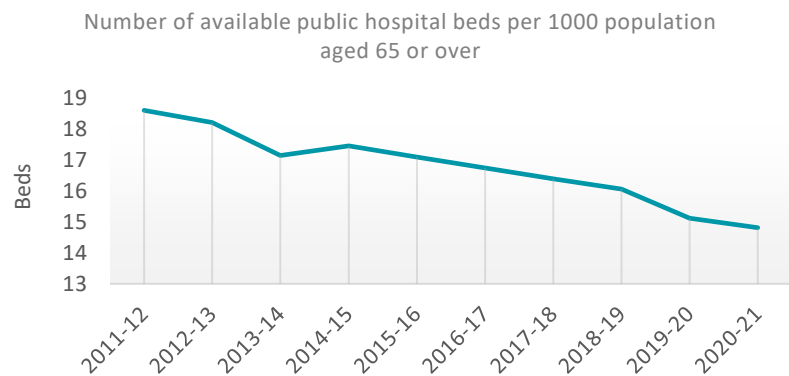


Figure 21: Number of available public hospital beds per 1000 population aged 65 or over

Access and capacity in EDs

Access to a public hospital in-patient bed is a factor in the effective operation of emergency departments. When a hospital is operating at capacity, there is no pathway to admit patients from the ED. Patients arriving by ambulance receive care from paramedics either in the ambulance or the hospital corridor (ambulance ramping) until there is an available bed and ED staff to whom to transfer care. The variability in the metrics used for reporting ambulance ramping among different States and Territories create a challenge in assessing the extent of the problem at a national level. The AMA reports that longitudinal data demonstrates a consistent upward trend in the duration it takes to transfer a patient from the ambulance to the care of the hospital ED and has been overall increasing year-on-year⁵⁸.

Demand for public hospital ED services continues to increase. The 8.8 million presentations to EDs in 2020-21 represent 339 presentations per 1000 population, rising from 321 presentations per 1000 population in 2017-18, an increase of 1.4% per year. The level of urgency of patients presenting to EDs is also increasing. From 2009-10 to 2021-22, the proportion of patients assigned to the three most urgent triage categories (resuscitation, emergency and urgent) increased from 42.8%⁵⁹ to 54.5%⁶⁰.

The pressure on public hospital EDs is reflected in waiting and treatment times. The proportion of emergency patients seen within the clinically recommended timeframe, within the emergency triage category, decreased from 80% to 65% between 2011-12 and 2021-22⁶¹.

⁵³ Australian Government, Department of Health and Aged Care. Budget 2023-24 Overview, 2023. Available from: https://www.health.gov.au/sites/default/files/2023-05/overview-budget-2023-24_0.pdf

⁵⁴ Australian Institute of Health and Welfare. Admitted Patient Care 2018-19, 2020. Available from: <https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients>

⁵⁵ Australian Institute of Health and Welfare. Admitted Patient Care 2017-18. Table 3.1, 2019. Available from: <https://www.aihw.gov.au/getmedia/df0abd15-5dd8-4a56-94fa-c9ab68690e18/aihw-hse-225.pdf?inline=true>

⁵⁶ <https://www.aihw.gov.au/reports/hospitals/ahs-2016-17-emergency-department-care/summary>

⁵⁷ <https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care>

⁵⁸ Australian Medical Association. Ambulance Ramping Report Card, 2022. Available from: <https://www.ama.com.au/articles/ama-ambulance-ramping-report-card>

⁵⁹ Australian Institute of Health and Welfare. Australian hospital statistics 2009-10, Emergency department care and elective surgery waiting times, 2010. Available from: <https://www.aihw.gov.au/getmedia/1b305ffc-b7a4-4f80-aa66-d90614c5f8f4/12271.pdf.aspx?inline=true>

⁶⁰ Australian Institute of Health and Welfare. Australia's hospitals at a glance, Hospital activity, 2022. Available from: <https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance/contents/hospital-activity>

⁶¹ Australian Institute of Health and Welfare. Time spent in emergency departments, 2023. Available from: <https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed>

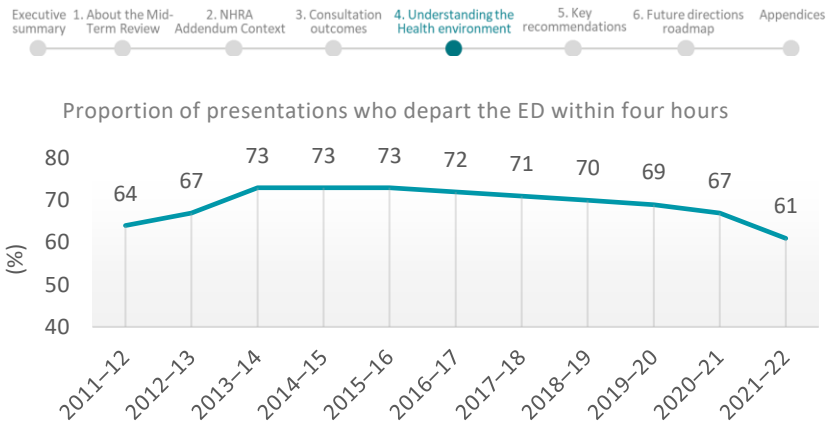


Figure 22: Proportion who depart the ED within 4 hours, average across all triage categories

There has been an increase in the overall amount of time that patients tend to spend in the ED. The proportion of people who completed their emergency presentation within four hours across all triage categories was in the range of 70-73% between 2013-14 to 2018-19. However, it dropped significantly to 61% in 2021-22, probably related to activity fluctuations due to COVID-19 (Figure 22⁶²). 90% of ED visits for patients who were subsequently admitted to the hospital were dealt with within 15 hours, 37 minutes in 2021-22, compared to 11 hours, 8 minutes in 2017-18.⁶³

Access and capacity of elective surgery services

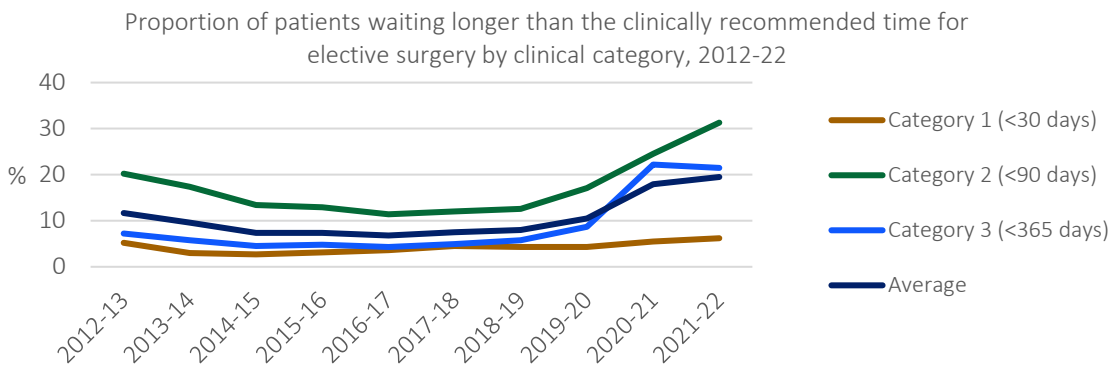


Figure 23: Proportion of patients waiting longer than the clinically recommended time for elective surgery by clinical category, 2012-22

Another consequence of insufficient or inaccessible public hospital beds is the restriction on the number of patients who can be admitted for elective surgery. The average proportion of patients waiting longer than the clinically recommended time for elective surgery, across all categories, increased from 6.8% to 8.0% between 2016-2019⁶⁴.

From 2019-2022, wait times for elective surgery increased significantly due to the COVID-19 restrictions on performing elective surgery and the resultant elective surgery backlog. The average proportion of patients waiting longer than the clinically recommended time for elective surgery, across all categories, was 19.5% in 2021-22 compared to 8% in 2018-19⁶¹ (refer to Figure 23). Despite the backlog in elective surgery, the median waiting time for category 1 (most urgent) patients was 13 days, mirroring the levels observed prior to the pandemic⁶⁵. A blockage in patient flows through the public hospital system can result in delayed care and may lead to poorer patient outcomes, longer lengths of stay, and higher hospitalisation costs. The Australian College of Emergency Medicine notes that, in 2018-19, more than 522,500 ED patients experienced access block, which they estimated cost the health system \$583 million (range of \$222-\$833 million)⁶⁶.

Public hospital interface issues that contribute to capacity constraints

Issues at the interface of public hospitals and the primary care, aged care and disability sectors also contribute to available hospital bed capacity. When these sectors are unable to provide suitable accommodation or care when a patient is ready to be discharged and remains in hospital, it reduces overall hospital bed capacity, compromises patient flow, and delays patient treatment. As of 31 May 2023, the average duration between NDIS participants being medically ready for discharge and actual discharge is 26 days⁶⁷. In 2020-21, there were a total of over 286,000 hospital patient days across Australia for eligible individuals waiting for residential age care⁶⁸. This translates to 9.2 hospital patient days per 1000 patient days and represents a decade-long decline from 11.2 days in 2011-12. The Review acknowledges that,

Average duration between NDIS participants being medically ready for discharge and actual discharge is 26 days.

⁶² Australian Institute of Health and Welfare. Time spent in emergency departments, 2023. Available from: <https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed>

⁶³ Australian Institute of Health and Welfare. Emergency department care 2020-21. Australian hospital statistics, 2021. Available from: <https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care>

⁶⁴ Australian Institute of Health and Welfare. Elective surgery waiting times, 2022. Available from: <https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-es>

⁶⁵ Australian Institute of Health and Welfare. Time spent in emergency departments, 2023. Available from: <https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-ed>

⁶⁶ Australasian College of Emergency Medicine. Access Block, 2021. Available from: [https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block-\(1\)/Access-Block](https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block-(1)/Access-Block)

⁶⁷ Data gathered by the National Disability Insurance Agency (NDIA) through manual collection by Health Liaison Officers (HLOs).

⁶⁸ Commonwealth Government of Australia. Report on Government Services, 2023. Available from: <https://www.pc.gov.au/ongoing/report-on-government-services/2023/community-services/aged-care-services/rogs-2023-partf-section14-aged-care-data-tables.xlsx>

while the most recent publicly available national data indicates 9.2 hospital patient days, more recent State and Territory-provided reporting suggests a notable deterioration since that time. When assessing this figure based on remoteness there was a significant variation when comparing major cities (7 hospital patient days per 1000 patient days) to those in regional and remote settings (for example, 47.6 hospital patient days per 1000 patient days for the remote setting).⁶⁹

Quality and safety in hospitals

Australia’s health system is relatively safe and high performing compared to other countries. The OECD compiled data spanning several health care quality and outcome indicator areas, revealing that Australia consistently outperforms numerous OECD nations across many indicators. However, there remains specific areas for improvement⁷⁰. The ACSQHC collects information on national measures of safety and quality and monitors appropriateness of care through the *Australian Atlas of Healthcare Variation*. Admitted patient safety and quality data from the AIHW shows that, from 2017-18 to 2021-22, the rate of hospital acquired complication (HACs) decreased from 2.6 per 100 to 2.1 per 100 hospitalisations (See Figure 24). In the same period, rates of potentially preventable hospitalisations (PPHs) decreased from 27.9 per 1000 population to 23.1 per 1000 population, an annual average decrease of 4.7%⁷¹. The *2017 NHRA Addendum* saw the introduction of safety and quality initiatives and a focus on reducing unnecessary hospitalisations, which may have influenced improved performance in these metrics in recent years.

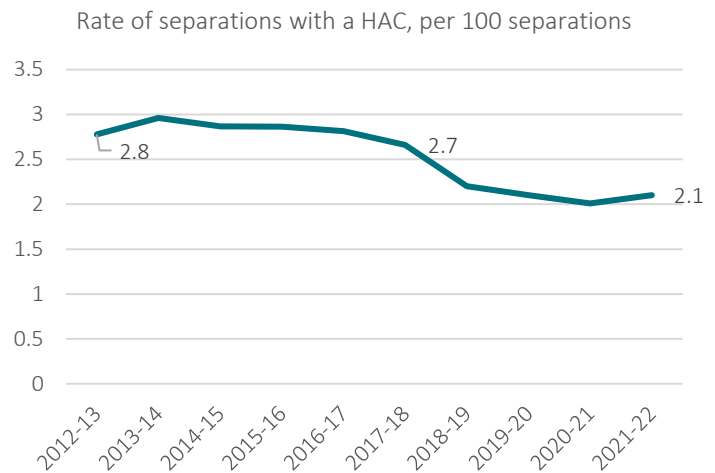


Figure 24: Rate of separations with a HAC, per 100 separations, 2012-2022

In 2021-22, 73-80% of patients who used hospital services as an admitted patient reported that staff always spent enough time with them, always listened carefully, and always showed respect⁷². This level of patient experience has remained consistent since 2016-17. People living in outer regional, remote, and very remote areas reported more positive experiences with ED doctors and nurses compared to those living in major cities⁷².

Health workforce

The health workforce in Australia is large and diverse. As of August 2023, the Australian Health Practitioner Regulation Agency (AHPRA) recorded a total of 877,119 registered health practitioners, an 18% increase on the 744,437 practitioners registered in June 2019, before the pandemic⁷³. The hospital workforce in Australia includes medical officers, nurses, diagnostic and allied health professionals, administrative and clerical staff, and domestic and other personal care staff. In 2021-22, there were 697 public hospitals in Australia that employed an average full-time equivalent of 174,574 nurses, 52,209 salaried medical officers, and 68,081 diagnostic and allied health professionals⁷⁴.

⁶⁹ Commonwealth Government of Australia. Report on Government Services, 2023. Available from: <https://www.pc.gov.au/ongoing/report-on-government-services/2023/community-services/aged-care-services/rogs-2023-partf-section14-aged-care-data-tables.xlsx>

⁷⁰ Australian Institute of Health and Welfare. OECD Health Care Quality and Outcomes Indicators, Australia 2021, 2022. <https://www.aihw.gov.au/reports/international-comparisons/oecd-health-care-quality-and-outcomes-indicators-2021/contents/about>

⁷¹ Australian Institute of Health and Welfare. Admitted patient safety and quality, 2022. Available from: <https://www.aihw.gov.au/reports-data/myhospitals/intersection/quality/apc>

⁷² Australian Bureau of Statistics. Patient Experiences, 2022. Available from: <https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release>

⁷³ Australian Health Practitioner Regulation Agency. More practitioners than ever want to work in Australian health systems, 2023. Available from: <https://www.ahpra.gov.au/News/2023-08-17--New-workforce-data.aspx#:~:text=The%20number%20of%20registered%20medical,registration%20as%20of%20June%202023.>

⁷⁴ <https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release#experience-with-health-professionals>

Maldistribution of the health workforce by skills and geography

There is a maldistribution of skills and location of the health workforce across Australia, particularly in rural and remote areas. Australia's overall doctor to population ratios is among the highest in the OECD and many areas of medical practice are in plentiful supply or even over-supply⁷⁵. However, the persistent imbalance in medical workforce distribution, both in terms of geographic location and specialisation, remains a root cause of widespread workforce shortages. Notably, the medical disciplines facing current or projected national undersupply include ophthalmology, dermatology, and psychiatry⁷⁶. Emergency medicine is in national oversupply but there are job vacancies in rural areas⁷⁷. The uneven distribution of medical expertise contributes to accessibility issues and longer waiting times for some medical specialist services and in rural and remote areas. Additionally, there is a higher proportion of junior doctors opting for non-GP specialty training, resulting in a faster growth rate of non-GP specialists compared to GP specialists⁷⁸.

Australia's overall doctor to population ratios is among the highest in the OECD and many areas of medical practice are in plentiful supply or even over supply. The persistent imbalance in medical workforce distribution is the root cause of widespread workforce shortages.

Across the nation, there is evidence of significant shortages of nurses, midwives, and allied health professionals. The shortage of nurses and midwives is pressing, with projections indicating a need for over 40,000 additional registered nurses by 2026⁷⁹. There are also shortages of allied health professionals across primary care, disability, aged care, and hospital care, in particular physiotherapists, radiographers, speech therapists, and social workers⁸⁰. Shortages in community-based care can lead to increased Potentially Preventable Hospitalisations (PPHs) if patients are unable to access timely community-based care. Furthermore, the lack of community-based care following hospital discharge can result in more prolonged hospital stays or avoidable readmissions.

The rural, remote, and regional specialist workforce is especially constrained. Approximately 28% of Australians live in rural, regional, or remote areas⁸¹. However, the specialist-to-population ratio in these remote areas is seven times lower than that in metropolitan regions⁸², despite a higher burden of chronic disease, risky behaviours, patient hospitalisations, mortality, injury, and poorer access to and use of primary health care services^{83,84}. The impending shortage of GPs looms large, particularly in rural and remote areas⁸⁵, leading to concerns of a loss in the generational transfer of practices, knowledge and skills. Further, the proportion of final-year medical students listing GP as their first preference speciality was 13.1% in 2022⁸⁶.

Specialist-to-population ratio in rural, remote, and regional areas is seven times lower than metropolitan regions.

The National Medical Workforce Strategy, developed in 2021, seeks to address these distribution imbalances in the medical workforce. Additionally, a National Nursing Workforce Strategy is currently being developed⁸⁷.

⁷⁵ Commonwealth Department of Health. National Medical Workforce Strategy: 2021-31 Investing in our medical workforce to meet Australia's health needs, 2021. Available from: <https://www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf>

⁷⁶ Medical Deans Australia and New Zealand, 'National Data Report 2020: 2015–2019 data from final year students at Australian medical schools', Medical Deans Australia and New Zealand website.

⁷⁷ Commonwealth Department of Health. National Medical Workforce Strategy: 2021-31 Investing in our medical workforce to meet Australia's health needs, 2021. Available from: <https://www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf>

⁷⁸ Australian Government Department of Health and Aged Care. National Health Workforce Data Tool Data selected: Number of practitioners by primary speciality in labour force in Australia 2013 to 2020, 2020.

⁷⁹ National Skills Commission. Projecting employment to 2026 [Insights], 2022. Available from: <https://labourmarketinsights.gov.au/industries/industry-details?industryCode=Q>

⁸⁰ National Skills Commission. Care Workforce Labour Market Study, 2021. Available from: <https://www.nationalskillscommission.gov.au/sites/default/files/2022-10/Care%20Workforce%20Labour%20Market%20Study.pdf>

⁸¹ Australian Institute of Health and Welfare. Rural and remote health, 2022. Available from: <https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health>

⁸² Australian Government Department of Health and Aged Care. Rural Health Workforce, 2021. Available from: <https://www.health.gov.au/topics/rural-health-workforce/about#australias-rural-health-workforce>

⁸³ Tomaschek, Rebecca, et al. "Improvement strategies for the challenging collaboration of general practitioners and specialists for patients with complex chronic conditions: a scoping review." *International Journal of Integrated Care* 22.3, 2022.

⁸⁴ Breadon, P., Romanes, D., Fox, L., Bolton, J., and Richardson, L. A new Medicare: Strengthening general practice. Grattan Institute, 2022.

⁸⁵ Australian Medical Association. The general practitioner workforce: why the neglect must end, 2022.

⁸⁶ Medical Deans Australia and New Zealand – Medical Schools Outcomes Database National Data Report, July 2023

⁸⁷ Australian Government Department of Health and Aged Care. National Nursing Workforce Strategy, 2023. Available from: <https://www.health.gov.au/our-work/national-nursing-workforce-strategy>

ABF and public hospital service delivery cost

The ABF funding model and the introduction of the NEP has kept public hospital cost escalation below health-related inflation. From 2012-13, the NEP grew by 20% compared to health CPI growth of 30% (Figure 25)⁸⁸. Despite the growth in population from 2012 to 2021 surpassing the growth in the number of available hospital beds, the number of acute separations and NWAU have shown notable increments of 13% and 39% respectively on a per capita basis⁸⁹ (Figure 26). This indicates hospital beds were used more efficiently to generate higher activity levels from 2012 to 2021. Additionally, total NWAU increased by 33% from 2013 to 2021 while the average overnight length of stay and the average cost per weighted separation decreased by 4% and 7% respectively⁹⁰.

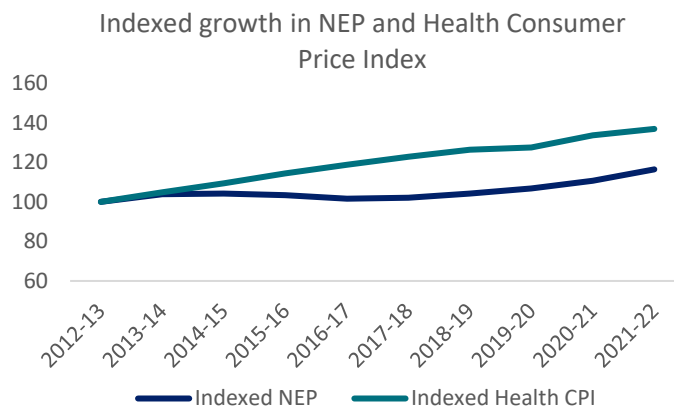


Figure 25: Indexed growth in NEP and Health Consumer Price Index

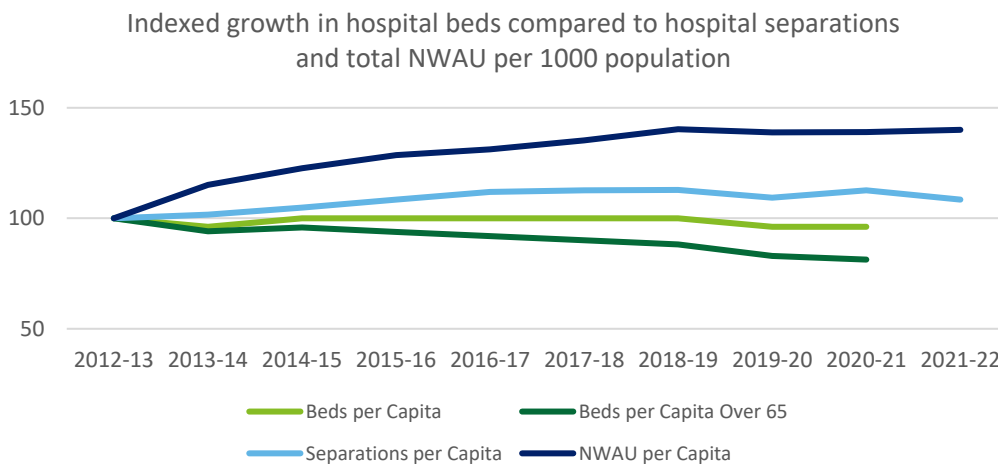


Figure 26: Indexed growth in hospital beds compared to hospital separations and total NWAU per 1000 population

While ABF has been effective in decreasing lengths of stay and cost per discharge, it does not incentivise value-based care and coordination/integration across settings. Countries implementing ABF models have expressed concerns about its suitability for patients with chronic conditions and complex ongoing needs⁹¹. The demand for this type of care will grow as the complexity of health needs grows.

COVID-19 impacts on the health system

During the COVID-19 pandemic, the Australian Government allocated funds and guarantees to State and Territory governments through the COVID-19 NPA, contributing 50% of the cost of COVID-19 related health expenditure⁹². Further, the Commonwealth and State and Territory governments established agreements with private hospitals, enabling the sharing of resources and the continued care of vulnerable populations who might have typically been treated in public hospitals. These agreements helped maintain the viability of private hospitals, allowing them to continue their operations once the pandemic response concluded. To prevent the transmission of COVID-19, the Australian Government introduced subsidies for a wide range of medical professionals that expanded access to telehealth services under Medicare for consultations that were previously not covered⁹³. The COVID-19 pandemic caused significant fluctuations in public hospital activity, evidenced by reductions in ED and admitted patient activity in 2019-20 followed by significant spikes in 2020-21^{94,95}. This has affected activity in emergency departments, admitted patient services, and elective surgeries. Figure 27 on the following page shows the volatility in the average daily ED

⁸⁸ IHACPA National Efficient Price Determination Reports and Australian Bureau of Statistics Quarterly Consumer Price Index releases

⁸⁹ Productivity Commission Report on Government Services 2023, National Health Funding Body Hospital Funding Reports 2012-22.

⁹⁰ Analysis based on information from AIHW Admitted Patient Care data, AIHW Hospital Resource Tables, and NHFB Hospital Funding Reports.

⁹¹ Appleby J., T Harrison, et al. Payments by Results: How can payment systems help to deliver better care? London; The Kings Fund, 2012.

⁹² Australian Commonwealth Government. National Partnership on COVID-19 Response, 2020. Available from: https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-04/covid-19_response_vaccine_amendment_schedule.pdf

⁹³ Australian Institute of Health and Welfare. COVID-19: looking back on health in 2020, 2021.

⁹⁴ Australian Institute of Health and Welfare. Admitted patient activity, 2023. Available from: <https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/apc>

⁹⁵ Australian Institute of Health and Welfare. Emergency department care activity, 2023. Available from: <https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/ed>



presentations nationally from 2018 to 2022. Notably, COVID-19 restrictions in early 2020 led to an 8.3% decrease in elective surgery admissions in public hospitals and a 5.7% decrease in private hospitals compared to 2018–19⁹⁶. This has resulted in a backlog in elective surgeries with the proportion of patients waiting over 365 days for elective surgery increasing from 2.8% to 7.6% between 2019–20 and 2020–21⁹⁷.

Average daily presentations to emergency departments, by month, all states and territories, 2018–19 to 2021–22



Figure 27: Average daily presentations to ED, by month, all States and Territories, 2018-19 to 2021-22

Health technology

Despite the significant challenges that the COVID-19 pandemic posed to the Australian healthcare system, it has also driven changes in technology adoption and reshaped consumer preferences, setting the groundwork for healthcare advancements. The pandemic accelerated the adoption of virtual health platforms and remote patient monitoring solutions, paving the way for more patient-centric and accessible virtual models of care. Additionally, the pandemic highlighted the potential of real-time data, data analytics, and predictive modelling to guide healthcare decision-making and for the coordination and delivery of care across care settings. While healthcare expenditure is expected to rise significantly in the next 40 years, investments in enabling new health technologies, integrated data systems, and innovative models of care are critical to strengthen the effectiveness, efficiency, and resilience of the Australian healthcare system.

⁹⁶ Australian Institute of Health and Welfare. Elective surgery activity, 2023. Available from: <https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/eswt>

⁹⁷ Australian Institute of Health and Welfare (2023). Elective surgery activity. Available from: <https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/eswt>

5 Key recommendations from the Review

This chapter provides detail regarding the recommendations identified as part of the Review, grouped into the 10 identified themes.

Recommendations identified as part of this Review are summarised in Figure 28. Further information on these recommendations are contained in sections 5.1 to 5.10, with other technical matters not addressed elsewhere at section 5.11.

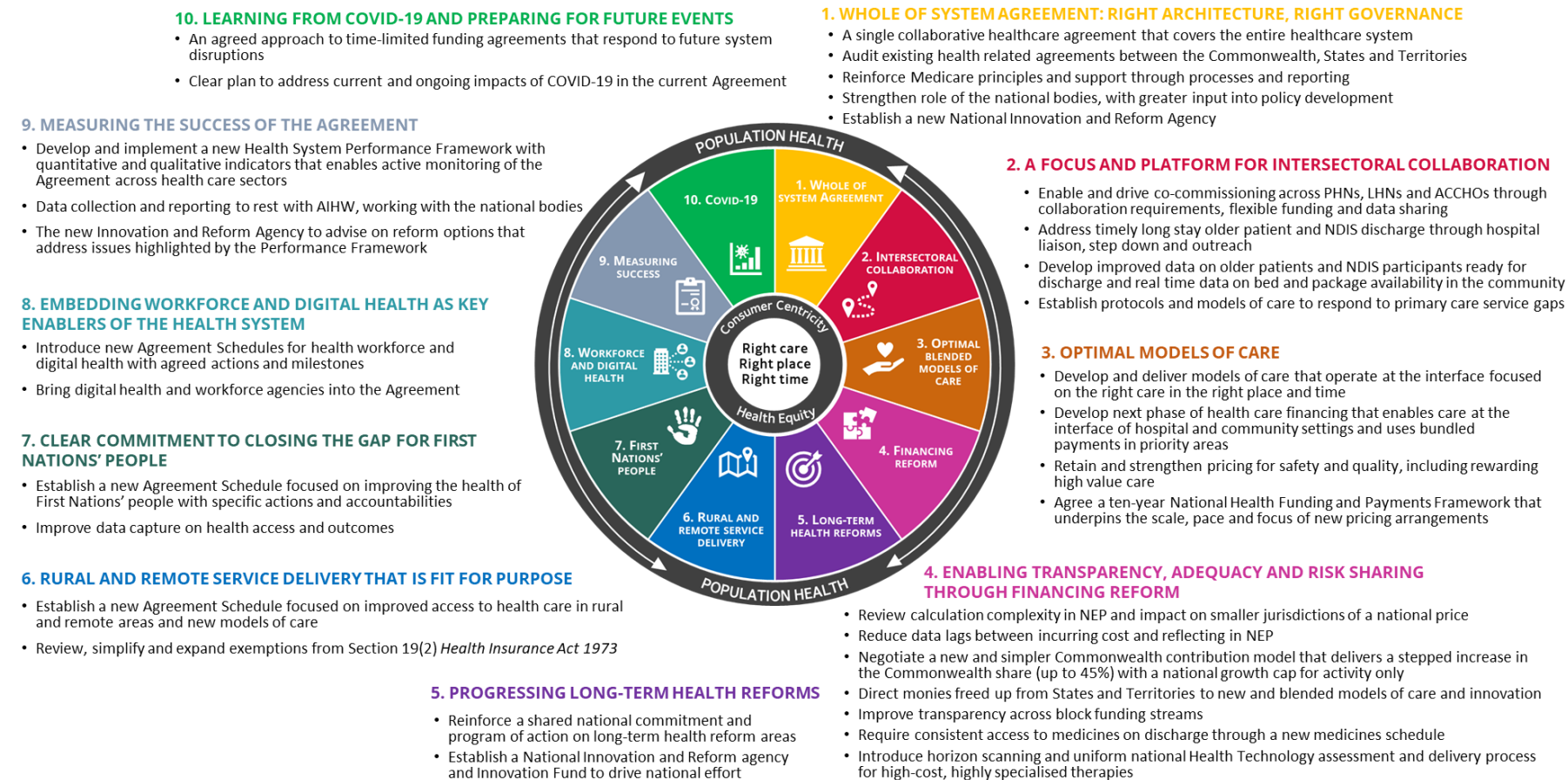


Figure 28: Summary of recommendations



5.1 A shared whole of Health System Agreement with the right architecture and governance

5.1.1 A single collaborative health system Agreement

5.1.1.1 NHRA as a system view

The NHRA aspires to be a broad-based agreement that “...sets out the shared intention of the Commonwealth, State and Territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system”⁹⁸.

While stakeholders agree there is a genuine commitment from all jurisdictions to deliver the goals of the Agreement, progress to date has been patchy with no clear vision of the future health system and insufficient alignment with the reform directions of health and related sectors.

Rather, the Agreement has operated narrowly as a technical funding Agreement, focused on the technical efficiency of the funding model, which has at times impeded progress on delivering safe, quality care in the right place and at the right time (allocative efficiency). This narrow focus is not surprising given it is the vehicle to deliver over \$24 billion a year in Commonwealth funding to the States and Territories primarily to support public hospital services⁹⁹. However, there is a lost opportunity that impacts on patient outcomes and funding sustainability if a broader view of the health system with its interdependencies is not taken.

The elements of the Agreement that take a system view (as set out in the Objectives of the Addendum at Clauses 5-7) which focus on improving health system value, outcomes and patient experience are increasingly important in an environment of rising demand and complexity. Almost half of all Australians (47%, or 11.6 million people) are estimated as having one or more chronic health conditions¹⁰⁰, requiring more specialised and coordinated care across the health system, with this figure projected to grow into the future.

A narrow focus on individual roles and responsibilities and technical efficiency will not be sufficient to achieve health system effectiveness and improve consumer outcomes in the future, nor will it promote efficient health spending.

Parties to the Agreement highlighted that inconsistency in the application, interpretation and implementation of activities to achieve the NHRA objectives have acted as barriers to reform. The wording of the NHRA objectives was seen as too ambiguous, with insufficient guidance on the agreed actions to deliver them, making it difficult to assess whether actions taken by Parties to the Agreement had delivered the intent. This is further compounded by the absence of a meaningful NHRA performance framework and indicators of success, which could be used to understand progress, monitor action and prepare for the future.

Patients ultimately bear the consequences of competing interests and differing interpretations impacting the intent of the NHRA and making the system increasingly complex and difficult to navigate.

5.1.1.2 Interjurisdictional collaboration

While funding and management of the different parts of the system fall to different levels of Government, only by working together can allocative efficiency be achieved in the interests of the health consumer. The right care in the right place at the right time is key to improving outcomes and sustainability. To do this well requires three levels of system alignment:

- a) Policy alignment to achieve system performance objectives between the broader health, primary, disability, private and aged care sectors.
- b) Jurisdictional collaboration and coordination between States and Territories, and with the Commonwealth to deliver system outcomes.
- c) Improved co-commissioning and governance structures and mechanisms that support alignment and collaboration at a local level between LHNs, PHNs and ACCHOs to execute the delivery of changes to the service system.

There are also segments of the health care sector not included in the NHRA, but with strong connections to public hospitals. The current Agreement acknowledges the areas of interface and priority areas of reform but has not enabled meaningful reform action. These interfaces are discussed further in section 5.2.3.

“When the goals of the NHRA become the victim of competing interests and interpretations, it is the patient who ultimately suffers inside a system that has become too complex without patient needs at the centre of the experience.”

⁹⁸ Clause 1a of the NHRA Addendum

⁹⁹ Administrator National Health Funding Pool. National Health Funding Pool Annual Report 2021-22, 2022. Available from: https://www.publichospitalfunding.gov.au/sites/default/files/images/documents/nhfp_annual_report_2021-22.pdf, pages 24

¹⁰⁰ Australian Bureau of Statistics. Health Conditions Prevalence, 2021. Available from: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/health-conditions-prevalence/2020-21>



5.1.1.3 Strategic, whole of system governance

To deliver the improvements in health outcomes and sustainability that the Agreement envisages, and that is needed into the future, requires a reshaping of the NHRA into a single collaborative “Australian Healthcare Agreement” that goes beyond technical hospital financing and covers the entire healthcare system.

This would establish and foster a shared vision and governance to allow Governments to engage on the system as a whole and to embed a culture of collaboration and trust. A technical hospital financing agreement forms part of this but should not be its sole purpose. This approach would integrate both the National Healthcare Agreement and the NHRA into a single Agreement that:

- Is a more holistic health agreement that recognises the interdependencies between the different health and care sectors that interface with public hospitals, including the disability, aged, and primary care and private hospital systems.
- Fosters a shared vision, and clear roles, actions and accountabilities for each sector and party in the Agreement in achieving system reform – moving towards “shared vision and responsibility, individual accountability”.
- Develops a national approach to addressing shared health objectives across Australia, while having the flexibility to adapt to specific jurisdictional health needs.
- Includes a clear vision of how the health system is likely to change over the life of the Agreement, and how these changes will be managed.
- Recognises the importance of consumer engagement and the role of the private sector in supporting health system outcomes.
- Is performance-focused and prepares for new challenges and opportunities, rather than technical issues alone. This includes mechanisms to ensure that data and expertise held by the national bodies are included in the Agreement and performance measure development and reporting.

5.1.1.4 Agreement structure going forward

A new Australian Healthcare Agreement should encompass measurable objectives, performance indicators and reporting mechanisms to reinforce cooperation, including:

- A clear statement of shared principles and objectives for the future vision of the health system, with specific principles that promote patient-centred care and continuity of care.
- Governance arrangements that embed shared accountability and an agreed approach to addressing existing and emerging risks.
- A clear articulation of the roles and responsibilities of all parties, together with a framework to understand and measure performance and hold the parties to account, recognising interdependencies across the broader service system.
- A comprehensive roadmap and implementation schedule to execute updated Agreement objectives and priorities.
- A broadly based and outcome-focused health system performance framework incorporating quantitative and qualitative indicators that accurately report the performance of the health system and with nationally consistent and locally relevant data on the performance of the Agreement against its objectives.
- Mechanisms to enable collaboration on health system direction and reform that includes not only the parties to the Agreement, but related health system providers and participants, such as the NHRA national bodies, LHNs, PHNs, ACCHOs, industry and consumer representatives.
- Recognition within the Agreement of whole of health system enablers, such as workforce, digital health, data and innovation, with a program of agreed goals and actions.
- Individual sections of the Agreement streamlined and updated to remove historical and out of date information.



Recommendation 1: The NHRA should:

- a) Be framed as a **single collaborative health system Agreement** that acknowledges that health system performance is a function of the hospital, primary, disability, aged care and prevention sectors working effectively together, in the interests of the consumer and system sustainability and which clearly sets out roles and responsibilities, actions and accountabilities of the parties.
- b) Describe the **shared vision, principles, objectives and reform goals for the health system**, take a strategic view to health system challenges and drive innovation, with input from national bodies, system providers and consumers.
- c) Establish a **health system performance framework**, that is broadly-based and outcome-focused, to guide actions and actively monitor progress.
- d) Include **individual Schedules**, that are streamlined and updated to reflect shared goals, with outdated material removed, and **key system enablers** (such as digital health and workforce) added.



There is broad recognition that the NHRA does not function in isolation but sits within a wider set of national and bilateral Agreements. This is inevitable as reform at a program level continues during the life of an Agreement and, from time to time, will be subject to separate funding streams and processes.

As part of a new Australian Healthcare Agreement, an audit of existing health related agreements should be undertaken to determine which, if any, of these should be cross-referenced or their actions reflected and supported through the NHRA. The Review is aware of nearly 80 health related agreements as at 30 August 2023 (listed at Appendix G) that currently operate outside the NHRA (sourced from the Commonwealth Department of Health and Aged Care). This does not mean folding the totality of related Agreements into the NHRA, but rather:

- ensuring that objectives and actions are mutually reinforcing
- that, where appropriate, action plans are reflected in the NHRA and
- in the future, that related agreements align with, and are guided by the shared vision, principles, objectives and reform goals for the health system proposed at Recommendation 1.

By way of example, a pressing priority is to assign functions and actions for mental health within the NHRA. Currently the Agreement acknowledges a shared commitment to improve mental health outcomes (Clause 6) but agreed actions are in the separate and subsequent *National Mental Health and Suicide Prevention Agreement*. The NHRA should reference the actions that the parties will take to improve mental health outcomes across the health system, integrating mental health strategies into optimal models of care, financing, innovation and performance elements of a new Agreement.



Recommendation 2: An **audit of existing health related agreements** between the Commonwealth, States and Territories should be undertaken to determine whether, and to what degree, they are suitable for inclusion in a new Australian Healthcare Agreement, with an agreed timeframe as to when any such inclusions would take effect. Future health related agreements that operate outside the NHRA should align with, and be guided by, the shared vision, principles, objectives and reform goals for the health system proposed at Recommendation 1(b).



Recommendation 3: The NHRA should **reaffirm the commitments to improving mental health outcomes** through the separate *National Mental Health and Suicide Prevention Agreement*, utilising the mechanisms agreed through the NHRA, including models of care, financing, innovation and performance monitoring, to progress agreed actions in the area of mental health.

5.1.2 Medicare Principles

A fundamental tenet of the NHRA is to embed the Medicare Principles as set out in Clause 8 of the Agreement into the operational arrangements for public hospitals:

“States (and Territories) will provide health and emergency services through the public hospital system, based on the following Medicare Principles:

- eligible persons must be given the choice to receive public hospital services free of charge as public patients;*
- access to public hospital services is to be on the basis of clinical need and within a clinically appropriate period; and*
- arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.”*

The NHRA seeks to ensure these Principles are implemented through the shared Objectives, overarching Roles and Responsibilities and Schedule G of the Agreement, that make explicit that eligible persons receiving public hospital services as a public patient will face no charges (with limited exceptions as set out in Clause G1), and that the default treatment of eligible persons presenting at public hospital emergency and outpatient departments is for them to be treated free-of-charge as public patient (Clauses G18 and G19). Further clauses that support the Medicare Principles are in those that go to private patient neutrality (Clause A13), pricing adjustments that deliver neutrality (Clause A44) and compliance measures that seek to identify duplicate NHRA and MBS/PBS funding of patient episodes. However, funding from sources beyond the NHRA, such as the MBS and PBS, has the potential to shift the focus from public hospital care towards private patient care to generate additional hospital revenue.

Although the NHRA allows patients to opt to be treated as private patients in a public hospital, concerns have arisen in consultation at what is considered a lack of transparency in informed decision-making. There is continued public concern about



admitted patients being coerced or feeling pressured to use their private health insurance^{101,102,103}. While many informed consumers intentionally decide to be private patients in a public hospital, some providers establish procedures and business models to direct patients being admitted to a public hospital and accessing outpatient services to private funding options. While confirming a patient's election status is necessary, discussions should remain neutral to the outcome, respecting both patient preferences and compliance with MBS and NHRA rules.

There is some evidence which suggests that health services have not taken enough action to ensure that private practice activities comply with the NHRA, the *Health Insurance Act 1973* and national MBS billing requirements^{104,105,106}. Non-compliant practices include not ensuring patient consent for private treatment and billing the MBS for services already paid for under the NHRA.

It is recognised that public hospitals attract sources of funding other than that which flows through the NHRA (such as MBS and PBS) that are not separately reported and that create opportunity at the hospital department level to increase revenue. These funding arrangements reflect complex interactions with rights of private practice and ultimately have implications for attraction and retention of a medical workforce. While States and Territories are not mandated to offer all potential public hospital services at every location, instances like the replacement of emergency care or non-admitted services with privately provided services can impact the capacity of patients to access treatment free of charge as public patients and do not always result in financial outcomes that benefit the jurisdiction as a whole or the patient.

In some instances, these practices can conflict with the Medicare Principles and NHRA compliance, where the Commonwealth will not fund patient services where the same service, or any part of the service, is funded through alternative funding mechanisms. Through the data matching business rules developed in consultation with all jurisdictions, the NHFB has been able to accurately identify duplicate payments for public hospital services through the NHRA and MBS annually since 2018-2019. These have been assessed by the Australian National Audit Office (ANAO) as potentially falling within an annual range of \$172 million to \$332 million¹⁰⁷, with more recent advice provided to the Review by the NHFB suggesting a figure closer to \$400 million. Limitations and variations in how jurisdictions report their non-admitted services means there has been limited success in identifying the extent to which public hospitals rely on the MBS to fund the delivery of non-admitted services to private patients.

Measuring the extent to which the availability of services align with Medicare Principles and NHRA requirements is difficult. To date there has been little measurement and reporting, resulting in limited insight into eligible patients' access to public hospital services.

Addressing these challenges requires greater transparency in the election process such as:

- More stringent requirements, principles and criteria to ensure informed financial consent when making a private patient election.
- Curbing the ability to make multiple changes of election during a hospital episode.
- An audit of patient election processes/forms, to ensure there is consistency and compliance with minimum requirements for admitted patient election, to ensure all patients are consistently informed of their choices, in accordance with Clause G30 of the NHRA.
- Ensuring that staff gathering informed financial consent identify themselves on the form to provide accountability.

Future iterations of the NHRA should incorporate a set of appropriate metrics to enhance visibility of performance against the overarching goal of providing access free of charge to public health services. This entails standardised reporting that underscores access to public hospital services for public patients across a predefined range of admitted, non-admitted and specialised services.

¹⁰¹ Australian Private Hospital Association. Private in public growth adds to premium woes, 2017. Available from: <https://journalists.medianet.com.au/Release/883946/3818719>

¹⁰² Royal Australian College of General Practitioners. Rejected referrals 'compromising patient care', 2022. Available from: <https://www1.racgp.org.au/newsgp/professional/rejected-referrals-compromising-patient-care>

¹⁰³ The Sydney Morning Herald. Vulnerable and shocked: Patients targeted by hospital revenue push, 2019. Available from: <https://www.smh.com.au/business/consumer-affairs/vulnerable-and-shocked-patients-targeted-by-hospital-revenue-push-20190311-p513ad.html>

¹⁰⁴ Victorian Auditor-General's Office. Managing Private Medical Practice in Public Hospitals, 2019. Available from: <https://www.audit.vic.gov.au/sites/default/files/2019-06/200619-Managing-Private.pdf>

¹⁰⁵ Queensland Audit Office. Right of private practice: Senior medical officer conduct, report 13: 2013-14, 2013. Available from: https://www.qao.qld.gov.au/sites/default/files/reports/rtp_right_of_private_practice_senior_medical_officer_conduct.pdf

¹⁰⁶ Independent Hospital Pricing Authority and Ernst & Young. Private Patient Public Hospital Service Utilisation, 2017. Available from: <https://www.ihacpa.gov.au/sites/default/files/2022-02/Private%20Patient%20Public%20Hospital%20Service%20Utilisation.pdf>

¹⁰⁷ The Auditor-General Report. Australian Government Funding of Public Hospital Services – Risk Management, Data Monitoring and Reporting Arrangements, 2019. Available from: https://www.anao.gov.au/sites/default/files/Auditor-General_Report_2018-2019_26.PDF



Recommendation 4: The **Medicare Principles** (that enable treatment to be provided free of charge to a public patient in a public hospital, access to public hospital services on the basis of clinical need and within a clinically appropriate period, and arrangements that ensure equitable access to services regardless of geographic location) **should remain a core feature of the NHRA**. The effective operation of the Medicare Principles should be supported by:

- a) Processes to ensure the Medicare Principles are being delivered in practice through greater consistency within and across jurisdictions of the private patient election process, that is straightforward and understood by the patient and ensures accountability for the provider: for example, through rigorous informed financial consent processes, restricting multiple changes of election during an admission, making explicit a requirement for recording private patient election for non-admitted services and reporting data on out-of-pocket patient costs.
- b) Reporting of all Commonwealth, State and Territory funding provided to public hospitals, both through the NHRA and through Commonwealth programs such as MBS and PBS, to give a more complete picture and better map trends over time.

5.1.3 National Governance arrangements

5.1.3.1 Governance evolution

At the time of the signing of the original NHRA and the current Addendum, the Commonwealth and State and Territory governments worked at a national level within the structures of the now dissolved COAG. With the creation of National Cabinet, not all of COAG's reporting and accountability responsibilities were assumed by other bodies, with flow-on impacts to the governance and monitoring of the NHRA.

Further, there have been changes to the responsibilities of the national bodies (outlined in Section 2.4) through the course of the Agreement, for example, the National Health Performance Authority (NHPA) ceased operation, with reporting functions transferred to the AIHW, and remaining functions assumed by the ACSQHC and Commonwealth Department of Health and Aged Care.

These changes to the national architecture have created barriers to delivering all elements of the NHRA as intended, with a lack of clarity about which bodies retain responsibility for which elements of the NHRA and their reporting arrangements.



Recommendation 5: The **NHRA should be updated to reflect current governance settings** related to National Cabinet, with a check of roles and responsibilities of bodies referenced in the NHRA undertaken to ensure they remain relevant and have an appropriate place in a new Agreement.

5.1.3.2 Existing NHRA national bodies

The five NHRA national governance bodies have improved governance and transparency across their main legislated functions:

- **IHACPA:** independent national price and cost setting.
- **The Administrator and NHFB:** independent Commonwealth public hospital funding calculation and administration.
- **ACSQHC:** national health system safety and quality service provision.
- **AIHW:** collection, analysis and reporting of health and hospital performance data.

5.1.3.3 Governance for a future Agreement

The national bodies are a national resource that could be better used to address some of the shortcomings of current arrangements. They hold very considerable technical expertise in their respective fields, have significant data holdings, are able to observe trends and have ideas about where there are opportunities for system improvements.

In a broad sense, there are opportunities to better utilise the national bodies to support reform directions and incorporate their skills and data into national policy development processes, in particular through their:

- Contribution to overarching strategic guidance and direction to support health reform, and a clear vision of a future health system.
- Independent advice on pricing, cost and Commonwealth/State funding contributions and where these can further develop to support system objectives.
- Contribution to performance monitoring and management of the Agreement and its operation across health and care sectors.

Beyond this strategic expansion of the national bodies' roles, their day-to-day operation should also be enhanced through:

- Stronger delineation of the roles and responsibilities of the individual national bodies and clarity as to how shared responsibilities will be managed.
- An agreement on how national bodies and jurisdictions will interact, with a greater focus on strategic issues, and with a clear process to raise and resolve technical issues.

- Mechanisms through which the parties to the Agreement and the national bodies can better support delivery of key reform strategies such as joint planning, collaborative commissioning and innovative funding - at a simple level, there should be a pathway for the national bodies to report to the Health Ministers’ Meeting on system challenges and potential reforms, with formal engagement between the national bodies, Health Ministers and Health Chief Executives at least annually.
- Consistent and accountable evaluation of the performance of the national bodies against the goals of the NHRA.

Further, there are areas of the current Agreement that would benefit from governance changes. Both digital health and workforce are key enablers of health system efficiency and effectiveness (further reference in Section 5.8).

- There is an existing Australian Digital Health Agency whose purpose is to achieve ‘Better health for all Australians enabled by seamless, safe, secure digital health services and technologies that provide a range of innovative, easy-to-use tools for both patients and providers’. There would be benefit in recognising the ADHA within the Agreement as a national body, noting the significance of its work to a future health system.
- A national focus on ensuring a sufficient and quality health workforce should also be recognised in the NHRA, either through a dedicated national health workforce planning body along the lines of the previous Health Workforce Australia or by explicitly identifying where this work will occur and supporting its purpose, strategies, and outcomes through shared effort in the NHRA.

Finally, it is important to have a dedicated focus in the Agreement on innovation and reform (further reference in Section 5.5). While innovation and long-term reform priorities are widely referenced in the NHRA, the capacity to deliver against these has been hampered both by insufficient funding and the absence of a dedicated national mechanism to agree priorities and develop joined up solutions. A National Innovation and Reform body would make it much more likely that the expectations of the Agreement are able to be met.

The current functions and coverage of the NHRA national bodies is illustrated in Figure 29, with specific suggestions for enhancement identified below.

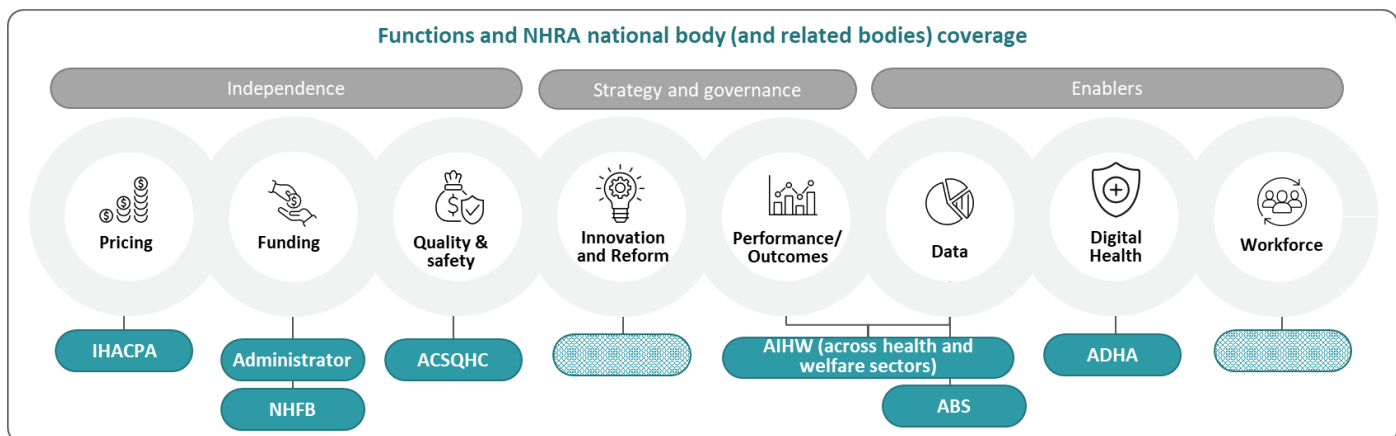


Figure 29: Functions and NHRA national body coverage

IHACPA:

- Give increased flexibility to developing payment pathways to bring innovative and integrated programs into the NHRA - a reframed role is required to reflect that clinical practice can evolve ahead of pricing.
- Leverage the benefit of having aged care and hospital pricing responsibility in one agency to better align pricing and incentives to achieve better allocative efficiency in and between the hospital and aged care sectors and step-down care.
- Contribute to the development of the NHRA Performance Framework described in section 5.9 (together with the AIHW, ACSQHC and NHFB).

Administrator / NHFB:

- Seek to strengthen reporting and transparency by including all Commonwealth and State funding flowing to public hospitals through NHFB processes.
- Contribute to the development of the NHRA Performance Framework described in section 5.9 (together with AIHW, IHACPA and ACSQHC).

ACSQHC:

- Play a greater role in collection and provision of data to inform reform across sectors, innovative models of care and long-term reform areas.
- Evaluate program impact and outcomes to inform jurisdiction program effectiveness and return on investment.
- Develop a clearer process for identifying new clinical care standards supported by a framework for assessing priorities.
- Contribute to the development of the NHRA Performance Framework described in section 5.9 (together with AIHW, IHACPA and NHFB).



Innovation and Reform (new agency):

- Provide dedicated leadership and structures to develop policy responses to emerging health system challenges, including those identified through the performance framework, identify areas for innovation and reform and drive a reform agenda.

AIHW:

- Work with jurisdictions to lead national data collection to better inform agreed priority areas.
- Establish NHRA Performance Framework minimum datasets and take the lead role in reporting against the performance framework.

ADHA:

- Continue to advance and enable the role of digital health solutions in supporting patient-centred care, including improving health outcomes, access and innovation.

Workforce (new focus):

- Undertake national and jurisdictional health workforce planning and analysis and guide health workforce training numbers aligned to community need, across sectors, across specialisations, and geographical locations.



Recommendation 6: The general **architecture of the national bodies** should be retained, but with:

- National bodies better utilised to support reform directions, with their expertise and data insights integrated into national policy development processes.
- Roles/responsibilities of the national bodies revisited to ensure they are clear and appropriate, and strengthened to enable them to form part of a unified response to emerging healthcare challenges and evolving patient needs.
- Jurisdictional engagement with national bodies better balanced between strategic and technical issues (rather than the current technical focus).
- A **new performance framework** informed and delivered (Recommendation 41) with input from all jurisdictions and the national bodies, and that includes the progress of the national bodies in delivering their accountabilities.
- A **new National Innovation and Reform Agency**, responsible for identifying emerging system pressures and driving innovation and long-term reform, working closely with HCEF and Health Ministers (linked to Recommendation 34).
- Digital health and workforce recognised** through dedicated bodies (existing or new) referenced in the Agreement, with relevant purpose, strategies and outcomes incorporated.
- Strategic engagement between national bodies, Health Ministers and Health Chief Executives to occur at least annually.

5.2 A focus and platform for intersectoral collaboration

5.2.1 Governance structures and mechanisms facilitating alignment and collaboration between PHNs, LHNs, and ACCHOs



The current Addendum recognises the importance of ‘...better coordination between the hospital, GP and primary health care, disability services and aged care systems...to ensure the health system meets the needs of communities. It includes a dedicated Schedule that details the shared objectives, roles and responsibilities and commitments to ‘...improve care coordination, particularly for people with chronic conditions and a disability, and transitions between residential aged care and primary and acute care settings’ (Clause F10).

The Addendum recognises that the current health care system is fragmented and the difficulties as a result for people to receive well-coordinated care, putting particularly those patients with complex needs at risk. In part this is a natural product of different levels of government bearing responsibility for different parts of the system, but it impacts on the ability of the system to conceive, deliver and scale good practice.

While there are shared commitments outlined in the Addendum to improve governance, particularly between PHNs and LHNs, these have not been consistently realised in practice. Action in this area is pressing, noting the rise in chronic and complex conditions and the importance of providing early intervention and multidisciplinary care. The increased prevalence of chronic conditions has elevated the rate of multimorbidity, where individuals have two or more chronic health conditions, requiring more specialised and coordinated care across the health system.

While the current Addendum highlights the importance of considering and consulting with PHNs, it falls short of recommending formal participation or establishing structures for planning and implementation. Consequently, PHNs are often overlooked in the initial stages of planning and their input is sought too late in the process to have a meaningful impact.

A core element of the Addendum is the commitment to reform ‘Joint Planning and Funding at a Local Level’ (one of the six LTRs), with a shared commitment to local commissioning, coordinated and pooled funding, shared reporting and accountability and better integrated and accessible patient-centred care. While the Review saw some examples where progress had been made along these lines, it was by no means systemic and there was a clear gap between aspirations and outcome.

The governance landscape is further complicated by the variability in collaborative practices of LHN Governing Councils, which are highly dependent on their respective Terms of Reference, with PHNs often having limited influence. This disconnect creates coordination challenges when attempting to provide primary care responses to broader healthcare issues, such as emergency response, due to the lack of inclusion and engagement with the primary care system. There are currently no tangible consequences or incentives in place to enforce cross-sectoral collaboration as envisioned in the NHRA Addendum.

While the Addendum has a set of clauses intended to encourage intersectoral collaboration between LHNs, PHNs, and health stakeholders, the effectiveness of these collaborative efforts varies significantly across Australia. Success is often reliant on personal relationships or specific resourced initiatives, and the degree of success can vary widely depending on the experience and networks of key personnel. Additionally, collaboration efforts are often challenged due to the lack of reciprocal engagement from key system partners and reluctance to share data.

Despite this, there is evidence of successful joint planning and funding activities, some of which have been nurtured through informal relationships. However, achieving nationwide, sustainable, and systemic change requires a coordinated strategy and guiding principles that encourage and facilitate collaboration across PHNs, LHNs, and ACCHOs. There is a need to strengthen intersectoral governance structures and mechanisms to foster alignment and collaboration between PHNs, LHNs, and ACCHOs through formal requirements in the Agreement.



Case study: The New South Wales Joint Statement – a template for success

New South Wales PHNs, New South Wales Health and its Local Health Districts (LHDs) have had a productive working relationship that is growing. The strength of these relationships has led to the development of the New South Wales Joint Statement which provides a framework for joint planning and commissioning that has the potential to be replicated in other jurisdictions. The Joint Statement aims to advance:

- A one health system mindset which supports thinking and acting beyond the current structures and boundaries in healthcare.
- Working together with shared principles and shared focus areas to address shared challenges.
- A regional focus for planning, commissioning, designing, and delivering healthcare backed by the right system support from the State and the Commonwealth.
- Planning and evaluating actions to improve healthcare experiences, population health outcomes and health system cost efficiency.

Under the New South Wales Joint Statement, three Working Groups advance key priority areas including: Care in the Community; Establishing Regional Planning Processes and Governance; and Data and Outcomes. The latter is implementing indicators to provide a shared understanding of performance in key areas of focus and support coordinated delivery of services across both LHDs and PHNs in response to key health system challenges including:

- Growing demand for healthcare services – to support joint regional planning to efficiently address the growing healthcare demand in local communities.
- Lack of shared governance and coordination – informing a shared governance and coordinated approach by implementing a set of shared indicators to provide visibility over the whole health experience (i.e., not just PHNs or LHDs).
- The need for more early intervention and prevention – including measures of screening and risk factors to understand the effectiveness of preventative health initiatives over time.
- The need for greater integration across the system – including intended measures of the individual experience of care in the Community Reported Measure.

5.2.2 The role of PHNs in commissioning and driving an integrated health service

The concept of a primary care integrating layer that can participate in local planning and commissioning of services and has a role in filling service gaps and delivering against local priorities has been a part of the NHRA since its inception, initially through Medicare Locals and now 31 PHNs across Australia. Getting these on the ground services right is essential in supporting care to be delivered where it is going to have the greatest impact and managing patient pathways at the interface of the primary and acute care systems.

While the role of PHNs is written into the NHRA, the capacity of the PHNs to deliver on the ground has been variable. In part this relates to the capacity of a PHN to operate as a genuine equal partner in local planning, when it has much less funding and fewer resources than LHNs, does not often align with LHN boundaries, and does not directly hold the care delivery levers which are in the hands of private providers of primary care services.

Further, the services and programs commissioned through PHNs have often been overly prescriptive, with limited funding and tight timeframes, restricting the development of co-designed, fit-for-purpose models suitable to local needs. Currently, PHNs operate with constrained and inflexible budgets, limited authority and capacity to plan, coordinate, and influence the development of integrated healthcare services and workforce planning.

That said, there are a number of high performing PHNs that have demonstrated the positive impacts these structures can have on communities at a local level and shown their ability to progress reform activity in the primary care space. Where most effective, PHNs play a pivotal role in:

- System coordination and integration
- Regional commissioning
- Primary care system stewardship and management
- Primary health care education, training, and workforce development
- Health system transformation and reform.

There are many examples presented to the Review where PHNs have assumed leadership roles within their communities to foster the development and performance of the primary care sector and are offering integrated care solutions across sectors (see Case Study: North Sydney Elderly and Frail Care Collaborative Commissioning initiative).

As part of a larger network, both at the national level through the PHN Cooperative¹⁰⁸ (collective function of which all 31 PHNs in Australia are members) and within their respective States and Territories, PHNs share successful models, lessons learned and resources to achieve shared objectives.

However, a lack of consistent recognition of PHNs' roles and responsibilities remains a challenge. The role and responsibilities of PHNs should be strengthened in the Addendum, with a requirement that they participate effectively in joint planning and commissioning activities. A genuine commitment from Commonwealth and States and Territory governments is required to foster this authorising environment, one that recognises the unique role and capabilities of PHNs within primary healthcare and local health services to plan and deliver targeted, impactful services, and provides sufficient flexibility in their funding to respond to local needs (see Case Study: The Health Alliance – Care Collective).

These requirements should be extended to the ACCHO sector. While there is only passing reference to ACCHOs in the current Addendum, they form part of the primary care landscape and should be required to work collaboratively with PHNs and LHNs to plan and commission local services.



Case study: North Sydney Elderly and Frail Care Collaborative Commissioning initiative

This joint initiative between Northern Sydney LHD and Sydney North PHN, focused on improving rapid care for frail and older people in Northern Sydney. GPs identify patients at high risk of hospitalisation who would benefit from more proactive care. The GPs then receive additional support for care coordination and navigation services to coordinate patients' care. The initiative provides access to specialist geriatricians, specialised exercise programs, falls prevention programs, home modifications, mental health services and nutrition guidance. Additional support is provided by Health Navigators who deliver concierge services and are available to provide support for health care professionals in Northern Sydney to navigate,

¹⁰⁸ The PHN Cooperative, <https://www.phncooperative.org.au/>

troubleshoot and coordinate community-based primary health, aged and social care and some hospital-based services for frail and vulnerable people within their care

The importance of PHNs' role in co-designing relevant, best practice and place-based solutions has been recognised in the *Primary Health Care 10 Year Plan*, the *Strengthening Medicare Taskforce*, and partially within the Addendum. However, to enable PHNs to fulfil this role more fully, explicit authority codified within relevant agreements should support PHNs to plan, coordinate, and commission local primary health care services.

This approach would enable PHNs to leverage their unique position as 'neutral players' in the market, offering a distinctive perspective and fostering collaboration among healthcare stakeholders in a non-competitive manner.



Case study: The Health Alliance – Care Collective: Improving access to primary healthcare and care coordination

In 2017, Metro North Health and Brisbane North PHN established the Health Alliance – building on the track record of collaboration and partnership in the North Brisbane and Moreton Bay region. A Joint Board Committee, drawing membership from both organisations provides shared governance, joint identification of issues and a collaborative response to health challenges that no one organisation can solve on its own.

The Care Collective collaborates with stakeholders across Metro North Health, Brisbane North PHN, and local primary health care providers to reduce demand on EDs by identifying a targeted cohort of complex patients and implementing a case management approach for chronic conditions such as chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). The initiative places a Complex Care Coordinator in GPs to enhance practice capacity and improve patient quality of life, health literacy, health outcomes and reduce ED presentations and hospital admissions.

The Care Caboolture Evaluation Report, finalised in August 2023, showed a 75% reduction in ED presentations for patients enrolled in the program, a 48% decrease in the proportion of clients with greater than one ED presentation per month and a significant reduction in unplanned admissions. Early data suggests the initiative is producing savings of more than quadruple its funding in reduced hospital service use (return on investment savings of \$1971 per month per client). Due to the early demonstrated effectiveness of the Care Collective-Caboolture, the program was funded for an additional two years by Queensland Health, as part of the Commonwealth Primary Care Pilot program. This additional \$5.3 million investment will facilitate the scale of the Care Collective in Caboolture and spread into Redcliffe, where a need for complex care coordination was also identified.

This case study highlights how governance mechanisms can facilitate effective joint planning and commissioning between LHNs and PHN in collaboration with local health services to deliver targeted, impactful services that address the health needs of the local community.



Recommendation 7: The **intersectoral architecture set out in the NHRA should be reinforced and improved** with a commitment to greater alignment and collaboration between PHNs, LHNs and ACCHOs. The future Agreement should:

- a) Establish a **nationally consistent governance framework** with formal governance structures, mechanisms, and roles and responsibilities that drive and enforce integration between LHNs, PHNs, and ACCHOs. This national governance framework should have the flexibility to accommodate jurisdictional variance and unique regional needs and reiterate current Agreement expectations of clinician and community engagement, particularly related to safety and quality of health care.
- b) Detail minimum requirements for how the Commonwealth and State and Territory health departments, PHNs, LHNs and ACCHOs will work together on **joint planning and commissioning**. These requirements should contain the following elements:
 - Balanced representation in local governance.
 - Local planning and co-commissioning focused on improving patient pathways and outcomes, with flexibility to innovate and design care models that are fit-for-purpose and support long-term health reform goals.
 - Shared and, where possible, linked datasets on population and service utilisation at the local level.
 - Agreed programs of work that address local health priorities, with greater funding flexibility for PHNs and ACCHOs to support local service needs.
 - Shared reporting and accountability arrangements to measure progress against initiatives and the impact on health outcomes and the quality of health services.

5.2.3 Health system interfaces

A major area of concern identified in consultations is the way in which the interface between the acute, primary, aged and disability care sectors operate and how transitions between sectors are managed. The Agreement recognises at Clause F2 a shared responsibility to support consumers, carers and their families to better navigate these sectors to optimise care and support and reduce avoidable hospital admissions. However, it does not identify concrete actions through which this will occur, nor how the roles and responsibilities of the parties will be managed.

5.2.3.1 Primary care interface

Finding a more effective and responsive way to manage the interface between the primary and acute care sectors was an issue raised across all States and Territories in consultations and in many submissions to the Review. Reduced access to primary care puts pressure on State-based health services, which operate as the provider of last resort for vulnerable communities. This is particularly the case where there are thin and failing markets, often, but not always in rural areas.

The impact of an insufficient or inaccessible primary care sector, lack of availability of multidisciplinary care and care coordination in the community was seen as having a serious impact on patient outcomes and building pressure on State and Territory-based health services, across emergency departments, out-patients and community-based health.

While this issue was strongly held and argued, a decline in affordability of GP services is not yet being seen strongly at a national level though there are some signs. As proxy measures of access, national bulk-billing rates, while falling, remain high with over 85% of non-referred attendances bulk-billed (Figure 30), though there has been a recent decline in the numbers of people who report that they are always or usually bulk-billed (Chapter 4: Figure 20). While growth in out-of-pocket costs for non-bulk billed services can be observed, growth has been reasonably steady over a long period (Figure 31).

Bulk billing rates for GP attendances over time, by key age groups

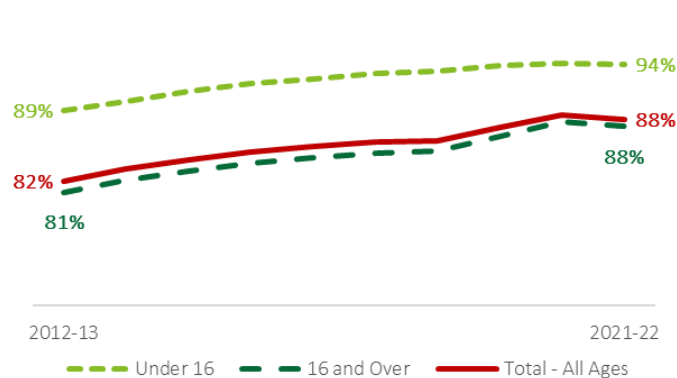


Figure 30: Bulk billing rates for GP attendances over time, by key age groups

Out of pocket costs for GP services over time, by age group (dollars presented as 21-22 dollars, using total CPI)

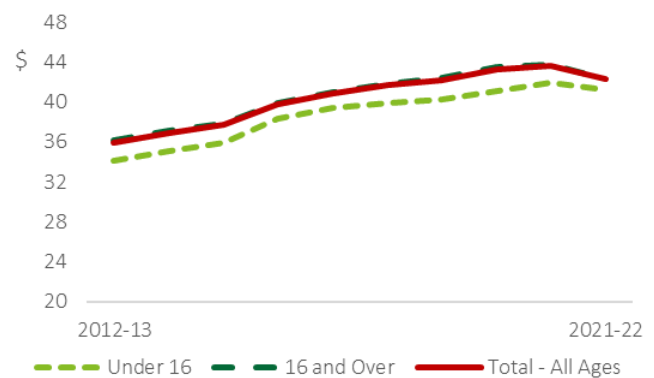


Figure 31: Out of pocket costs for GP services over time, by age group (dollars presented as 2021-22 dollars, using total CPI)

Measures of access to primary care are difficult to interpret at a highly aggregated national level and more work is needed to develop a clear picture, both nationally and locally. As noted by the *Strengthening Medicare Taskforce Report*, ‘...while most Australians enjoy access to quality primary care services...accessing primary care for some Australians is becoming harder. Since the pandemic began, more people are presenting at emergency departments or delaying care, practices are finding it harder to recruit GPs and other health workers, and bulkbilling rates are falling’¹⁰⁹.

There are two elements to the primary care interface relevant to the effective operation of the NHRA:

- Are consumers receiving quality care in the community with early intervention and coordination across primary care providers acting to prevent or delay hospital admission? The *Strengthening Medicare Taskforce Report* observed that the impact of fee-for-service primary care focused on GP rewarded episodic care and fast throughput, rather than comprehensive continuity of care that is team-based.
- Are quality primary care services able to be accessed when they are needed at the local level, preventing avoidable emergency department presentations or admissions? It was clear from submissions that there are significant gaps at the local level, particularly where there are thin markets and the continued provision of primary care relies on a small number of providers. These were often, but not always in rural areas, with some jurisdictions reporting wait times of three to four weeks in capital city areas.

A range of recent Commonwealth government initiatives are seeking to improve access to primary care with a \$6 billion *Strengthening Medicare* package announced in the 2023-24 Budget, which includes tripling bulk-billing incentives. However, there is more to do in the context of a new NHRA to better monitor and map primary care access and to develop models of care that can respond to service gaps by making the best use of scarce resources, with equitable and sustainable funding attached. These models need to be able to be stood up quickly at the local level while long term solutions are being developed. This will

¹⁰⁹ Commonwealth Department of Health and Ageing. *Strengthening Medicare Taskforce Report*, December 2022: Page 4



require a collaborative approach building on the co-commissioning flagged at Recommendation 7 and the optimal models of care at Recommendation 11.



Recommendation 8: Measures of primary care access, able to be monitored at the local level, should inform the operation of the NHRA, including:

- a) whether and when **different models of care are mobilised** to respond to serious service gaps that would otherwise result in avoidable hospital presentations
- b) **collaborative planning at the local level** that would underpin the need for action and the escalation pathways through which action would be taken
- c) a capacity to act quickly to use available resources to greatest effect with equitable funding arrangements agreed in advance.

The triggers for this need to be negotiated as part of a new Agreement but should ensure there is every incentive for primary care to work effectively without intervention.

5.2.3.2 Aged and disability interface

A common concern raised with the Review was delays in transitioning elderly patients and NDIS participants who are ready to be discharged from public hospitals to appropriate accommodation. These often stem from a lack of access to appropriate aged care and disability services, particularly in rural areas, and can also lead to potentially preventable ED and hospital admissions. Discharge delays lead to greater numbers of “maintenance type” patients occupying acute care beds, which can result in poorer patient outcomes and experiences and limits the number of beds available for individuals who require acute care. These interface issues compound the demand for public hospital services, which often serve as the provider of last resort.

Discharge issues at the public hospital and aged care interface

Reports from jurisdictional health departments highlighted the impact of aged care-related discharge delays in public hospitals. In 2020-21, a total of over 286,000 hospital patient days across Australia were reported for individuals eligible and waiting for residential aged care, translating to 9.2 hospital patient days per 1000 patient days¹¹⁰, with anecdotal evidence identified to the Review that this figure has since increased. Notably, there is marked variation when comparing major cities (7 hospital patient days per 1000 patient days) to regional and remote areas (47.6 hospital patient days per 1000 patient days). By way of example, New South Wales reported 385 Residential Aged Care Facility (RACF) patients in New South Wales public hospitals on 26 April 2023, collectively exceeding their expected discharge date by a total of 15,034 bed days¹¹¹. These challenges are more pronounced in regional and rural areas. In Western Australia, as of 3 May 2023, the wait times for aged care services were more than four times higher than in metropolitan areas (50 days compared to 11.5 days)¹¹². The shortage of aged care beds in these regional and rural areas can prevent patients from being discharged safely to their homes, disrupting patient flow and affecting overall patient outcomes.

Discharge issues at the public hospital and disability care interface

As of 31 May 2023, there were 1331 NDIS participants medically ready for discharge in public hospitals across Australia¹¹³. The average duration of their readiness for discharge and actual discharge was 26 days¹¹³. NDIS participants in hospital face similar discharge barriers to elderly patients, such as administrative delays and lack of appropriate accommodation and support services, particularly in regional and rural areas. These difficulties compound the already significant challenges faced by rural and regional residents, making their health care journey considerably more arduous than that of their metropolitan counterparts.

Nationally, there is a growing recognition of these problems, and a desire to accelerate practical solutions that support seamless and efficient care across the health system interfaces. While the causes of discharge delay are multi-factorial, key contributing factors include the lack of real-time data on residential beds and community aged care places, the absence of available and appropriate aged care and disability accommodation and support services, a lack of clarity as to who is coordinating patient transitions and family choice not supporting timely discharge.

5.2.3.3 Optimise data collection, integration and governance

A fundamental gap is the absence of a nationally consistent approach to collecting data on patients who are occupying a hospital bed while awaiting aged care or disability services when medically ready for discharge (long-stay patients). Accurately quantifying the magnitude of this issue in a timely manner, and its impact on bed availability, including at the regional level, is currently limited.

¹¹⁰ Australian Government Productivity Commission. Report on Government Services, 2023: Chapter 14 aged care services. Available from: <https://www.pc.gov.au/ongoing/report-on-government-services/2023/communityservices/aged-care-services>

¹¹¹ New South Wales Department of Health. Written submission to the NHRA Addendum Mid-Term Review, 2023.

¹¹² Western Australia Department of Health. Written submission to the NHRA Addendum Mid-Term Review, 2023.

¹¹³ Data gathered by the National Disability Insurance Agency (NDIA) through manual collection by Health Liaison Officers (HLOs). All data are point in time and represent NDIS participants known to the NDIA at the date of reporting.

Real-time data sharing on long-stay patients through the inclusion of disability and aged care identifiers in hospital data collections, and on the availability of aged care and disability places at the local level, would support more proactive management of these patients from the point of admission (see Case Study: Western Australia's Real-time Data Portal for Aged Care).

Stronger cross-portfolio governance and accountability for performance at the interface is also required. In July 2022, preliminary work by the AIHW identified a very limited set of formal health system performance indicators that jurisdictions agree are suitable for national reporting. This program of work will be critical in enabling comprehensive intersectoral performance data and fostering collaboration across all relevant sectors.



Case study: Western Australia's Real-time Data Portal for Aged Care

Western Australia estimates that on any given day, there are over 100 older people waiting in Western Australian hospitals for aged care services, including residential aged care beds. There is no nationally consistent database to easily identify appropriate and available aged care beds. As a result, hospital staff can spend many hours across several days calling residential aged care facilities searching for available and appropriate beds for their patients. This distracts hospital staff from their core duties and contributes to discharge delay, with older patients waiting in hospital beds despite being medically ready for discharge while looking for available beds.

The Western Australia Government is working collaboratively with the aged care peak body, Aged and Community Care Providers Association (ACCPA) to deliver a real time bed availability portal. The Western Australia Government has provided a grant to the ACCPA to support the development of the portal, to be launched in June 2023. The portal will be sector owned and led.

In the first instance, the portal will be accessed by hospital staff to identify appropriate and available aged care beds for patients awaiting aged care services. The portal will include residential aged care beds, transition care program beds, and respite beds. It will support search functions by location, bed type, or care needs.

The portal is anticipated to decrease discharge delay by reducing the time older people spend in hospital while available aged care beds are identified. This reduces risks for the older person, improves overall patient flow and ensures hospital beds are available for people who need hospital care. The portal will also allow hospital staff to focus more on hospital care, rather than spending time contacting aged care facilities. The portal will also improve efficiencies for aged care providers who currently send emails to multiple health service providers with their bed availability.

This case study demonstrates how a real time bed availability portal has the potential to facilitate discharge from public hospitals, achieving better patient outcomes and experiences while reducing costs associated with bed block. There is potential for a similar tool to be applied nationally across both aged care and disability sectors to inform national discussions around the supply, distribution and funding of aged care and disability accommodation and support services.

5.2.3.4 Increase capacity of timely and appropriate aged care and disability accommodation and support services

The availability of timely and appropriate aged care and disability services, particularly in regional and rural areas, has been presented to the Review as a key driver of discharge delays and potentially preventable hospital admissions. A number of factors have been put forward as contributing to this including:

- The financial viability of aged care services: the StewartBrown report¹¹⁴ released in October 2023 revealed that the national average operating cost of RACFs, both public and private, results in a loss of \$16.54 per bed day, despite the Commonwealth's additional Basic Daily Fee supplement of \$10 per bed day and the short-term transition benefit arising from the introduction of the Australian National Aged Care Classification (AN-ACC) subsidy from October 2022. This financial strain impacts bed availability with residential aged care providers sometimes reluctant to accommodate older individuals with complex needs.
- The capacity of Aged Care Assessment Teams (ACATs) to keep up with the assessment and planning processes and to proactively monitor and support older patients can lead to delays in hospital discharges or unnecessary admissions.
- Lack of transition care places and step-down beds to provide short-term placement options while an aged or disability patient is awaiting a residential bed or aged care package or receiving rehabilitation services to support their discharge.

There appears to be a gap in the current system in providing proactive management and service planning for older patients and people with disabilities once admitted to hospital and in providing sufficient transition care or step-down beds to enable timely discharge and support better outcomes.

Despite the limitations in the current approach, there are examples of innovative and efficient initiatives that facilitate timely patient discharge and prevent unnecessary hospital admissions (see Case Study: Residential Aged Care District Assessment and Referral Service Rapid Response). Initiatives to address the access block related to long stay older patients include mobile outreach and rapid response teams for elderly patients in RACFs, top up payments to RACFs/community providers, funding

¹¹⁴ StewartBrown (2023). Aged Care Financial Survey Report

home modifications and increasing nursing supports. Successful initiatives implemented at the local level should be evaluated, shared and implemented more broadly across Australia.

While there is acknowledgement of shared responsibility between the Commonwealth, States and Territories at the public hospital interface, the Addendum does not have explicit financial incentives to facilitate the timely discharge of elderly patients. The future Agreement could strengthen collaboration between the aged care sector and public hospitals by introducing financial incentives and/or cost sharing arrangements to encourage the timely discharge of elderly patients.



Case study: Residential Aged Care District Assessment and Referral Service Rapid Response (RADAR RR)

RADAR RR is a Queensland Ambulance Service (QAS) emergency substitution model of care. It has been implemented as part of the wider RADAR service focusing on improving the health of older persons residing in RACFs by providing a comprehensive, acute care consultative nursing, medical and pharmacy outreach, or telehealth service. The service provides early intervention for deteriorating or dying elderly individuals and facilitates subsequent on-referral to specialist outpatient teams or initiation of appropriate end of life care pathways. It also provides individual complex case management including for frequent ED presenters, or those with specialist needs such as behavioural and psychological symptoms of dementia; working in partnerships to facilitate best practice across the health care continuum.

RADAR RR comprises a multi-disciplinary team led by emergency and geriatric consultants, nurse practitioners, nurse navigators and pharmacists. It provides out of hours support for RACF staff and GPs to ensure a safe alternative to ED transfer and management and assists with navigation of the health care system.

This case study demonstrates shared accountability and shared benefit at the interface of public hospitals and aged care sectors to provide patient-centred care for high-risk elderly individuals in RACF. It demonstrates how data can be collected and shared under intersectoral governance structures to provide effective care, mitigating unnecessary hospital admissions.



Recommendation 9: Collaboration between Aged Care and public hospitals should be strengthened through shared responsibility for supporting older patients to be discharged from hospital when clinically ready and to reduce avoidable ED presentations and hospital admissions. New strategies to address these long stay older patients (LSOP) include:

- a) A **national data collection** to assess number and acuity/needs of LSOP. This is an early foundation that should commence immediately.
- b) Greater availability and use of **transition care places** to support discharge from hospital to home, including step-down beds that are cost-shared and can bridge the gap between the hospital and a residential facility or community package.
- c) Creation of mechanisms (such as brokers, real time bed availability data, hospital liaison officers) to **actively manage placement of older people**, from the point of admission to discharge.
- d) New models within residential aged care and the community (mobile outreach or rapid response teams) to support **placement of hard-to-place individuals** (including role of specialist dementia units and dementia training programs).
- e) **Financial incentives** to better share risk where discharge is delayed and, for those with particularly complex needs, potential top-up payments to support placement with a RACF or community provider.

A significant hurdle in providing timely care is the shortage of appropriately skilled health workers, a challenge shared across health, aged care and disability sectors. Inconsistencies in salaries, pricing and payment arrangements for similar services across sectors further exacerbate workforce issues, leading to resource allocation distortions. These disparities may increase over time and result in more individuals seeking care in public hospitals due to the unavailability of services in the aged care or disability sectors, particularly in regional and remote areas. Actions from one sector to improve the available supply of services may negatively impact supply of services in another. Addressing these interconnected workforce issues across health and social care sectors requires joint solutions from all levels of government.

5.2.3.5 Proactively facilitate NDIS participant discharge from public hospitals

The NDIA, with input from Disability Ministers, has introduced operational improvements and actions that have advanced hospital discharge reforms, such as monthly dashboards and an increased number of hospital liaison officers that help to facilitate faster discharge. Since the implementation of these initiatives, the average duration between medically ready and discharge for NDIS participants in hospital has decreased from 39 days on 31 October 2022 to 26 days on 31 May 2023¹¹⁵. The discharge process should ensure continuity of care involving clear communication about, and coordination of, participant care between providers, health care staff, participants, and their support network (see Case Study: Regency Green). Progress in this area should be consolidated and advanced further through the integration of real time data and strengthened intersectoral governance mechanisms.

¹¹⁵ Data gathered by the NDIA through manual collection by Health Liaison Officers. All data are point in time and represent NDIS participants known to the NDIA at the date of reporting.



Case study: Regency Green – transitional support and accommodation for NDIS participants

Due to the critical pressures on the hospital system, South Australia Health established Regency Green to ensure people can access support in a more appropriate setting and free up hospital beds for those who have acute care needs.

Regency Green is a 21-bed transitional support and accommodation service used to enable NDIS participants with a primary psychosocial disability, who no longer require acute medical care to discharge from hospital whilst they await longer term arrangements. Participants in the service continue to receive their mental health care through the relevant LHN Community Mental Health team and also engage with their usual NDIS providers for community engagement.

This case study demonstrates the benefit to participants and to functioning of the interface between systems of a more joined up model of care. There is potential to apply a similar model for long-stay older patients across the nation.



Recommendation 10: The proactive approach being taken to **support the transition out of hospital to home of people with a disability who are NDIS eligible and ready for discharge** should continue, supported by its own national data collection along the lines of that at Recommendation 9(a), with a focus on delivery of joint and concurrent responses across sectors, and further review of the mechanisms to ensure **continuity of care** for NDIS participants during a hospital stay to ensure optimal patient outcomes.

5.3 Optimal models of care

To adapt to the changing health needs of the population (including the effects of population ageing and increase in chronic and complex conditions), future models of care need to enable collaboration between, and blending of, services along the care continuum where services and supports are tailored to the needs of the individual rather than the funding constraints of the system.



5.3.1 NHRA enabling care across the continuum

The Addendum acknowledges that public hospitals operate within a broader health and social care eco-system, however stops short of defining the mechanisms and incentives required to enable the design and scaled delivery of innovative care models that meet the evolving needs of the community and individuals. Rather than promoting the development of contemporary care models, the current arrangements tend to discourage innovation particularly at scale by the way services are defined, counted and funded in the Addendum.

The illustrated patient pathway in Figure 32 (provided by a jurisdiction) highlights the pain points for the system in designing and delivering services that meet an individual’s needs and reflecting contemporary best practice, especially for priority patient cohorts that traverse care settings, such as the frail elderly, people living with chronic diseases and/or mental health issues, and maternity care patients.



Cheryl is an 83-year-old women with declining mobility, Parkinson’s disease, signs of dementia and she is reluctant to take medication. She lives with her 87-year-old husband. Their family does not live nearby, but they both want to remain living at home for as long as possible.

Sub-optimal current pathway

- Ambulatory care**
Cheryl wakes up one morning with redness and swelling around her left eyelid.
Her husband calls their local medical practice for an appointment, but the GP is only available in one week’s time.
Throughout the day Cheryl gradually feels worse. By the evening she is anxious, and her husband phones for an ambulance
- ED care**
Cheryl is taken to the ED where they find that she has ophthalmic shingles.
She is discharged the same night with a script for medications.
She forgets the script at the hospital.
- Ambulatory care**
Cheryl does not take the prescribed medications and over the next two days the pain worsens.
Her husband calls for an ambulance again.
- Admitted care**
Cheryl is triaged and waits for an hour before she is seen by staff.
She stays in hospital for two days.
- Cheryl is discharged from the ward and waits for patient transport home.
Cheryl’s shingles is improving, however her increasing mobility issues and behaviour around medication is still unresolved.



Improved optimal pathway

- Cheryl was identified as at high risk of hospitalisation through her usual GP’s reviews of patient data. The GP enrolled Cheryl in a *Frail Care Pathway*.
As part of the program, Cheryl has prescheduled appointments with her GP. **Promotion and prevention**
- During her first prescheduled appointment, Cheryl’s GP identifies her mobility is declining and the falls risk it poses.
The GP contacts the *Geriatrician Outreach to GP Service* to discuss options which includes medications to trial, next steps and referral to Neurology Clinic. **Primary health care**
- Once medication started there is a significant improvement in her mobility,**

10 months later, Cheryl wakes up with redness and swelling around her left eyelid.
Her husband calls their local medical practice for an appointment. She receives a same day appointment as the Care Team know that Cheryl is a high-risk patient.
The GP calls the *Geriatrician Outreach to GP Service* to discuss trialling stepwise progression.
Cheryl avoids the need for an ambulance to the ED. **Sub-acute and rehabilitation care**
- 2 months later, the GP realises Cheryl is still experiencing pain because of the shingles, during a prescheduled appointment.
GP phones the *Geriatric Rapid Response Team* who visits Cheryl within 4 hours at her home.
The *Geriatrician Outreach to GP Service* and *Geriatric Rapid Response Team* work together and discuss the case with the GP and family and organise an Urgent Pain Review.
Cheryl avoids being hospitalised. **Primary health care**

Figure 32: Frail Elderly Patient pathway – suboptimal and optimal

Clauses A96 through A101 of the NHRA explicitly outlines mechanisms to explore and trial new and innovative models of care supported by appropriate funding models. As noted in the discussion of Long-term health reforms (section 3.5), it was identified by stakeholders that the exploration and trialling of innovative models of care has been slow and impacted by the COVID-19 pandemic. It was felt that current funding models are focused on pure activity rather than outcomes and integration of the end-to-end healthcare journey. At present, there is limited or no reference to outcomes for patients or the relative efficiency of providing care in alternate settings. This view is further highlighted through limitations in the metrics to quantify and understand patient reported experience and outcomes.

The case study below provides an example where a service has been established targeting patients with diabetes in Victoria.



Case study: Integrated Diabetes Education and Assessment Service (IDEAS) in Victoria

IDEAS is a Victorian Community Health-led alternative to hospital outpatient services for people with Type 2 diabetes. IDEAS was developed by healthAbility and Eastern Health in 2009 and is now delivered across six community health service sites, integrating with outpatient departments across Eastern Melbourne. IDEAS diverts patients from busy public hospital waitlists and delivers comprehensive diabetes care from specialist doctors in the community, combined with community health wrap

around support services. The model has resulted in reduced wait times for patients, reduced demand on hospital services, and provides cost-effective, accessible care in community-based settings.

There is no dedicated funding source for IDEAS, so providers draw on funding from multiple sources, including the MBS and the State funded Community Health Program. Current funding arrangements for IDEAS are unsustainable and prevent scalability. Innovation is hampered by the funding parameters of the NHRA, that do not recognise community health service providers or support non-clinical care. The sustainability and scalability of IDEAS will require a funding model that facilitates care outside of hospital settings, supports both clinical and non-clinical care, and recognises the role that community health or other like public services can play in reducing hospital demand.

5.3.2 Priority areas of focus

It is acknowledged that services develop in response to the funding, governance structures and incentives that exist within the system. While improvements have been made within individual service streams (such as acute, primary and disability settings), there is consistent feedback from stakeholders of service gaps and coordination challenges across patient pathways. Further, a level of unwarranted variation in healthcare persists and there is an opportunity for the NHRA to reinforce established care pathways system wide.

While much work has been progressed by the ACSQHC, IHACPA and NHFB exploring innovation in service design and funding, there has not been defined priority areas of focus and a clear mechanism to develop and adopt new models through the Addendum. Section 5.2 (A focus and platform for intersectoral collaboration) highlighted the important interface points between the acute, primary, aged and disability services systems in creating a more joined up system of care.

The *2023 Intergenerational Report* projects that demand for health and social care services over the next four decades will grow faster than the economy, posing a significant fiscal threat¹¹⁶. This growth is partly explained by population growth and an ageing dynamic, but also by non-demographic growth related to consumer expectations and advances in technology¹¹⁶. The NHRA requires a focus and a set of priorities that moves beyond simply responding to demand to one that shapes demand for health to keep people well and enable their participation in society. This requires a connected care model that lowers the trajectory of demand especially for acute care.

A future Agreement must set key areas of priority focus or problem statements that will form the basis of the next evolution of funding and service reform, enabling and driving progress towards improved models of care that:

- a) **Respond to demand** – through volume and price signals, ensure services are delivered efficiently and meet the needs of patients. The Addendum has taken large and important strides forward in the measurement and funding of services delivered to patients. The next evolution of the Agreement should look to build on these foundations and the work progressed by various bodies to better meet the needs of the community through the lens of quality, value and evidence.

Priority areas of focus for improving models of care that respond to demand include:

- i. The 17 clinical standards that have been developed and additional Standards that are under development by the ACSQHC
 - ii. Accelerating data sharing and governance across providers and with consumers
 - iii. Developing bundles of care for discrete patient needs, for example related to uncomplicated maternity care, hip and knee replacement or stroke, where a package of care is defined to drive improvements in quality, value and cost.
- b) **Shapes demand** – encouraging health systems to plan for, and develop services and processes, that better meet the needs of the community earlier in a care pathway, reducing the reliance on acute care interventions. This call on acute capacity coupled with known demographic and non-demographic growth pressures is a useful starting point to develop better models of care. The priority areas of focus identified to the Review include models that seek to:
 - i. **Reduce potentially preventable hospitalisations (PPH) as reported by the AIHW:** Almost 50% of all PPHs are for five common conditions (see Observation: Healthcare Variations and Cost)¹²⁰. While clinical pathways have been developed to lower admission rates, they have not been consistently implemented across Australia¹²⁰. Innovative models of care that more effectively prevent and manage these five conditions (acute and chronic) have the potential to significantly reduce the rate of PPH.
 - ii. **Address frail elderly care:** Frailty develops because of age-related decline, which results in vulnerability to sudden health status changes triggered by relatively minor stressor events. It is estimated that a quarter to half of people over 85 years are frail, and these people have significantly increased risk of falls, disability, long-term

¹¹⁶ Australian Government Department of Treasury. 2023 Intergenerational Report, 2023. Available from: <https://treasury.gov.au/publication/2023-intergenerational-report>

care and death¹¹⁷. More holistic and wellness-focused models of care that involve education, enablement and rehabilitation to optimise function in older people can reduce PPHs¹¹⁸.

- iii. **Improve primary and emergency care:** Increasing the availability and effectiveness of primary health care to provide more continuous and coordinated care across healthcare settings can reduce the number of PPHs¹¹⁹. Additionally, models of care that provide urgent care services virtually or outside the hospital can minimise unnecessary presentations to ED (see Case Study: South Australian Virtual Care Services).



Observation: Healthcare Variations and Cost

The Fourth Australian Atlas of Healthcare Variation reported more than 330,000 potentially preventable hospitalisations in Australia in 2019-20 were due to five conditions: heart failure, chronic obstructive pulmonary disease, diabetes, cellulitis and kidney and urinary tract infections¹²⁰. The ASCQHC has reported that, by improving the management of these five conditions through clinical pathways focused on lowering admission rates, the Australian public hospital system could potentially have avoided 330,000 hospitalisations, representing 1.6 million bed days and \$2.1 billion in total hospital expenditure in 2019-20.

To better respond to, and shape, demand it is essential that there are enabling features in place that require the collaboration of all health system participants:

- **A pathways approach**, which considers the end-to-end patient journey as a continuum between care settings and acuity levels and can be cyclical as well as stepped. This means that services wrap around a patient based on their individual care needs.
- **National financing and governance**, to oversee the allocation of total funding and activity across the healthcare continuum. This will hold the patient at the centre and incentivise a drive towards optimal health outcomes rather than input units, enhancing allocative efficiency.
- **Long-term funding models**, which enable the investment of required capacity, capability and capital to establish and operate health services. This can take the form of incentivising hospital avoidance activities or enabling investment in digital technologies to establish and deliver virtual care services delivered out of hospital (refer to case study below). This should draw upon existing funding streams (i.e., ABF, Block, MBS and/or PBS) to design and implement the refined model.
- **Priority groups identified**, so that initial allocation of funding can coordinate the funding reform, data sharing, transparency and accountability components which will be essential for driving towards sustainable change.
- **Co-commissioning of services by PHNs, LHNs and ACCHOs in conjunction with acute health services** (covered in section 5.2) has been noted as an opportunity to bring greater coordination across funding streams. This can further align funding streams and patient outcomes across the continuum of care through more efficient allocation of resources and activity. This coordination of commissioning of services will need to consider key enablers to drive effective service planning and funding allocation decisions.



Case study: South Australian Virtual Care Services (SAVCS): virtual ED

SAVCS was launched in December 2021, as a state-wide adult focused service. It provides a Virtual Emergency Service and a Regional Virtual Service from 8am to 10pm every day. It comprises a multi-disciplinary team of paramedics, medical consultants, nurses who interface with onsite clinicians.

This virtual ED model of care is providing rapid access to care for consumers, front-loading care delivery with senior clinical decision makers. The model has shown a positive impact on reduced inpatient hospitalisation and ED requirements.

Since its establishment, SAVCS has received over 15,000 referrals, with 85% coming from South Australia Ambulance Service. 80% of the calls received were without physical ED attendance and admission. It is estimated that SAVCS has released more than 80 inpatient beds.

¹¹⁷ Song X, Mitnitski A, Rockwood K. Prevalence and 10-year outcomes of frailty in older adults in relation to deficit accumulation. *J Am Geriatr Soc.* 2010;58(4):681–7, 2010.

¹¹⁸ Ryburn B, Wells Y, Foreman P. Enabling independence: restorative approaches to home care provision for frail older adults. *Health and Social Care in the Community.* 2009;17:225–234.

¹¹⁹ OECD/EU. *Health at a Glance: Europe 2018: State of Health in the EU Cycle.* Paris, 2018.

¹²⁰ Australian Commission on Safety and Quality in Health Care. *The Fourth Atlas, 2021.* Available from:

https://www.safetyandquality.gov.au/sites/default/files/2021-04/The%20Fourth%20Australian%20Atlas%20of%20Healthcare%20Variation%202021_Full%20publication.pdf



Recommendation 11: The NHRA should prioritise **the development of optimal models of care**, using agreed innovative financing mechanisms, through:

- a) Enhancements that both **respond to, and shape demand for health services**, with a priority focus on:
 - Reducing rates of potentially preventable hospitalisations
 - Scaled adoption of the ACSQHC Clinical Standards and Pathways
 - Bundling care for certain agreed pathways (maternity care, hip and knee replacement, stroke)
 - Embedding digital and technology solutions, including by enabling virtual care
 - Improving access to quality services in rural and remote regions.
- b) Establishing **guidelines for the development of evidence-based care models and pathways** that consider:
 - The needs of patients
 - Whole of system pathways
 - Model of care enablers including data sharing and governance, capacity for local tailoring and adoption, workforce, funding, infrastructure and technology.
- c) An **Innovation Funding Pathway** that, from the outset, maps the transition from seed funding to operation at scale, subject to evaluation milestones being met (linked to Recommendation 34). The process by which innovative models of care will be initially funded and then brought to scale should form part of the ten year National Health Funding and Payments Framework at Recommendation 16.

5.3.3 Alternative funding mechanisms

While ABF is the predominant mechanism of funding public hospitals (around 85% by cost) it is not the only method through which health care services are, or could be, funded. Table 2 sets out a range of funding mechanisms, their risks and benefits and examples of their use.

Table 2: Funding mechanisms (high-level only)

Funding mechanism	High-level description	Benefit	Challenge	Example
ABF	Hospitals are paid based on the volume and complexity of treated patients, underpinned by the NEP (a price signal).	Drives a level of consistency in the care delivered across the system.	May incentivise increased activity, resulting in unsustainable volume and potentially associated with adverse health outcomes.	Separation of ABF and MBS/PBS funding streams for inpatient and outpatient activity.
Bundled payment	Single payment for all services related to a specific treatment, condition or patient parameter, possibly spanning multiple providers in multiple settings.	Incentivise optimal health outcomes, maximise the value of the services they provide and hospital avoidance where clinically appropriate.	Requires an extremely well defined treatment requirement for specific treatment of condition in order to ensure that the costs of service delivery are covered through the single payment.	Orthopaedic care (inpatient, ambulatory and rehabilitation) or maternity (refer case study below).
Value-based	Payments may link clinician, hospital, or health system compensation to performance on specific cost, quality, and equity metrics.	Providers may be more motivated to change how they deliver care when more of their revenue is tied to this payment.	Unpredictable revenue streams and financial risk that it entails.	Pay for performance initiatives
Block funding	Traditional funding model where funding/grants are provided to deliver services, usually linked to their client numbers, services delivered and potentially on a historical basis.	It gives an organisation certainty as they know well in advance how much funding they will be receiving for the delivery of a program or service.	Funding may not reflect community need and current environment.	Smaller health services, or for activities that are difficult to price.
Blended funding	Accessing multiple funding streams at the intersection of programs tailored to the needs of the individual patient, with payments made based on the achievement of objective outcome measure. Enabled through the relaxation of allocation to specific care settings.	Can be applied directly for patients who are transitioning between care settings with overarching national governance and coordination.	May not be a shared definition on outcome appropriateness between clinician, patient and funder.	Long stay in-patients awaiting Aged Care supports who can begin to access their aged care funding via a hospital prior to discharge to home.



Funding mechanism	High-level description	Benefit	Challenge	Example
Fee for service	A health care provider receives a payment each time a patient is admitted (or readmitted) or for each test performed.	Ethical bond between the patient and the physician as the patient has purchased the time and skill of the physician to do everything possible for the patient.	Over-servicing in order to maximise revenue and without resolving patients' problems completely, patients will tend to re-present.	X-ray or pathology test.
Population funding	Per capita funding – payment per person by geographical area that is adjusted to take into consideration morbidity and higher costs associated with health care delivery.	Equitable level of funding for a specific area based on key demographic factors.	Limited incentive to maximise level of activity, often resulting in underservicing and reduced access to services.	Rural loading, mental health, socioeconomic status.

5.3.4 Building on the foundations of ABF

After ten years of operation, it is timely to consider whether and how the system of funding public hospitals and hospital related health care can be adapted for future challenges. This process has already started with changes to the NHRA that commenced in the 2017 Addendum through safety and quality reforms to reduce sentinel events, hospital acquired complications and avoidable readmissions (refer to Clauses A161 to 179).

There are three types of approaches to pricing to consider in this regard, which highlight the focus of the current Agreement as well as the opportunities for reform that can position the financing system to be more responsive to, and shape, future demand:

- (1) **A pricing model that responds to demand through volume and price-based payments:** this largely describes the current model of funding through ABF. Public hospitals are funded largely on the activity they deliver at an established price, with the relative complexity of their activity recognised. The risk, as noted in consultation, is that this rewards hospital activity seen through a lens of individual transactions and so can drive activity toward the expensive hospital setting and fragment the care pathway with little accountability for outcomes. It is not the best model for episodes of care that span multiple settings (for example, joint replacement surgery requiring subacute rehabilitation) or for frequent users of hospital services (such as those with chronic conditions).
- (2) **A pricing model that shapes demand by funding services outside the hospital and earlier in the pathway** to slow the demand for acute care. This can involve establishing incentives and payments for health services to focus on early intervention and care to reduce downstream acute care demand and provide flexibility to fund services in non-hospital settings (primary, aged and disability care) best placed to meet the health needs of individuals.
- (3) **A pricing model that drives innovation by delivering value-based care, paying for outcomes and enabling alternative delivery models that are digital and data enabled.** This incorporates funding models that accelerate the adoption of high value care modalities (and seek to reduce low value care), provide incentives to accelerate changes in clinical practice in line with evidence and manage the introduction of new technologies; explore outcome-based payments models that focus on improvements in health rather than the volume of activity; and payment models that are digitally and data enabled. This model would incorporate blending of payments that incentivises the delivery of care in the most appropriate setting and with an outcome-based element.

5.3.4.1 Incorporating alternative funding mechanisms in the NHRA

The next Agreement should seek to investigate and incorporate alternative funding mechanisms within the NHRA that drive system performance and outcomes more directly, delivering both the technical efficiency to which the Agreement aspires and allocative efficiency focused on optimal patient pathways and outcomes. This should recognise the benefits of using a range of funding approaches as appropriate, with ABF remaining as the core mechanism but further developed and adapted to fully realise its potential to effect change.

Internationally, a number of countries are reforming the way health services are funded to create new incentives to drive value, improve sustainability and achieve greater coordination of care across the system. A high-level summary of international developments, focusing on high value care and integrated funding systems is at Appendix H.

Reflecting on the pricing models outlined above, a new Agreement should develop financing reforms that seek to **shape demand** and **drive innovation**, addressing the elements of setting of care, how an episode of care is defined and paid for and paying for outcomes. Finally, the building blocks of moving from reactive to proactive financing needs to put a range of enablers in place and map a transition pathway to enable the system to respond accordingly.

Progress in this area needs to be driven and supported by the work of the NHRA national bodies, particularly the evidence regarding avoidable hospital admissions and delivery of low value care, both of which detract from system sustainability and innovative approaches to financing.

5.3.4.2 Setting of care

A future Agreement should incentivise the provision of safe and quality care in the most cost-effective setting, such as primary care, aged care or in a person's home, where there is evidence that these services can directly contribute to reducing demand for expensive hospital services.

The NHRA acknowledges that acute services occur outside the walls of the hospital through rules to capture the activity, and allows some flexibility for alternate funding models, but only with respect to services that were previously provided in-hospital.¹²¹

The concept of what constitutes a hospital, what a hospital service is, and who provides it (and how) are constraining innovation. While the Agreement does enable temporary arrangements to be trialled (Clauses A97 and A26(d)), innovative models are often not deemed eligible or are not adequately and/or sustainably funded.

The Review was provided many examples of arrangements that sought to deliver services outside the hospital door, with a focus on improving care outside the hospital for frequent users of hospital services or intervening before acuity and complexity increased. However, States and Territories reported that getting these services agreed for shared funding was difficult and they were often left as sole funder. It was also acknowledged that the predominant incentive of the NHRA funding mechanism was to respond to acute demand through traditional hospital-based services.

“The current approach to implementing the NHRA runs the risk of suffocating rather than encouraging innovation in service delivery due to the rigidity of the underpinning pricing / funding model.”



Case study: Hospital avoidance models of care

Some examples of arrangements that have sought to deliver services outside the hospital include:

HealthLinks (Victoria): Victoria trialled this capitation funding model program, which enabled five health services to better treat chronic conditions outside of hospital. Participating health services had the flexibility to use projected inpatient funding to create a capitated funding model (flexible funding) to design care around the needs of patients at high risk of multiple unplanned hospital admissions. The capitated funding model provided a funding source that could be used to deliver a more flexible mix of services in home and community settings, beyond traditional hospital-based settings. This program was discontinued in July 2022 as compliance with ABF coding and classification standards did not enable Victoria to reflect the impact of the program over a longer evaluation period and or support the reform to scale.

Pathways to Assistance and Treatment (Australian Capital Territory): A custom-built mobile clinic that offers the full range of minor procedures and services common in a standard GP clinic, enhancing client access to health care in public housing. The service aims to reduce the number of people who present to the ED with complex health issues that could have been dealt with earlier in primary care. These clinics are staffed by a carefully recruited and trained interdisciplinary team of a GP, nurse, mental health practitioner and alcohol and drug practitioner, together filling an important gap in medical access for many who would not have access to healthcare without it.

Many examples emerged during COVID-19 of hospital services being quickly adapted to be delivered using virtual platforms. Through innovative use of technologies, flexible funding and workforce arrangements and close collaboration across providers, these became exemplars of providing patient-centred care in a home or community setting. A new Agreement should harness the rapid uptake of innovative virtual care models that emerged during COVID-19 and embed their key features.

A future Agreement should revisit the way in which services delivered outside the hospital and designed to improve patient outcomes and reduce hospital demand can be incorporated into the Agreement. It will be important to ensure a transition arrangement is put in place to mitigate against the national activity growth cap being exceeded, as a result of new activity being brought within the Agreement.



Case study: Virtual models of care

Some examples of virtual models of care include:

rpavirtual (New South Wales): The Royal Prince Alfred Virtual Hospital (rpavirtual) delivers hospital care in the community, using technology to provide clinicians with patient data to remotely treat and monitor patients round the clock, acting as a bridge between hospital inpatient services and the community, with specialist review and in-person assessment as required. A 2020-21 Evaluation report showed savings of 15 bed days per person for COVID positive patients, totalling 25,000 bed days saved.

¹²¹ Clause 17 of the 2011 NHRA grandfathered those services that were provided in hospitals in 2010 as eligible for continued Commonwealth funding at specified hospitals (known as the A17 list).

COVID-19@homeplus (Tasmania): Established in December 2021, COVID@home initially provided care to Tasmanians who had tested positive to COVID-19 and has now evolved through COVID@homeplus to provide care to other vulnerable people with respiratory illnesses who meet other referral criteria as a hospital avoidance initiative. Enrolled patients have access to a multidisciplinary support team to monitor symptoms and receive care at home monitoring kits. As at May 2023, the program had supported over 36,800 people and alleviated pressure on primary care and hospital emergency departments.



Recommendation 12: The **scope of public hospital services referenced in the NHRA should be reviewed**, with a view to removing reference to what was deemed to be a hospital service in 2010 (Clause A22), **and broadened** to address current disparities between States and Territories and to incorporate those services that are provided beyond the hospital door, including virtual services and in-reach/out-reach services, where the primary purpose is to both respond to, and shape demand for acute care by replacing or avoiding a hospital admission, with an appropriate transition to ensure any impact on activity growth caps are managed.

5.3.4.3 Bundled payments

In the course of consultations, stakeholders identified the merit of including in the Agreement a structured approach to bundle payments for certain end-to-end episodes of care, that encompass the ‘before, during and after hospital’ components of an episode, and provide an incentive to deliver care in the most quality and cost-effective setting.

A recent study conducted by IHACPA suggested that up to 20% of NHRA funding could be better utilised through bundled payments¹²². In an earlier report in 2017, the then IHPA investigated the potential for bundled pricing models for:

- Uncomplicated maternity care
- Hip and knee replacements e.g., a single payment for non-admitted, admitted, and sub-acute services, and
- Stroke e.g., bundle ABF payments across care types and weighted for complexity.

The report noted that bundled pricing for maternity care could drive a change in how and what services are delivered, with the impact dependent on the profile of patients, stages of care and services in the bundle, as well as the degree of risk adjustment and the pricing approach. For example, a single price across the antenatal and birth stages of care could send a price signal which supports a greater focus by public hospitals on preventative care during the antenatal period to reduce the potential complexity of the birth and flow-on impacts for post-natal recovery.

Consideration should be given to implementing bundled payments, through a structured national approach, where doing so would improve the quality of care and outcomes for patients, enable greater efficiency and support better and more integrated patient pathways. Uncomplicated maternity care may be a good starting point, given the detailed work that has already occurred, the strong interest among stakeholders and the shared national approach of the *Women-centred Care Strategy*¹²³. Another area that has seen cost savings in other countries is bundling the acute and sub-acute components of a surgical episode of care.¹²⁴

The opportunity for bundled payments is greatest where there are defined care pathways covering all elements of care, that are able to be costed and counted (for maternity care this would include screening, ultrasound/scans, pathology, and triage, to identify pathway entry points, assessment milestones, risk identification, service navigation and management and support needs), where optimal care is grounded in evidence, where there is a method to identify variance and drive improvement, and there is stakeholder engagement. A key enabler of bundled payments is the capacity to identify individual patients through the care continuum using linked data sets, underpinned by an Individual Health Identifier.

Considerable development work will be required by the Commonwealth, States and Territories, together with the national bodies and relevant stakeholders, to identify and agree priority areas, develop a work program and pilot arrangements to refine a new payment approach.



Case study: Maternity bundled pricing model

Maternity care is a predictable care pathway which, in Australia, usually leads to a hospital admission for birth care, has clear start (ten weeks gestation) and end points (six weeks postpartum) to the pathway which allows for identification of clinically warranted and unwarranted variation in care. Care is fundamentally multi-disciplinary, encompassing both primary and secondary (acute or urgent) care.

Maternity care is one of the leading causes of hospital admission and is a driver of public hospital costs. While funding is relatively predictable with around 300,000 births annually and reflects a comparatively fixed cost, there are observed

¹²² Independent Health and Aged Care Pricing Authority. Future Funding Models for Australia’s Public Hospitals: A discussion paper on options for funding Australian public hospitals into the future, November, 2021.

¹²³ Council of Australian Governments Health Council. Woman-centred Care: Strategic directions for Australian maternity services, 2019.

¹²⁴ Neville, Dr Sarah Elizabeth (2023). “What makes bundled payments work? Lessons from the US”. IHACPA Conference 2023, the Future of Funding. Brisbane, Australia August 2023.

variations in outcomes and costs, and therefore the potential to generate system efficiencies and improved outcomes. Further there are access barriers, particularly in rural and remote areas and for First Nations' families, that lend themselves to alternate funding approaches using multidisciplinary care models and expanded scope of practice.

Currently maternity care funding is fragmented, spanning the MBS (for primary care by GPs, general practitioner with obstetrics, endorsed midwives and specialist obstetricians, pathology and imaging), public hospital funding, private health and consumer contributions (out-of-pocket costs). The elements of the overarching funding model are inefficient, costly and not integrated between primary and acute care. The DRG-based funding model is in general linked to a medical event (e.g., birth), and does not fund care as a continuum (e.g., Midwifery caseload care which is focused on keeping healthy pregnant women and their unborn baby well and preventing unnecessary hospital attendance and/or admission). There are many examples of discontinuity of care which adds to cost and impacts on outcomes.



Recommendation 13: A structured program of work should be undertaken to **develop and implement bundled payments** within the NHRA for certain end to end episodes of care (before, during and after a planned hospital admission), with an **initial focus on maternity care**, and with additional priority areas identified early in the Agreement in consultation with the national bodies and relevant stakeholders. Bundled payments should be implemented across several priority areas within the period of the next Agreement.

5.3.4.4 Paying for value/outcomes

A further area for financing reform is a move toward value-based payment models, as a means of shaping outcomes and improving system sustainability.

Under current arrangements, the NHRA's funding and pricing determination mechanisms generally do not seek to influence or drive toward or away from specific types of activities, even when there is evidence that a particular procedure is of little to no benefit or presents risks to patients, requires rework and incurs opportunity cost (where higher value care could have been provided).

One of the Long-Term Reform areas of the current Agreement (Clauses 17 to 22) sought to develop *Paying for Value and Outcomes* reforms that created incentives for providers to focus on patient outcomes, equity and best practice clinical care and agreed that the Parties would develop a *National Health Funding and Payments Framework* to progress trials of funding and payment reforms at program and system levels. In the absence of dedicated resourcing, little progress has been made on this shared objective.

Information is already available through the national bodies that can identify those activities that are of low value and that should either be removed from the list of activities that will be funded through the NHRA or be priced at a lower level to disincentivise their delivery. Some States and Territories have already begun these processes as a means of improving the sustainability of their hospital system.

An alternative approach is to offer incentives through the funding model for those pathways that are best practice and preferred. In reality, a combination of the two is likely to be most effective in changing behaviour. Key steps in this regard would encompass:

- Introduce funding for performance improvement via an incentive approach that rewards **high-value or high-quality care**. There would be merit in leveraging the work of the ACSQHC on outcome measures to design a specific incentive program to be implemented over time.
 - Specific health conditions of concern, with established clinical quality registries (CQRs) already incorporating Patient Reported Outcome Measures (PROMs) could be targeted first, with effort then allocated to other priority medical conditions as local investments in harmonising data infrastructure is achieved.
- Ensure **price signals** are applied consistently to remove incentives for low and no value care.
 - Create a 'do not do' list of low-value treatments identified by the ACSQHC; and defund procedures that fail cost-effectiveness tests, aligned with the recent Productivity Commission (PC)¹²⁵ recommendation that Australian governments more quickly respond to authoritative assessments of **low-value procedures** (see observation: low value care).
 - In operationalising this there is a requirement to specify what low value care activities should be measured via a national list, determine how low value care activities will be identified and reported in a timely manner, and how they would be acted on and evaluated over time.
- Dedicate funding through the proposed National Innovation Fund for **trials and evaluation of innovative approaches** to service delivery, with a focus on supporting high value interventions (refer to Recommendation 34, section 5.5.4).

¹²⁵ Productivity Commission. Inquiry Report No. 84, Shifting The Dial, 5 Year Productivity Review, 2017. Available from: <https://www.pc.gov.au/inquiries/completed/productivity-review/report/productivity-review.pdf>



Observation: Low value care

It has been estimated that only 60% of health care is consistent with guidelines, with 30% considered wasteful or low value and 10% harmful.¹²⁶ Wasteful health care was identified in the CareTrack Australia study. In studying 22 conditions, it 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.¹²⁷ There has been significant investment in identifying low or no value care in Australia and internationally, including:

- **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 use differs across the country and why this might be occurring.
- **Choosing wisely**¹²⁸ 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 necessary.
- States and Territories more advanced in their planning have introduced **reporting and clinical audit and review processes** to identify clinicians who have unwarranted levels of low value care that can then be addressed by hospital administrators.
- **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 to understand and/or explain efforts to reduce low-value care. The authors reinforce both the individual and contextual determinants including the need to address repeated behaviours that do not require decision-making processes, i.e., guided by habit more than attention, the impact of passive interventions (education, guidelines, do not do lists) do not appear effective, with effectiveness increased with active interventions (financial incentives, data feedback and system level interventions).



Recommendation 14: A new Agreement should develop and implement pricing approaches that **reward high value care and penalise low value care**, providing incentives to accelerate changes in clinical practice and manage introduction of new technologies, supported by evidence, effectively accelerating the approach foreshadowed in the *NHRA 2020-2025 Addendum*.

5.3.4.5 Safety and quality

The 2017-2020 Addendum implemented a policy of paying for safety and quality with the aim of improving healthcare, with a focus on sentinel events, hospital acquired complications and avoidable hospital readmissions. These continued into the 2020-2025 Addendum (Clauses A161-171), portrayed as '...part of a multifaceted, system-wide approach to safety and quality, which includes national standards, accreditation and workforce development'. To date under the Addendum, there have been three pricing adjustments:

- Hospitals receive no payment for critical clinical events, as set out in the Australian Sentinel Events List, that result in death or serious injury.
- Hospitals receive a penalty for defined hospital acquired complications.
- From 1 July 2022, a pricing adjustment was introduced for defined avoidable hospital admissions.

The ACSQHC publishes data on these safety and quality measures, with observed declines in hospital acquired complications. From 2015-16 to 2021-22, rates of HACs dropped by 30% (300 to 211 per 10,000 in-scope separations) and the number of separations with a HAC decreased by 20%. Stakeholders observed in consultation, however, that the way in which safety and quality pricing works in the Agreement does not always result in the intended outcome:

- Where there is a lack of visibility of safety and quality adjustments at the LHN level, it is unlikely to result in changes to clinical practice. Evidence provided to the Review suggested the extent to which penalties are material and flow through to hospital funding and are felt by the relevant clinical unit is limited.

¹²⁶ Braithwaite, J., Glasziou, P. & Westbrook, J. The three numbers you need to know about healthcare: the 60-30-10 Challenge. BMC Med 18, 102, 2020. Available from: <https://bmcmecine.biomedcentral.com/articles/10.1186/s12916-020-01563-4>

¹²⁷ Runciman, W. et. al. CareTrack: assessing the appropriateness of health care delivery in Australia. Med J Aust 2012; 197 (2): 100-105. Available from: <https://www.mja.com.au/journal/2012/197/2/caretrack-assessing-appropriateness-health-care-delivery-australia>

¹²⁸ Choosing wisely, <https://www.choosingwisely.org.au/>



- The current base plus growth funding model, together with back-casting (which puts the current and previous year on the same basis) effectively nullifies the effect of Commonwealth funding adjustments for safety and quality performance (further addressed at Recommendation 22 (b)).

While the intent of these safety and quality reforms, and the ambition set out in the Agreement to continue to advance these is welcome, there is opportunity to further develop and enhance the reforms and their application to ensure they are achieving the intended objective of improving safety and quality in health care.



Recommendation 15: The **safety and quality reforms** introduced in the *NHRA 2017-2020 Addendum* should be **retained and strengthened** along the lines set out in Clause A162 of the Agreement, with continued scrutiny of the specific adjustment areas and their application to ensure they remain fit for purpose and are achieving their intended objective.

This section of the Report has set out a range of reform areas to take the benefits of ABF to the next level and introduce financing arrangements most able to deliver the shared vision, principles, objectives and reform goals that a new whole of system healthcare agreement will deliver (Recommendation 1) Many of these reform areas are foreshadowed in the current Addendum but little significant work has occurred to date, impacted by a lack of resources and the effect of COVID-19.

The reform areas are complex and will require careful planning, prioritisation and implementation. Establishing trials and building the evidence base, having integrated data systems and accurate cost data, use of shadow pricing and management of transitions will be required but must be underpinned by an overarching plan agreed between the Commonwealth and the States and Territories as part of a next Agreement and which clearly sets out what the parties intend to achieve by when, with performance milestones and accountabilities in place.

In addition, the right building blocks will be required, including underpinning data and knowledge sharing, identification of patient cohorts and outcomes and an authorising and collaboration environment for the national bodies and stakeholders to advance these reforms in an enduring way.



Recommendation 16: The scale, pace and focus of new pricing arrangements should be underpinned by a **ten-year National Health Funding and Payments Framework**, informed by the national bodies and agreed between the Commonwealth, States and Territories, which incorporates blended models of care, virtual care, bundled payments and paying for value and outcomes, with clear and measurable milestones and accountabilities and an agreed transition path.

5.4 Enabling transparency, adequacy and risk sharing through financing reform



5.4.1 Financing public hospitals and health care

The development and implementation of the NHRA from 2012 brought with it major structural reform to the organisation, funding and delivery of public hospital services through the national adoption of activity-based funding (ABF) as the predominant mechanism of funding public hospitals. The radical and innovative nature of this reform should not be underestimated. Prior to this, while some States and Territories had put in place some form of ABF, a move to a nationally consistent system, with common classification systems, national cost collections and national efficient pricing and cost, determined through independent pricing and funding bodies, was a very significant step.

National implementation of ABF brought with it the capacity to measure and compare hospital output transparently on a consistent basis and provided an incentive for the system to respond to demand for acute care. At the same time arrangements were put in place to recognise that not all health activity can be funded on an activity basis, where it is neither practical or appropriate to do so (Clause 3 of the Addendum), with block funding arrangements continuing for small rural and remote hospitals and other relevant services, using nationally consistent cost formulae.

The move to ABF was accompanied by commitments from the Commonwealth to increase its share of public hospital funding over time and sought to improve access to, and efficiency of, public hospitals and transparency of hospital funding flows. There is evidence that, both on funding share and efficiency grounds, there has been progress:

- Commonwealth funding delivered through the NHRA increased from \$13.1 billion in 2012-13 to \$25.8 billion in 2022-23 (97% increase), representing an increase in Commonwealth share from 33.7% to 40.3%¹²⁹
- Figure 33 shows the increase in technical efficiency between 2012 and 2021, with both the growth in separations per capita and in the value of national weighted average units (a measure of complexity) increasing compared to the growth in beds¹³⁰.
- Transparency has also been enabled through the operation of the NHFB and Administrator in overseeing and reporting on the calculation and payment of the Commonwealth contribution to the NHRA and the work of IHACPA in establishing classification, costing and pricing systems.

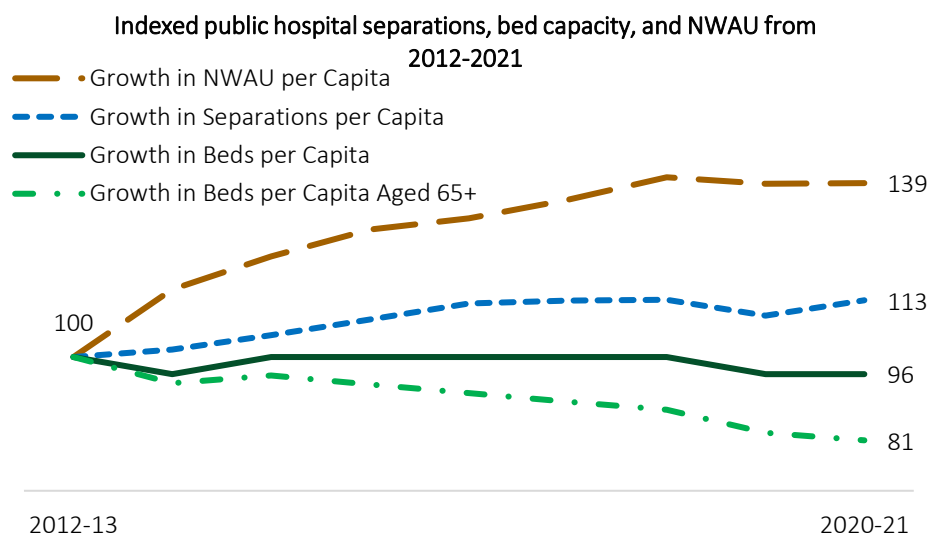


Figure 33: Indexed public hospital separations, bed capacity, and NWAU from 2012-2021

It is important that the benefits of ABF are not lost in future funding Agreements. A great deal of collaborative work has been undertaken to put in place the foundation classification systems, costing methods and activity data collections, and to develop national price and costing models. Reporting through IHACPA and the NHFB enables transparency and delivers tools that can be used for benchmarking purposes. ABF remains an essential tool to understand, measure and seek to improve the efficiency of public hospital services.



Recommendation 17: Activity based funding should be retained as a foundational element of a future Agreement. ABF has proven value in enabling transparency, accountability and consistency of funded episodic activity and provides a solid basis from which to enhance and evolve funding incentives to support health outcomes for consumers and system improvements.

¹²⁹ National Health Funding Body funding reports 2012-22. Available from: <https://www.publichospitalfunding.gov.au/public-hospital-funding-reports>

¹³⁰ Analysis based on AIHW admitted patient data, public hospital funding reports, public hospital data from 2023 Productivity Commission Report on Government Services

5.4.2 Reducing complexity

The evolution of ABF over the ten years of the Agreement has necessarily brought with it a degree of technical complexity as the classification system and pricing framework have been refined to keep pace with clinical practice and stakeholder feedback and to apply decisions regarding safety and quality and private patient services. It would be timely to review the pricing framework to ensure that all technical adjustments are operating as intended and are achieving the right balance between transparency, simplicity and outcome.

5.4.2.1 Impact on smaller jurisdictions

The NEP is clearly defined in the NHRA as a national price, acknowledging that different States will need to contribute differently relating to their geography and location. Importantly there are adjustments between States and Territories to address fiscal imbalance through Commonwealth Grants Commission processes. Nevertheless, smaller States and Territories expressed ongoing concern to the Review of the impact of their size and geography on funding allocations.

Currently the basis of NEP and NWAU calculations are a function of the national average cost per separation across all geographies, types and scales of hospitals. While the adjustment factors seek to reflect the cost of an individual episode of care within a hospital, thereby accounting for unavoidable and legitimate variations, a number of jurisdictions put to the Review that the NEP does not reflect the true cost for smaller population jurisdictions (South Australia, Western Australia, Tasmania, the Northern Territory and the Australian Capital Territory), due to their higher cost of health service delivery, lack of scale, sparse population distribution and higher wage costs. This is most acutely felt in the smallest of States and Territories.

“While larger jurisdictions have the ability to cross-subsidise between smaller and less efficient hospitals, smaller jurisdictions have far less of an ability to cross-subsidise in this way.”

Smaller States and Territories have observed that these legitimate cost differences are not fully reflected in the NEP due to the significantly smaller proportion of hospitals contributing to the National Hospital Cost Data Collection (NHDCDC) used to calculate the NEP, where the volume and scale of services that larger jurisdictions deliver greatly outweighs those of smaller jurisdictions. The NHFB reports that 76% of in-scope activity in 2021-22 was delivered in three States (New South Wales, Victoria and Queensland).¹³¹

IHACPA has undertaken a number of studies in recent years that seek to account for legitimate cost variations in the delivery of public hospital services. Drawing on input from smaller jurisdictions, IHACPA should further consider adjustments, including the potential for the following:

- The NEP being further adjusted for smaller jurisdictions to better reflect instances experienced by these jurisdictions where they are disproportionately disadvantaged or penalised if their cost of services exceeds the NEP.
- The weightings used to determine delivering services in similar types of facilities and similar locations across the country.
- Including a separate and further adjustment factor for smaller jurisdictions to compensate for the lower scale / volume and higher disproportionate cost associated with these populations on the total population. The calculation could be based on an agreed average cost difference between each small State and Territory compared to the national average.



Case study: Small Hospitals Activity Targets (New South Wales)¹³²

The New South Wales Small Hospitals Funding model was introduced in 2017-18 to support a better interface in patient care between rural ABF hospitals and small hospitals. This is particularly applicable to the rural Districts, which operate with lesser patient volume.

The model adopts a fixed and variable cost methodology and replaced the previous model based on the then IHPA small hospitals model. The model has been used again in 2022-23. In the 2022-23 model, the variable component for delivering activity in New South Wales Small Hospitals has been pegged to the 2022-23 State Efficient Price of \$5,095. The fixed component of the funding model has been set at \$1.35 million per facility.

Where additional activity in a small hospital setting has been negotiated, the New South Wales State price was applied to this activity.

¹³¹ Administrator National Health Funding Pool. The National Health Funding Pool Annual Report 2021-22, page 45. Available from: https://www.publichospitalfunding.gov.au/sites/default/files/images/documents/nhfp_annual_report_2021-22.pdf

¹³² South Western Sydney Local Health District. Notes to the State Outcomes Budget Schedule, 2022-23 Service Agreement, 2022. Available from: <https://www.swshd.health.nsw.gov.au/pdfs/ScheduleC-2022-2023.pdf>



Recommendation 18: The IHACPA, in consultation with jurisdictions and the NHFB, should undertake a further **review of the calculation of the NEP to seek to reduce calculation complexity and address the particular funding challenges for smaller jurisdictions** unable to operate at the scale and without the cost base of larger jurisdictions. The impact of the NEP and the calculation of Indigenous, residential and treatment location adjustments should also be reviewed to ensure they are operating as intended.

5.4.2.2 Timeliness of activity and cost data

The NEP for a given financial year is calculated based on cost data provided by States and Territories from the three years prior, which creates a time lag between the NEP and the actual cost of service delivery, including as they relate to workforce costs and bargaining outcomes, cost inflation on supplies/consumables and related supply chain distribution and, most recently, the downstream impacts of COVID-19.

The capacity to provide more recent data as the basis for the NEP is influenced by the processes to collect data to meet submission deadlines, which are highly manual, a shortage in the costing workforce and the need for quality assurance to ensure data accuracy and avoid the risk of costing errors.

The lag in data that informs the NEP creates a financial risk for hospitals that need to deliver services at the current cost, a particular concern in recent years due to higher levels of inflation, and makes it difficult for hospitals to use the NEP for activity and capacity planning. This also means that States and Territories face a liquidity risk if costs escalate rapidly, and need to find ways to address the higher cost of healthcare provision now while they wait for the NEP to catch up.

Further, the most common barriers to the introduction of new adjustments, or perceived inadequacy of existing adjustments, is a lack of evidence available in reported cost and activity data, including due to jurisdictional limitations in allocating costs accurately at the patient level or limitations in the collection of patient characteristics data. Others may be rejected due to low materiality and/or misalignment with the Pricing Guidelines.

The calculation of the base average cost per separation that feeds into the NEP as well as the calculation of changes in the patient classification NWAU cost weight values requires a better way of progressing NHCDC approaches and processes. While there are no easy answers in this regard, a number of potential approaches were identified in consultation as follows:

- Rather than basing the NEP for a given year on data that is up to three years old, determine a “preliminary NEP” based on the best available (but unvalidated) information. When the data for the relevant year becomes available, then a “final NEP” could be determined, subject to a reconciliation process.
- Apply statistical methods to develop the NEP rather than rely on detailed patient costing data. The approach and type of statistical methods that could be applied would need to be worked through with IHACPA.
- Simplify data collection processes or at the very least use the most recent or interim data collections for determining the cost that is used to factor into the NEP. This would make best use of the most recent data for the NEP but still enable the more detailed process to shape the NWAU calculation.
- As the Agreement potentially moves towards alternative funding models that shape demand and drive innovation, the level of sophistication in creating granular level of service codes within classifications may become less important (for pricing purposes rather than for other benefits that detailed patient classification systems provide).



Recommendation 19: A process should be undertaken that identifies and tests options, in consultation with jurisdictions, to calculate the NEP using **more recent activity and cost data** than the current three-year-old data, with an agreed option implemented in the course of the next Agreement.

5.4.2.3 Cross-border arrangements

The NHRA Addendum establishes a set of principles (Clause A110) to apply to cross border hospital activities where a patient who is normally a resident of one State or Territory accesses services in another State or Territory, including that:

- The State or Territory where a patient would normally reside should meet the cost of services (including the cost of transfer back to their resident State or Territory).
- Where a patient is transferred from their resident State or Territory to another jurisdiction the referring hospital is to meet the costs of medical transfers.
- Patient out-of-pocket costs related to discharge home from the provider State will be met through the patient’s resident State travel assistance scheme.
- Payments flows associated with cross-border services should be administratively simple and not result in any unintended GST distribution effects.
- There should be transparency of cross border flows.

The expectation of the NHRA is that individual States and Territories will enter their own arrangements consistent with these principles, therefore relying on the capacity of any two parties to negotiate mutually agreeable arrangements. For many jurisdictions, cross border flows are a relatively straightforward element of their operations with flows out of and into a State broadly in balance.

That is not the case in all instances. For example, around 18% of public hospital separations in the Australian Capital Territory are New South Wales residents, compared to around 0.2% of Australian Capital Territory residents as a proportion of New South Wales separations, with cross border activity in the Australian Capital Territory accounting for between 25-30% of total admitted patient activity. In cases such as this, any costs over and above the NEP such as those related to fixed infrastructure costs or block-funded activities such as teaching, training and research, need to be met by the receiving jurisdiction.

Because the NHRA only puts in place principles in respect of cross border flows, their effective administration relies on the capacity of any two parties to enter mutually satisfactory arrangements. There would be benefit, particularly for smaller jurisdictions where there is an imbalance in negotiating power, to add more specific guidelines and requirements to the Agreement as to how these principles will be applied in practice. Consideration should be given to one or more of:

- A standardised approach to pricing for cross border patients (including explicit cost-sharing arrangements).
- Introducing an adjustment factor to pricing that recognises a contribution to block (TTR) payments and a “tenancy” cost of use of infrastructure. Alternatively, an activity-based contribution to depreciation costs could be made. These additional parameters could be relatively consistent either at a national level or vary between large vs small jurisdictions related to volume of cross border flow.
- Reimbursement of infrastructure and capital costs incurred by provider States and Territories for hospital services provided to cross border patients, above certain thresholds.



Recommendation 20: The principles underpinning cross border arrangements as set out in the Agreement should be confirmed but **augmented with guidelines** that enable timely and fair outcomes applied on a consistent basis, including making allowance for capital and block components of funding, above certain thresholds of cross border activity.

5.4.2.4 Methodology for funding neutrality for private patients in public hospitals

The NHRA mandates that States and Territories provide public hospital services consistent with the Medicare Principles (see Section 5.1.2).

The NHRA seeks to ensure this is implemented in practice through those aspects of the Agreement that go to private patient neutrality (PPN) (Clause A13), and pricing adjustments that deliver neutrality (Clause A44). These clauses seek to achieve ‘...overall payment parity between public and private patients in the relevant jurisdiction’, removing incentives and penalties for treating private patients in public hospitals, where a patient election is made.

Public hospitals derive significant revenue from private health insurance and MBS benefits, with an estimated \$683 million spent solely on MBS for privately admitted patients in public hospitals in 2020-21.¹³³

Private patient neutrality clauses have been implemented through IHACPA determining a cost-weight price for private patients in any year and adjusting the price to the extent required to achieve overall payment parity in the relevant jurisdiction. This approach differs from the usual method for the calculation of the Commonwealth’s funding contribution (which is determined on an episodic basis, not a global basis), and from the usual approach to influencing hospital behaviour (as any penalty is applied to the State or Territory, and not the hospital or LHN that treated more private patients).

The complexities in the application of PPN has been reported as generating negative funding impacts on States and Territories.

The private patient neutrality adjustment has applied since 1 July 2021 however the clauses have proved difficult to implement in the funding model and added significantly to the overall complexity of the model. Further review and consideration is required on the implementation and methodology of PPN, particularly related to the calculation of growth funding, whether the clause and operation achieves the desired policy intent of Parties, and ensuring the methodology for adjusting payments does not unfairly penalise the public system. This may mean the methodology for PPN requires simplification. Several options were raised in consultation that could be considered in a review:

“Pricing adjustments (for private patient neutrality) only being applied as a penalty rather than as a result of collaboration.”

- Utilise the private hospital NHDC datasets as the basis for price and cost weights (assuming utilisation of actual cost of service delivery which is comparable to the public system). This aims to test there are no positive or negative impacts, as the basis of pricing is on the private cohort of data rather than the public calculation.
- Deem private patients out-of-scope for Commonwealth NHRA funding, with Commonwealth funding for private patients provided through the MBS program and underwriting private health insurance through the PHI rebate. This would have no impact on patient choice or doctor’s rights to exercise rights of private practice.

¹³³ Australian Institute of Health and Welfare. Health expenditure Australia 2020-21, 2022. Available from: <https://www.aihw.gov.au/getmedia/931a083a-e2a1-4f0d-9a09-140d55682711/Health-expenditure-Australia-2020-21.pdf?inline=true>



Recommendation 21: A review should be undertaken by IHACPA, in consultation with jurisdictions and the NHFB, regarding the requirements and implementation of the **arrangements for determining funding neutrality for private patients in public hospitals**, particularly in the calculation of growth funding, to determine whether the policy intent of the parties is being achieved, and what if any adjustments are required.

5.4.3 Commonwealth funding share and growth cap

5.4.3.1 Accelerate the Commonwealth contribution

An explicit objective of the NHRA (Clause 7k) is to ‘...ensure the sustainability of funding for public hospitals by increasing the Commonwealth’s share of public hospital funding through a 45 per cent contribution to the costs of growth, subject to the operation of the National Funding Cap’. In the Agreement, this commitment is met through the ‘base plus growth’ funding model which took effect from 2014-15, with the addition of the National Funding Cap from 2017-18.

Change in Commonwealth Contribution Rate from 2013-14 to 2022-23

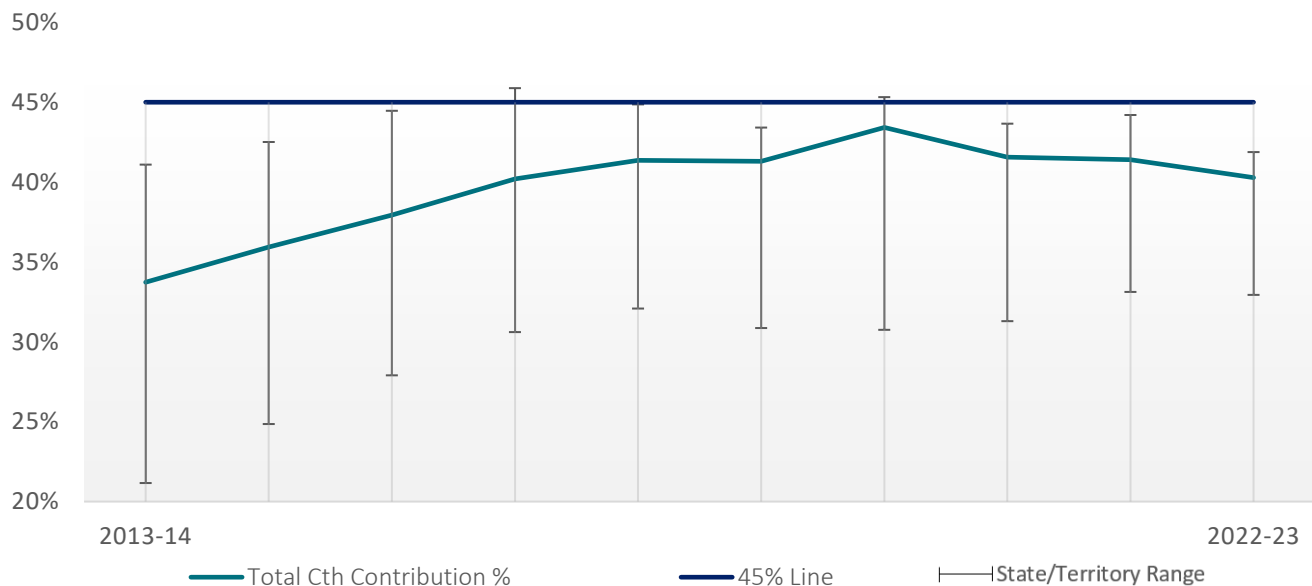


Figure 34: Change in the Commonwealth Contribution Rate from 2013-14 to 2022-23

Three elements of the operation of the funding model warrant consideration:

- (1) **45% Commonwealth contribution:** in consultation there was a degree of misunderstanding about the Commonwealth commitment to 45% share of public hospital funding. Although the formula to effect the Commonwealth share was always a base plus growth model, there is a widespread view that the Commonwealth is funding 45% of the cost of public hospitals (or aspires to). As can be seen from Figure 34 this is not the case. While there has been an increase in the Commonwealth share over time (from a national average 33.7% to 40.3% over the life of the Agreement) many stakeholders argue that this is too slow. Further, the operation of the national funding cap constrains the pace at which the Commonwealth share will increase in future years as it constrains the level of activity to which it contributes. Evidence presented to the Review suggested that the Commonwealth share may decrease or at best flatten in the post-COVID-19 period as a consequence of the operation of the cap and effect of COVID-19 activity levels.
- (2) **Variability between States and Territories:** for historical reasons there are significant differences between States and Territories in the extent of the Commonwealth share of public hospital funding. The whisker plots at Figure 34 show the variability between the lowest and highest jurisdiction in terms of Commonwealth share – in 2022-23 there was a range of 32.9% to 41.9%. While there has been a narrowing of this difference over the course of the Agreement (an initial range of nearly 20 percentage points between the lowest and highest Commonwealth share compared to nine percentage points now), the gap remains significant resulting in additional financial pressure on those States and Territories who sit below the median.
- (3) **The base plus growth model:** there is a question as to whether the base plus growth model remains fit for purpose. While it has been successful in gradually increasing the Commonwealth’s contribution over time, this is not occurring very quickly and embeds inequities between jurisdictions. Further it requires complex technical work arounds, such as back-casting (which puts the base year and the new year on the same basis in terms of the NEP and NWAU and ensures that efficient growth is calculated on a consistent basis based on changes to underlying methodologies, such as introduction of new adjustments). The inherent complexity of back-casting and related growth-funding calculations can also impact on the transparency of public hospital funding and the understanding of pricing and funding incentives by system stakeholders and decision-makers, particularly at the LHN and hospital level.

An alternative proposed to the Review was to move to the Commonwealth maintaining an “equitable” funding share and value, for example by the Commonwealth contributing a fixed percentage of the NEP of the NWAU delivered by each State and Territory. Given the likely financial impact of this, one approach is to step toward a 45% NEP percentage through the next Agreement (at a pace subject to costing and negotiation) beginning by bringing lagging jurisdictions up to the national average and then stepping toward 45% over several years.

An increase in the Commonwealth share over time, and greater equalisation between individual jurisdictions, could allow a portion of the funds currently being contributed by the States and Territories to be freed up for other purposes. It will be important that these funds remain in the health system, given the level of support that will be needed for new models of care (as set out in Section 5.2 and 5.3 of this Report) and innovation. There should be a requirement as part of a negotiation on a new funding model that the States and Territories, at a minimum, maintain, and preferably grow, their contribution to health spending through the various mechanisms designed to improve allocative efficiency and for the National Innovation Fund.



Recommendation 22: A new Agreement should put in place a **new and simpler funding model to gradually increase the Commonwealth contribution to 45% of nationally efficient public hospital activity** through:

- An initial injection of Commonwealth funds into those States and Territories that sit below the current median contribution rate to bring them closer to the national average.
- Consideration of a new funding model that sets the Commonwealth contribution as a fixed percentage of the national efficient price of each State and Territory’s total NWAU.
- A stepped transition to increasing the Commonwealth percentage contribution to 45% over the course of the Agreement.



Recommendation 23: State and Territories should maintain their level of contribution to health funding through the transition at Recommendation 22, noting that this would allow State and Territory funds displaced through an increased Commonwealth contribution to be **directed to support new and innovative models of care consistent with the National Health Funding and Payments Framework** at Recommendation 16.

5.4.3.2 Reframe the 6.5% national funding cap



Observation: What is the 6.5% national funding cap?¹³⁴

The growth in annual Commonwealth national health reform funding for national public hospital services will not exceed 6.5% a year (the Funding Cap) – Clauses A56-58. The Funding Cap includes a:

- State-based Soft Cap** of 6.5%, to be applied to the Commonwealth national health reform funding entitlement of each State and Territory throughout the financial year; and
- A National Funding Cap** of 6.5%, to be applied to the Commonwealth national health reform funding entitlement for all States and Territories throughout the financial year.

States and Territories may be entitled to additional funding over the Soft Cap if there is funding available under the National Funding Cap (a Redistribution Amount) upon completion of the annual Reconciliation. The Redistribution Amount will be determined as the total of any funding remaining under the National Funding Cap, resulting from a State and Territory with growth less than 6.5%.

A further area of concern raised with the Review was the way in which the 6.5% national funding cap is framed, particularly in an environment of cost pressure.

The current annual implementation of the national growth cap strongly incentivises States and Territories to deliver as close as possible to 6.5% growth in ABF entitlement each year, as every dollar under 6.5% is effectively lost for all future years, and every NWAU delivered over 6.5% permanently reduces their funding for all future years, as efficient growth in activity is calculated on NWAU delivered, not NWAU funded by the Commonwealth. However, the consequence of this is that the States and Territories are incentivised to deliver enough NWAU to reach 6.5% growth each year, but no more. This means that temporary needs, such as an elective surgery blitz to recover from a pandemic are potentially deterred by the national funding cap.

The funding cap incorporates both price and activity growth and applies across the Commonwealth funding entitlement of each State and Territory throughout the relevant financial year. Including price growth in this calculation is particularly contentious

¹³⁴ Administrator National Health Funding Pool. Public Hospital Funding, Funding Formula. Available from: <https://www.publichospitalfunding.gov.au/public-hospital-funding/funding-formula>

due to the level of inflationary pressure that jurisdictions currently face, a fact made more acute by the lag between when costs are incurred and when they flow through to the NEP.

A number of jurisdictions reported that, for current projections, the proportion of funding growth that is driven by price variables is greater than activity. This is significantly limiting their ability to grow service capacity to address projected demand, particularly in a post-COVID demand environment and arguably shifting the financial burden to them as a reasonable level of demand growth is unavoidable. This proportion of funding growth is illustrated in the following jurisdictional case study provided as part of this Review.

Case study: Components of the NHRA contributing to Funding Growth: A view from one jurisdiction

A significant proportion of funding growth is currently being utilised by price as shown on the right-hand side of the chart.

Previously, price growth utilised an average of 2.6 percentage points of funding growth. However, price is now estimated to average 4.5 percentage points driven by the incorporation of COVID-19 cost in the 2022-23 price.

Over the forward years, the level of activity growth available under the 6.5% funding cap, once price growth is accounted for, is significantly limited and will impact jurisdictions’ ability to grow services to address backlogs in elective surgeries, decrease the elective surgery waitlist and meet the demands of the population.

Year	ABF - Price	COVID Response - HSP	Public Health	ABF - Volume	Guarantee Top-up	Soft Cap	Block	ABF - Volume to reach cap	NT NHRA Growth
2018-19	2.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.6
2019-20	2.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.6
2020-21	2.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.6
2021-22	4.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.5
2022-23 (e)	4.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.5
2023-24 (f)	4.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.5
2024-25 (f)	4.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.5
2025-26 (f)	4.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.5

The operation of the funding cap should be reviewed to ensure it does not erode the shared responsibility between the Commonwealth and States and Territories to provide the best possible health outcomes, especially as the system recovers from COVID-19 volatility. One option that would return the funding cap closer to its intended purpose would be to reframe it as an activity cap only and remove the inclusion of price growth. There are strong efficiency drivers on all parties to the Agreement, more so on the States and Territories as they bear more of the cost of services, such that caps on price are less relevant.

A reframed national growth cap that is a **cap on activity only** should be set at a lower amount (say 4-5% with price excluded), subject to negotiation. The NHRA already provides some exceptions to the national cap, such as for high-cost, highly specialised therapies for the first two years of delivery (refer to section 5.4.5 for further information on high-cost, highly specialised therapies). There remains a place for this in a new Agreement and such arrangements may also be relevant where there are priorities agreed by the parties that require additional effort or a greater sharing of responsibilities, for example activity delivered to First Nations’ people or care provided to aged care or disability patients whose medical episodes are complete.

Recommendation 24: Consideration should be given to **reframe the 6.5% national funding cap** to an activity cap alone (~4-5% activity growth), with price growth not subject to a cap but based on an efficient price calculation using contemporary activity and cost data.

5.4.4 Block funding and public health funding

The NHRA (Clauses A49 to 55) sets out the reasons and process for use of block funding to support those public hospital services that are most appropriately funded in this way. When ABF was introduced as part of the NHRA there was considerable uncertainty regarding the feasibility of moving all components of funding to ABF in the short or medium term, so ABF classification systems for as many types of activity as feasible were created, with remaining activities to be paid as block funding.

Block funding from the Commonwealth is managed through the National Health Funding Pool account to the State or Territory and distributed to health services/other organisations based on specific funding arrangements established by each State and Territory. These block funding components predominantly relate to the activity of small rural and regional hospitals with lower patient volumes, teaching training and research and public health allocations. A fixed plus variable model is used to determine Commonwealth contributions of block funding.

As at March 2023, IHACPA has identified that 400 hospitals are designated for block funding¹³⁵.

The general criteria for block funding are that the technical requirements for applying ABF are not able to be satisfied and that there is an absence of economies of scale that mean some services would not be financially viable under ABF.

¹³⁵ Independent Health and Aged Care Pricing Authority. National Pricing Model 2023-24, 2023. Available from: https://www.ihacpa.gov.au/sites/default/files/2023-03/national_pricing_model_technical_specifications_2032-24.pdf

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Block funding that is set in these circumstances are based on a scale of NWAU levels for the relevant hospitals.¹³⁶

Small rural hospitals typically serve smaller populations with lower patient volumes compared to larger urban facilities. In an ABF model, where reimbursement is tied to the number of patients treated or procedures performed, these hospitals may struggle to generate sufficient revenue to cover their fixed costs. This can lead to financial instability and risk of closure. Block funding helps ensure that these hospitals remain open and can continue to offer services that are tailored to community needs.

The NHRA currently enables block funding for small rural health services through flexible funding models for thin markets like the Multi-Purpose Service model. This flexibility enables local tailored healthcare by providing flexibility, autonomy, and the ability to allocate resources according to specific community needs, including programs for out-of-hospital care.



Recommendation 25: Block funding arrangements should be retained as a feature of a future NHRA, recognising that certain services and functions, particularly in rural and remote areas, are more appropriately funded in this way.

5.4.4.1 Transparency in Teaching and Training funding

The Commonwealth Government provided \$678 million for TTR in 2021-22¹³⁷. However, there is limited transparency and reporting on the allocation, distribution and use of this funding and the outcomes it generates. This is particularly relevant for regional and rural hospitals as TTR funding is considered to be largely consumed by tertiary, quaternary services with a lack of rural and regional recognition.

Attempts have been made to make the scope of TTR funding more objective and transparent. In 2015, the then IHPA undertook a TTR costing study with an overall finding that the data provided an adequate starting point for the development of a teaching and training classification, but that there was insufficient data to support a research classification.¹³⁸

IHACPA's Australian Teaching and Training Classification (ATTC) national classification is not yet able to be implemented due to a lack of jurisdictional reporting and consistency. States and Territories report on a "best endeavours" basis. Requiring States and Territories to report on the ATTC as a national minimum dataset would improve transparency and enable workforce planning. It would also enable the existing NHRA teaching and training funding to transition amounts away from Block funding and facilitate the transition of this stream to ABF.

IHACPA's *Pricing Framework for Australian Public Hospital Services 2023–24* states it will continue to work with jurisdictions on investigating alternative models to block funding until the ATTC can be enabled.¹³⁹



Recommendation 26: There should be greater transparency in the funding and investment in Teaching and Training functions.

5.4.4.2 Transparency of Public Health funding and prevention activities

Currently, the Addendum maintains a 'Public Health' funding allocation which represents the historic consolidation of several stand-alone payments that were incorporated into the NHRA at its inception in 2012. The funding allocation is based on a legacy indexation model – the historical Specific Purpose Payment (SPP) growth factor and gives States and Territories full discretion over the application of public health funding to the outcomes set out in the NHRA (Clause A15).

The Commonwealth provides \$500 million per annum nationally for this type of funding. If this was a standalone payment it would represent the second largest ongoing transfer of health funding from the Commonwealth to the States and Territories, (though a small proportion of overall public hospital funding). However, this funding is accompanied by no reporting or transparency. This became particularly apparent during the COVID-19 pandemic when the Commonwealth had limited visibility of the application of NHRA public health funding.

There are a number of areas that warrant further development:

- There should be greater transparency of the allocation of public health funding through the NHRA. A future Agreement should align to the *National Preventive Health Strategy 2021–2030* with relevant NHRA public health funding supporting the objectives identified in this Strategy.

¹³⁶ Administrator National Health Funding Pool. Public Hospital Funding, Funding Types. Available from: <https://www.publichospitalfunding.gov.au/public-hospital-funding/funding-types>

¹³⁷ Administrator National Health Funding Pool. National Health Funding Pool Annual Report 2021-22, 2022. Available from: <https://www.publichospitalfunding.gov.au/publications/national-health-funding-pool-annual-report-2021-22>, page 60

¹³⁸ Independent Health and Aged Care Pricing Authority. Hospital Teaching, Training and Research Activities National Best Endeavours Data Set Technical Specifications for reporting. Available from: <https://www.ihacpa.gov.au/resources/hospital-teaching-training-and-research-activities-national-best-endeavours-data-set-technical-specifications-reporting>

¹³⁹ Independent Health and Aged Care Pricing Authority. National Pricing Model 2023-24, 2023. Available from: https://www.ihacpa.gov.au/sites/default/files/2023-03/national_pricing_model_technical_specifications_2023-24.pdf

- There should be an established process at the local level to undertake preventative health on a systemic basis. This was identified as an issue by the Productivity Commission in its report, *Shifting the Dial: 5 Year Productivity Review*. This report recommended that Australian Governments allocate funding to PHNs and LHNs for improving population health, managing chronic conditions, and reducing hospitalisations at the regional level. This is consistent with two of the existing strategic priorities in the Addendum: Prevention and Wellbeing and Joint Planning and Funding at the Local Level.
- Consideration could be given to applying a more rigorous, evidence-based growth calculation in the public health funding stream to better reflect the drivers of public health risk and weighted population characteristics and status, including consideration of all determinants of health e.g., social and cultural determinants as appropriate. The growth funding methodology could evolve in the long term to include outcome and cost-effectiveness factors in population and preventive health, which will likely become more tangible with the development of the Australian Centre for Disease Control (CDC) and ongoing health reforms.
- It is likely there will be additional Commonwealth-State and Territory arrangements negotiated with the CDC establishment, which may intersect with the NHRA. The joint commitment of all jurisdictions to the CDC presents an opportunity to ensure that funding for public health activities, such as health protection (including public health laboratory capacity), health promotion and preventive health initiatives, is used efficiently. It will be important to avoid duplication across funding sources, particularly around investments in public health infrastructure and preventive health activities, as well as the CDC's role in addressing emerging issues in the health system and public health emergency readiness.



Recommendation 27: A new Agreement should improve transparency and reporting on **Public Health funding and investments**. Funding through the NHRA should be harmonised with investments and priorities of the Australian Centre for Disease Control, once established, and align with the *National Preventive Health Strategy* (see Recommendation 44).

5.4.5 PBS reform and high-cost, highly specialised therapies

Medications are the most common medical intervention and an essential component of our health system and treatment options provided to patients. As such, the NHRA is a component of the broader health ecosystem which supports the achievement of the core objectives of the National Medicines Policy (NMP)¹⁴⁰ to ensure:

- Equitable, timely, safe and affordable access to high-quality and reliable supply of medicines and medicines-related services for all Australians.
- Medicines are used safely, optimally and judiciously, with a focus on informed choice and well-coordinated person-centred care.
- Support for a positive and sustainable policy environment to drive world-class innovation and research, including translational research, and the successful development of medicines and medicines-related services in Australia.

The NHRA includes provisions for the supply of medicines to public hospital patients, in concert with other funding streams (e.g. Section 85 and Section 100 of the *National Health Act 1953*) and outlined in Pharmaceutical Reform Arrangements (PRAs) with specific jurisdictions. These elements cover overnight and same-day inpatients upon discharge, outpatients and high-cost therapies in different ways, and are reflected in different parts of the Addendum:

- States and Territories are to provide and fund pharmaceuticals for both public and private admitted patients, in a public hospital during the time they are admitted, and for public non-admitted patients in public hospitals.
- Supply of PBS medicines: Clauses 11c and A10 of the Addendum: outlines that the Commonwealth Government will contribute the funding for PBS subsidised medicines dispensed according to individual jurisdictional PRAs (in place with all States and Territories except New South Wales and the Australian Capital Territory).
- Governance and availability of high-cost, highly specialised therapies: Clauses C11 through C16 and Appendix B of the Addendum: outlines the collaboration process to enable the adoption and availability of new and next generation high-cost, highly specialised therapies and how their funding will be allocated between the Commonwealth and States and Territories and as part of broader activity considerations.

Table 3 provides a summary of the multiple funding streams for medicines used in hospitals, how they apply and some examples of medicines included in each category.

¹⁴⁰ Department of Health and Aged Care. National Medicines Policy, 2022. Available from: <https://www.health.gov.au/sites/default/files/2022-12/national-medicines-policy.pdf>, page 1.

Table 3: Summary of Medication funding streams and examples

PBS “Section 85 drugs”	PBS “Section 100 drugs”	Inpatient Medications	High cost, highly specialised therapies
<p>Medicines available on the general schedule of the PBS and can be accessed for outpatient and discharge medication supply via those jurisdictions with PRAs in place.</p> <ul style="list-style-type: none"> • Antihypertensives • Anticonvulsants • Oral and injectable hypoglycaemics • Topical corticosteroids • Inhaled therapies for asthma and chronic obstructive airways disease 	<p>Highly specialised medicines used for the treatment of complex medical conditions that require ongoing specialist medical supervision.</p> <ul style="list-style-type: none"> • Some Human Immunodeficiency Virus (HIV) antiretrovirals • Some monoclonal antibodies • Immunosuppressants for organ transplantation • Some antineoplastic agents (e.g., chemotherapy) • Clozapine for schizophrenia 	<p>Medicines provided to a patient during an overnight or same-day episode of care which are either continuation of therapy prior to admission or commenced as part of the episode of care.</p> <p><i>Jurisdictions who do not have a PRA will include public outpatients and discharge medication supply within this category.</i></p> <ul style="list-style-type: none"> • Analgesics • Antiemetics • Antihypertensives • Antimicrobials 	<p>Therapeutic Goods Administration (TGA)-approved medicines or biologicals delivered in public hospitals where the therapy and its conditions of use are recommended by the Medical Services Advisory Committee (MSAC) or the Pharmaceutical Benefits Advisory Committee (PBAC), and the average annual treatment costs at commencement is greater than \$200,000 per patient (including ancillary costs) – and where the therapy is not otherwise funded through a Commonwealth program or the costs of the therapy would be appropriately funded through a component of an existing pricing classification.</p> <ul style="list-style-type: none"> • Kymriah® – for the treatment of acute lymphoblastic leukaemia in children and young adults
Pharmaceutical Reform Arrangements		NHRA	

5.4.5.1 Pharmaceutical Reform Arrangements

In Australia’s public hospitals, subsidies for PBS Section 85 drugs dispensed from a hospital pharmacy can only be accessed if the jurisdiction is a signatory to the PRA as set out in the Business Rules to the NHRA at Section G5. Hospital pharmacies in jurisdictions not covered by a PRA are able to apply to supply Section 100 Highly Specialised Drugs (HSDs), however other Section 100 medicines are not covered by this arrangement. During the year 2020-21, 21% of all PBS medicines were dispensed by public hospitals either on discharge or in the outpatient setting.¹⁴¹ Of the total public hospital PBS expenditure, Section 100 HSDs contribute approximately 52% of these costs and these medicines are specifically funded via the *National Health (Highly Specialised Drugs Program) Special Arrangement 2021*. HSDs are for the treatment of complex medical conditions that require ongoing specialised medical supervision¹⁴² and include HIV anti-retrovirals, Hepatitis drugs, monoclonal antibodies, and clozapine (antipsychotic).

Bilateral PRAs commenced in 2001, initially with Victoria and followed by all other States and Territories by 2010, except for New South Wales and the Australian Capital Territory who remain without a PRA. These PRAs provide the mechanism by which public hospitals can access the subsidies through the PBS when supplying medicines for admitted patients on discharge, non-admitted patients and same-day admitted patients.

The intent of PRAs is to enable consistent and equitable access to medicines upon discharge and in the outpatient setting, with a particular focus on continuity of care. There is a risk where these arrangements are not in place, that patients do not receive a consistent supply of medications, putting the onus on the patient to access primary care and community pharmacies to bridge supply gaps, with the associated time and cost this may entail. The reasons for New South Wales and Australian Capital Territory not entering into PRAs were not submitted to the Review, though it is understood from informal discussions that analysis of the risks and benefits of participating in the PRAs have been considered by the jurisdictions and at those times the benefits did not outweigh the risks or costs. Given the evolving nature of the health system, developing models of care and the desire for

¹⁴¹ Submission from the Society of Hospital Pharmacists of Australia, Review analysis of PBS Expenditure and Prescriptions Report 1 July 2021 to 30 June 2022.

¹⁴² Services Australia. Highly specialised drugs - Services Australia, accessed 5 September 2023. Available from: [https://www.servicesaustralia.gov.au/highly-specialised-drugs#:~:text=Highly%20specialised%20drugs%20\(HSDs\)%20are,is%20part%20of%20the%20PBS.](https://www.servicesaustralia.gov.au/highly-specialised-drugs#:~:text=Highly%20specialised%20drugs%20(HSDs)%20are,is%20part%20of%20the%20PBS.)



consistent access to medicines, there is another opportunity to revisit New South Wales and Australian Capital Territory entering into PRAs with the Commonwealth.

In an environment where not all States and Territories are signatories to the PRA, there is a risk that the costs of medicines that make up part of the calculation of the National Efficient Price, distort the price of the NEP itself and ultimately penalise those jurisdictions that do not have PRAs (i.e., New South Wales and Australian Capital Territory).

There is an opportunity to improve patient outcomes and eliminate inconsistencies by creating either a new schedule in the NHRA or amending current Clauses A9 and A10, to articulate how the NHRA is intended to support a core intent of the NMP, equitable access to affordable and high-quality medicines for Australians. The new arrangement would replace PRAs and be the catalyst for adoption of PBS reforms in all States and Territories. This would have the potential to deliver benefits including:

- National consistency in deployment of PBS subsidised medicines, without the need for maintenance of individual agreements between the Commonwealth and jurisdictions.
- Improved continuity of medication access and compliance for patients in New South Wales and Australian Capital Territory.
- More accurate reflection of the costs of medications delivered via public hospitals in reporting to IHACPA.



Recommendation 28: A new Agreement should deliver **nationally consistent access to medicines across the care continuum**, noting the benefits to patients of continuity of care on admission and discharge.

- This would replace Pharmaceutical Reform Arrangements (PRAs) and require negotiations with, and preparations by, New South Wales and Australian Capital Territory for access to PBS medicines in public hospitals for admitted patients on discharge, non-admitted patients and same day admitted patients.
- Interim PRA arrangements for New South Wales and the Australian Capital Territory in the lead-up to a new Agreement could be progressed, if supported by those jurisdictions.
- This change could be implemented either through a new Medicines Schedule added to the Agreement, or through amendments to current Clauses A9 and A10 which address access to the Pharmaceutical Benefits Scheme.

5.4.5.2 High-cost, highly specialised therapies

High-cost, highly specialised therapies are defined in the NHRA as those TGA-approved medicines or biologicals delivered in public hospitals where the therapy and its conditions of use are recommended by the MSAC or the PBAC, and the average annual treatment costs at commencement is greater than \$200,000 per patient (including ancillary costs), and where the therapy is not otherwise funded through a Commonwealth program or the costs of the therapy would be appropriately funded through a component of an existing pricing classification. For these therapies, the Agreement outlines that the Commonwealth contributes 50% of the growth in the efficient price or costs, and that those costs are exempt from the funding cap for a period of two years from the commencement of service delivery of the new treatment.

Provisioning for high-cost, highly specialised therapies in the Addendum is important as their inclusion enables equity of access to new and novel therapies, which may not be available to the population via other funding mechanisms. This is separate to the HSD Program referred to in section 5.4.5.1, where PBS Section 100 drugs made available through public hospitals attract PBS subsidy.

To date, high-cost, highly specialised therapies jointly funded under the NHRA include cell and gene therapies. While there are currently only four CAR-T cell therapies and two gene therapies that are TGA-approved, there are several cell and gene therapies in the development pipeline. In 2019, the United States Food and Drug Administration (FDA) predicted that it would approve between 10 to 20 new cell and gene therapies a year by 2025. The anticipated increase in number and diversity of these therapies to be marketed in the future is anticipated to present significant resourcing and cost challenges, noting that not all of these therapies will necessarily meet the definition to be funded under the NHRA.

Novel high-cost therapies often require complex protocols that involve the close management of a patient in a high acuity setting and end-to-end supply chain management. This can include long stays in ICU, expensive diagnostic tests (some of which are only available overseas and therefore ineligible for MBS funding), specialist pharmacists, and relocation of carers and families for extended periods to be close to the patient. Additionally, effective delivery of these therapies can require coordinated and extremely stringent quality management systems and consistency in how health services deliver these therapies.

The NHRA sets out the Commonwealth contribution of 50% of the unit price for high-cost therapies plus associated ancillary costs, which should include direct 'wrap around' costs.

However, there is currently no consistent approach to managing the total costs of some high-cost, highly specialised therapies, for example there is no consistent approach to capture/report on ancillary costs as each facility has its own way of reporting costs. This leads to variation in access to these treatments due to differing State and Territory priorities and policies and a lack of clarity with respect to long-term sustainability of high-cost, highly specialised therapies provision.

These examples further highlight the adoption readiness challenges public hospitals face as new high-cost therapies are approved for use in Australia and incorporated into clinical models of care. Given that hospital budgets are set annually based

on projected activity and casemix, the addition of an unanticipated high-cost therapy treatment during the financial year, places financial strain upon hospitals as the additional costs are not reflected in their ABF revenue.



Case study: CAR-T cell therapy

In January 2020, the Federal Government announced the funding for CAR-T cell therapy, Kymriah®, that included an estimated annual patient population of between 200 and 250 people with Diffuse Large B Cell Lymphoma, Transformed Follicular Lymphoma and Primary Mediastinal B Cell Lymphoma accessing the high-cost therapy. At the time of approval, the estimated treatment cost was \$500,000 per patient.

The delivery of this treatment is limited to specialist treatment centres (e.g., the Peter MacCallum Cancer Centre and Royal Children's Hospital in Melbourne, Royal Prince Alfred in Sydney and a few others). There is currently only one TGA registered commercial development and manufacturing organisation in Australia, Cell Therapies Pty Ltd, based in the Peter MacCallum Cancer Centre as part of the Biomedical Precinct in Parkville, Melbourne. The existing agreements see the Federal Government contribute 50% of the treatment cost and associated ancillary costs.

Patient access to CAR-T cell therapy, given the specific infrastructure required, is limited to a small number of public health services. There could be an opportunity to explore opportunities to leverage capacity in CAR-T cell treatment centres in private hospitals where eligible public patients could be treated. This could be particularly useful if/when the indications for usage are expanded by MSAC in the future.

Governance and approvals of high-cost therapies

Australia has a history of early adoption and application of new and novel medications and therapies, facilitated by the HTA process including assessment by MSAC and PBAC.

However, advice provided to the Review highlighted that this process in respect of high-cost, highly specialised therapies is being hampered by:

- A lack of effective horizon scanning and forward planning across all governments to support prioritisation of, and provision for, high-cost, highly specialised therapies.
- Fragmented and often undefined approval and implementation processes, that jurisdictions have been reluctant to use, in part due to uncertainty as to which wrap around services delivered as part of the treatment journey, are eligible for the NHRA-established HTA process.
- A shift towards access to high-cost therapies earlier in the evidence cycle which, while positive for some patients, means that there is more uncertainty about the number of patients who will access the therapies and the flow on financial impacts for health services. This can also result in a shorter preparation period for health services to deliver the high-cost therapies.
- Concern that not all stakeholders are participating in the HTA process for high-cost, highly specialised therapies, for example, National Blood Authority (NBA) and Organ and Tissue Donation Authority (OTDA), in respect of novel blood products and next generation cell and gene-modified cell therapies, with flow-on impacts to jurisdictions.
- A lack of joined-up decision making about how to best support access to these therapies for eligible patients, regardless of their geographic location, in a structured and planned way.

These compounding factors reduce equitable access and referral, even for approved therapies. As a result, there is a risk that eligible patients can miss out on access to effective and cost-effective treatment options.

More broadly, the current Addendum sets out, not only a process for HTA assessment, but also aspires to establish a national unified framework:

C10: The parties further agree to jointly develop a federated approach to health technology assessment, with a view towards a unified framework in the longer term. The goal is to increase the impact of HTA on policy, funding (investment and disinvestment) and service delivery decision making at all levels of the health system.

While the Addendum acknowledged that a unified framework was ambitious, this should be a priority of the next Agreement, with a view to harmonising not only the assessment process but also the implementation process for high-cost, highly specialised therapies, noting their growing incidence and reach, and the importance of enabling eligible patients fair and equitable access. Consideration should be given to designating treatment centres, along the lines of the approach previously taken to Nationally Funded Centres, with fair apportionment of costs of both products and treatment.

Financial sustainability

Access to novel and effective medicines is a core attribute of the National Medicines Policy which impacts how medicines are used in the hospital system. The increasing specificity of the medicines is often linked to upfront genetic testing and profiling which influences treatment selection. It is noted that where these close links exist that the approval process requires coordination between both the PBAC and the MSAC.

The specific nature of some upfront genotyping investigations can see diagnostic testing occurring outside of Australia. This results in out of pocket or unfunded costs to patients or health services to optimise access to appropriate medicines. Added to this is the concentration of some specialist services to major metropolitan health services (e.g., access to CAR-T cell therapy). These circumstances have an impact on equitable access to medicines needed for individual conditions.



Recommendation 29: A structured **horizon scanning process** should be established for high-cost, highly specialised therapies, with involvement of all jurisdictions, and with input from relevant stakeholders, including but not limited to the National Blood Authority, Organ and Tissue Donation Authority, Pharmaceutical Benefits Advisory Committee and Medical Services Advisory Committee, to support forward planning and priority setting.



Recommendation 30: A **unified national HTA process for the assessment and delivery of high-cost, highly specialised therapies under the NHRA should be progressed**, that addresses issues of national consistency, risk sharing, access (including the potential for private sector delivery), affordability, timeliness and information sharing.



Recommendation 31: The unified HTA framework and methodology at Recommendation 30 should:

- a) **Drive consistency** in identification of all costs associated with delivery (Commonwealth, State and Territory funded), but also lifetime potential avoided health system costs, through strengthened data collection and analysis.
- b) **Take a cross-modal approach** that compares new high-cost, highly specialised therapies to the range of treatments/technologies for the same indication (e.g., medicines, devices, surgery).

5.5 Progressing long-term health reforms

5.5.1 National commitment

Schedule C of the NHRA Addendum sets out the commitment of the parties to shared action on long-term health system reform (LTR) to achieve the critical priorities of:

- Improving efficiency and ensuring financial sustainability
- Delivering safe, high-quality care in the right place at the right time through:
 - nationally cohesive health technology assessment
 - paying for value and outcomes
 - joint planning and funding at a local level
- Prioritising prevention and helping people manage their health across their lifetime through:
 - empowering people through health literacy
 - prevention and wellbeing
- Driving best practice and performance using data and research through:
 - enhanced health data.

Despite the specific reference to the six LTRs¹⁴³ in the Addendum, developed and agreed through a collaborative process between all jurisdictions, and with specific processes and actions committed to in the Agreement, progress on advancing the LTRs has been limited, has lacked ambition, been constrained by lack of funding and resources and is not generating the system level improvements that the Addendum envisaged.

The Review identified a number of projects that have been supported through the LTR agenda, with the majority resulting from the original sign-on bonus paid to States and Territories¹⁴⁴ rather than directly related to this element of the Agreement. Projects supported State and Territory priorities linked to the LTR agenda and, while all projects are to be evaluated and lessons shared, there is no pathway to ongoing funding or scaling explicitly required from these projects.

Table 4: Sample of LTR activities funded via the Health Innovation Fund

Title	Jurisdiction, funding, timeline	Target population	Description	LTR priority area
Equitable health outcomes for people who experience mental illness	New South Wales \$9.2m Complete	High risk population groups affected by mental illness.	Aimed to achieve equitable health outcomes and address service gaps for high-risk population groups affected by mental illness. <ul style="list-style-type: none"> • Youth Aftercare Pilot: Community based assertive outreach support model targeting individuals under 25 years who have significant risk of suicide. • Health Literacy Initiative: codesigned education and training program to improve health literacy responsiveness of organisations to be implemented across New South Wales PHNs. 	Prevention and wellbeing and Enhanced health data
Technology enabled referrals to proven secondary prevention services (Formerly Digital Doctor)	New South Wales \$4.8m Complete	Patients admitted to New South Wales hospitals with cardiovascular disease, diabetes and obesity.	Established a streamlined clinical referral system to connect patients to self-management and clinical support services, using existing electronic medical record systems. Focus was rural and regional patients to improve access to cardiac rehabilitation and diabetes management programs.	Prevention and wellbeing and Enhanced health data
Acute and Emergency Tele-Psychiatry and Tele-Mental Health	Western Australia \$11.7m Complete	Country mental health patients, Western Australia Country Health Service Clinicians and GPs.	Used the Emergency Telehealth Service platform to deliver new tele-psychiatry and tele-mental health services in country Western Australia. The service enabled patients who presented to any regional Western Australia hospital with acute mental health problems to have access to a specialist mental health nurse and/or psychiatrist on a 24/7 basis.	Paying for value and outcomes and Prevention and wellbeing
Health Information Exchange Feasibility study	Northern Territory	Northern Territory Population.	Northern Territory Health is developing, to proof-of-concept stage, a prototype Health Information Exchange (HIE) focused on chronic	Enhanced health data

¹⁴³ Australian Commonwealth Government. National Health Reform Agreement Long Term Reforms Roadmap. Available from: <https://www.health.gov.au/resources/publications/national-health-reform-agreement-nhra-long-term-health-reforms-roadmap>

¹⁴⁴ The Health Innovation Fund (HIF) is a \$100m fund linked to signing onto the 2018 Heads of Agreement (\$50m) and the 2020-25 Addendum (\$50m). Projects funded under the HIF have to aligned with the objectives of the NHRA long-term reforms and is provided to States and Territories to fund trials that support health prevention and the better use of health data (consistent with the reforms outlined at Clauses 7(c)(v) and (vi)).





Title	Jurisdiction, funding, timeline	Target population	Description	LTR priority area
	\$0.5m to 31/10/23		kidney disease. The project will investigate how to link, integrate and share health data and information between clinicians and across sectors in the Northern Territory to deliver patient-centred integrated care.	
Torres and Cape Health Care Commissioning Fund (TORCH)	Queensland \$4.6m to 30/11/24	Torres and Cape population	TORCH aims to improve health outcomes in the region by better coordinating care pathways, funding, governance and decision making across health services.	Paying for Value and Outcomes and Joint Planning and Funding at the local level

Clause C5 specifies that reform activities will be delivered within existing resources, however competing priorities particularly in relation to the COVID-19 pandemic has meant this has been difficult to achieve. Most work on LTRs relies on intergovernmental teams in all jurisdictions, who are already stretched in responding to multiple other demands.

In summary, the leadership and resourcing required to implement LTR, to create a burning platform for change and provide incentives to sustain reform, has been significantly underestimated. The lack of funding attached to the reforms has made it difficult for all parties to fund the necessary work to address the six LTR priorities. While there is some useful work underway the reform approach is lengthy and bureaucratic, with other urgent matters often overtaking the concentrated effort required to navigate and untangle reform obstacles.

A renewed commitment to the LTR Roadmap is needed to re-invigorate, accelerate and disseminate LTR action and innovation at scale through updated structures, processes and governance, via a shared national commitment. This will require dedicated resourcing that prioritises this work in every jurisdiction and nationally.

This commitment must allow for, and focus on:

- The reform areas where system reform is urgently needed within five years, and where national collaboration is required for success. While stakeholders generally supported the LTRs set out in the current Addendum, they should be reviewed through a collaborative process as to their relevance into the future.
- Each reform area should be clearly defined with agreed actions, linked to funding and accountability. The reform directions should be sufficiently compelling to engage clinicians, patients and the community.
- There needs to be transparency and coordination of the reforms that are underway, the actions that are being undertaken and an agreed pathway at the start as to how these will be incorporated into long term funding, if successful, whether through the NHRA or other funding streams. There has been significant reluctance for States and Territories to take on pilot projects where long-term funding remains unclear.
- Re-focusing on long-term reforms will require stronger and more explicit partnerships with primary care providers, mental health and community sectors and aged and disability services. The next iteration of the NHRA should include mechanisms to drive commitment and collaboration across the system through these partnerships.
- A deliberate process of sharing lessons learned across jurisdictions.

The national response to COVID-19 showed that, when appropriately authorised and resourced, the system can respond innovatively and adapt policy and practice. Retaining this mindset is challenging, however, as Governments return to program budget management and cost containment and away from a common purpose and goal for population health outcomes.

Recognising that many issues concerned with financing and organisation of health and care in the NHRA are long-term, investment and commitment to funding arrangements (longer than five years) and research funding in health economics, evidence-based policy design and rigorous evaluation is required to provide stability and predictability of high value health, aged and disability care.

Funding agreements such as the Health Innovation Fund Federation Funding Agreement¹⁴⁵ (a national \$100m fund provided when jurisdictions signed up to the 2020-2025 Addendum referenced above) enabled innovative initiatives to be established. However, as it was one off funding, it did not support the full implementation of programs (see Case Study: Lumos). The NHRA must consider how joint funding could be better configured and applied to promote and achieve the LTRs. Ultimately, the current approach to implementing the NHRA and LTRs runs the risk of suffocating rather than encouraging innovation in service delivery due to the rigidity of underpinning funding arrangements.

¹⁴⁵ Under the Health Innovation Fund the Commonwealth provides \$100 million to States and Territories to fund trials that support health prevention and the better use of health data (consistent with the reforms outlined at Clauses 7(c)(v) and (vi)).



Case study: Lumos - New South Wales¹⁴⁶

The stronger environment for data sharing and linkage, with supporting infrastructure, has been advanced by the clearly stated objectives provided within the LTR Enhanced Health Data stream, including through initiatives such as Lumos in New South Wales, which was part-funded under the Health Innovation Fund attached to the Addendum.

Lumos provides new insights on the patient journey through the New South Wales health system. De-identified data from GPs is linked with other health service data to provide a more comprehensive view of patient pathways. This can help identify opportunities for improving patient outcomes and experiences. The data asset is continually growing and spans regional, remote and metropolitan areas across New South Wales.

Stable funding has enabled data collections that link care episodes across primary and acute services and is reported at the practice level so that a patient's care needs are understood at all parts of their care journey.



Recommendation 32: A new Agreement should **reinforce a shared national commitment and program of action on long-term health reform areas**, with a collaborative process to confirm or vary the current long term reform areas and with governance structures, incentives, resources, and success measures to drive the implementation of the reforms.

5.5.2 Prevention

The objectives of the NHRA Addendum 2020-25 recognise that ‘...responsibility is shared between the Commonwealth and the States and that all governments have a responsibility to ensure that systems work together efficiently and effectively to produce the best outcomes...’ (Clause 1e). A key enabler is to ensure sufficient priority is accorded to prevention and holistic health and wellbeing, an area where the efforts of all levels of government need to come together.

Prioritising prevention and helping people manage their health across their lifetime, including by empowering people through health literacy and prevention and wellbeing, is one of the four strategic priorities of the Addendum, comprising two of the six long term reform areas. While there are a range of aspirations and objectives set out in the Agreement, little evidence was presented to the Review that progress had been made.

The recent *National Preventive Health Strategy* set a target of increasing national health expenditure for public and preventive health activities to five per cent by 2030¹⁴⁷. The NHRA is one of the platforms to achieve this goal, noting its existing allocation for public health, and its capacity to develop sustainable innovative ways to finance preventive health activities, including through data sharing, and coordinated cross-sector investment using a cohort-specific and risk-based approach. Further, the establishment of the Australian Centre for Disease Control is intended to provide national leadership in preventive health across both communicable and non-communicable diseases.

Pivoting the Agreement to have a greater focus on early intervention and diversion programs that seek to respond to the rising burden of chronic disease (as set out in Section 5.3) will assist in this regard, but more needs to be done earlier to reduce that burden and to address the related social determinants of health. A prevention action plan should be included in the Agreement which clearly sets out the actions that the parties agree they will take over the course of the Agreement to deliver the prevention reform objectives, the resources that will be made available and the accountabilities and milestones to assess progress.



Recommendation 33: A **renewed focus on prevention activities** should be set out in the Agreement which directly addresses the rising burden of chronic disease in the community, complements the *National Preventive Health Strategy 2021-2030* and work of the Australian Centre for Disease Control and provides a shared program of action, with clear accountabilities, funding and milestones.

5.5.3 Governance

To advance a long-term reform agenda as part of a new Agreement will require dedicated resourcing (both workforce and funding). Establishing a stand-alone innovation entity to drive reform and innovation would ensure a dedicated focus. This is envisaged as a small group of experts, rather than a large government ‘agency’ working with all jurisdictions and the national bodies, with an authorising power to develop and drive uptake of innovative models, to engage closely and work collaboratively with Health Chief Executives and Health Ministers, and review system performance data to advise where innovation opportunities sit.

¹⁴⁶ <https://www.health.nsw.gov.au/lumos>

¹⁴⁷ National Preventive Health Strategy, 2021. www.health.gov.au/sites/default/files/documents/2021/12/national-preventive-health-strategy-2021-2030.pdf



This **Innovation and Reform entity** would:

- Comprise skills and experience in system policy, financing, clinical and non-clinical expertise in developing models of care, evaluation, change management, and research and data analysis.
- Work closely with all jurisdictions and the national bodies to ensure national buy-in and priority setting, drawing on the skills and expertise held by Agreement participants and evaluation-based learnings, with strong reporting lines through HCEF to Health Ministers.
- Have clear performance measures, milestones and outcome-based accountability.
- Advise on whole of system, clear and ambitious outcomes and benchmarks to advance national reform objectives.
- Develop a range of innovative models at the point of care that could be trialled and rolled out by States and Territories on an opt-in basis, acknowledging there would be a need for different models for different States and Territories and for different regions based on local priorities and needs. This would be heavily dependent on the effectiveness and collaboration of individual PHNs, and local priorities identified through co-commissioning and planning activities.
- Operate as a national knowledge exchange hub to support rapid uptake of proven ideas.
- Focus on ensuring impacts can be translated to a local level.
- Identify how innovative models interact with existing pricing and funding models to support adoption at scale.
- Conduct routine evaluations based on agreed LTR and innovation parameters.

There are a number of options through which to establish a new entity as follow:

- Adding a new national body to the Agreement, the national Innovation and Reform Agency, established under Commonwealth legislation with the agreement of all States and Territories, and with the specific functions outlined above. This is the recommended option as it would provide a discrete and dedicated focus on reform activities.
- Adding responsibility for innovation and reform to the remit of one of the existing national bodies, such as the Australian Commission on Safety and Quality in Health Care, as a separate and clearly defined role with dedicated resources; or
- Establishing a Commonwealth-State Taskforce, as a separately managed and resourced unit, working to HCEF and with a dedicated workforce, management structure and budget.

5.5.4 Funding

A key constraint on implementing the current LTR agenda has been the absence of dedicated reform funding. There is a need to identify a potential funding stream that can be ear-marked for ongoing innovation and reform activity. This would drive much stronger and sustainable action. One option is to identify a slice of any additional funding that may flow in a new funding agreement and earmark it for reform, whether this be through a component of a reformed growth cap or through funds freed up in jurisdictions as a result of an increased Commonwealth funding share.

The process of taking an idea from initial testing, through evaluation to implementation at scale should be mapped out in advance using the Funding Innovation Pathway at Recommendation 11. For this to be effective will require a national fund equitably drawn from all jurisdictions and with the governance that gives confidence that all jurisdictions will benefit.



Recommendation 34: A focus on innovation and reform in the Agreement should be supported by:

- a) A **National Innovation and Reform Agency**, authorised to develop and advise on long term system reforms and innovation, working with all jurisdictions and the national bodies, with strong reporting lines through HCEF to Health Ministers, and informed by performance data flowing from the Agreement (linked to Recommendation 6).
- b) An **Innovation Fund**, drawn from new and freed up monies delivered through the NHRA **that can support short term activities**, while working with jurisdictions and the national bodies on options to implement successful innovation and reform at scale using the 'Funding Innovation Pathway' at Recommendation 11.



5.6 Rural and remote service delivery that is fit for purpose

5.6.1 Establish a dedicated Schedule in the NHRA for improving equitable access to health care services in rural and remote areas

5.6.1.1 Strengthen the governance model for rural and remote service provision

In rural and remote areas, primary, aged and disability care services often struggle to be viable due to thin markets and workforce availability. The numbers of aged care beds in rural and remote areas can prevent older patients from being safely discharged, and a lack of NDIS and aged care services in these areas add to hospital bed block pressures. Limited access to health services partially contribute to the higher rate of potentially avoidable deaths (see Figure 35)¹⁴⁸ and potentially preventable hospital admissions (see Figure 36)¹⁴⁹ in remote and very remote areas compared to major cities. Additionally, limited access to primary care in rural and remote areas means that elderly patients and individuals living with a disability turn to rural and remote hospitals for multidisciplinary care, resulting in extended hospital stays.

While the NHRA designates the Commonwealth as system managers for primary and aged care, it falls short in defining their market development role to ensure aged, disability and primary care services in rural and remote areas are accessible and sustainable. There have not been readily available mechanisms for the States, Territories and Commonwealth to work together and to develop flexible models to improve access to services in these areas. To relieve the additional pressure on acute health services, State and Territories report that they need to step in as default providers of primary and aged care services.

Potentially avoidable deaths (aged under 75)

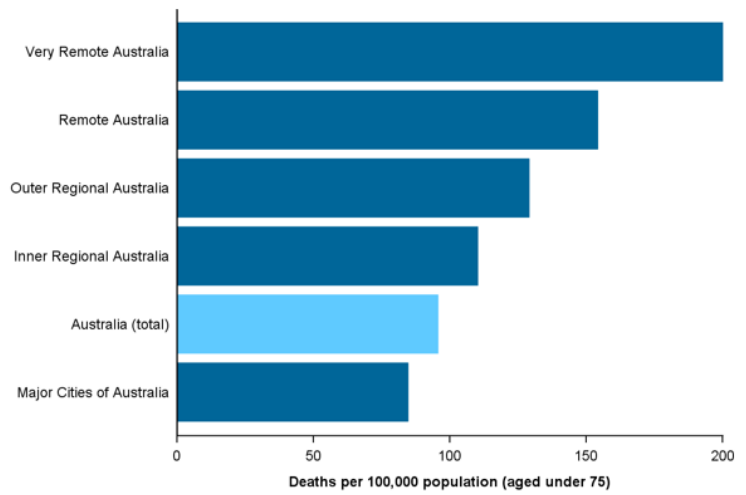


Figure 35: Potentially avoidable deaths (aged under 75) by remoteness area, 2017-2021

Age-standardised rates of total potentially preventable hospitalisations, by remoteness area, 2012-13 to 2017-18

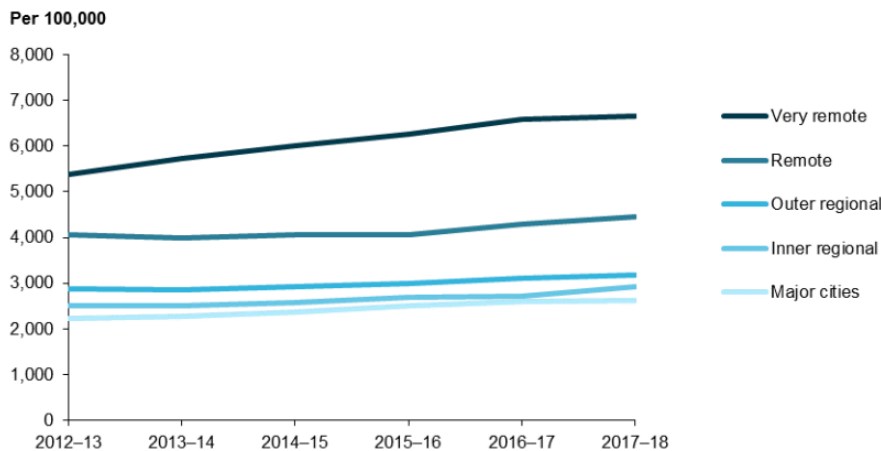


Figure 36: Age-standardised rates of total potentially preventable hospitalisations, by remoteness area (2012-13 to 2017-18)

Clause 14 of the NHRA specifies the Commonwealth’s commitment to affordable aged care regardless of geographic location. The future NHRA should affirm the same commitment to ensure equitable access to primary care in rural and remote areas. The future NHRA should include accountability and escalation mechanisms to address market failure in the primary care and disability sectors in rural and regional areas.

¹⁴⁸ Remoteness area, 2017-2021. <https://www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/contents/mort-books>

¹⁴⁹ <https://www.aihw.gov.au/getmedia/20bc5bf9-d46c-40a7-96c1-d632a1d448bc/aihw-hpf-50.pdf.aspx?inline=true>



Recommendation 35: The NHRA should set out **roles and responsibilities in the governance of rural and remote health care provision** and include provisions that:

- a) Outline the **Commonwealth's stewardship role** in ensuring the accessibility and sustainability of primary, aged and disability care in thin rural and remote markets.
- b) Establish **clear accountability and escalation** mechanisms to address market failures in rural and remote primary, aged and disability care.
- c) Establish governance and pathways to support the development of **flexible models** to improve access to primary care, aged care and disability care in rural and remote areas.

Rural and remote communities face unique challenges including in maintaining an enduring healthcare workforce, access and affordability, and dealing with the immediate impact of climate change. However, the Review could not identify a comprehensive and integrated strategy to drive the necessary policy change and reform to address these unique challenges in the context of the NHRA.

The first *National Rural Health Strategy* was released in 1994. Since then, there have been several updates and revisions to this strategy, with the most recent being the *National Strategic Framework for Rural and Remote Health (NSFRRH)*¹⁵⁰, endorsed by Health Ministers in November 2011. Stakeholders considered that the NSFRRH has not been used to actively guide health policy decisions, there has been limited reporting on progress toward the NSFRRH's goals, and its effectiveness has not been evaluated. Consequently, the NSFRRH was not seen as having been consistently or comprehensively implemented.

Presently, there are various programs and incentives falling under the *Stronger Rural Health Strategy (SRHS)*¹⁵¹ - a 10-year strategy from 2018–19 to improve the health of people through the supply of a quality health workforce that is distributed across the country according to community need. While the SRHS reveals gaps and inconsistencies in addressing rural and remote health workforce needs, it does not constitute a comprehensive or integrated policy approach. An ongoing evaluation of the SRHS is being conducted.

There is a need for the NHRA to adopt a coordinated national approach to address the health disparities in rural and remote communities, recognising the significant differences in health outcomes between rural and remote communities and metropolitan areas. This should be reflected as an additional Schedule in a future Agreement, covering the following components, described further below:

- a) Consistent national datasets and minimum standards of access to primary, disability, aged, and hospital services
- b) Models of care that can be delivered within rural and remote areas and that are cognisant of infrastructure and workforce limitations
- c) A sustainable health workforce
- d) Reviewing regionality weightings to ensure rural and remote hospitals are funded fairly
- e) Accountable and equitable distribution of TTR funding to regional and rural hospitals.

5.6.1.2 Develop consistent national datasets and minimum standards of access to primary, disability, aged and hospital services

A solid evidence base is required to develop effective policies tailored to rural communities. Currently, workforce models and approaches that are effective in urban areas are often used as the reference for rural programs, which can result in unfavourable outcomes. A lack of reliable data to demonstrate program effectiveness in rural and remote regions compounds this.

Nationally consistent health service data for primary care in rural and remote Australia is needed. The three main sources of national data on rural medical workforces: Bettering the Evaluation and Care of Health (BEACH), Medicine in Australia – Balancing Employment and Life (MABEL), and the Rural Workforce Agencies (RWAs) National Minimum Datasets have been discontinued.

A framework defining minimum standards and consistent datasets for primary, disability, aged and hospital services could serve as a tool for maintaining services in rural and remote areas and for proactive benchmarking purposes. This should include workforce KPIs to monitor workforce distribution among States and Territories, allowing active monitoring of service delivery and identifying at-risk communities for necessary action and higher-level monitoring. This needs to be supported by clear accountability and escalation pathways to ensure the provision of an acceptable minimum level of service to all Australians living in rural and remote areas. To be effective, a place-based approach is needed that links to the needs of specific communities and supports multiple approaches to address their needs.

¹⁵⁰ Department of Health and Aged Care. National Strategic Framework for Rural and Remote Health, 2016. Available from: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/national-strategic-framework-rural-remote-health>

¹⁵¹ Department of Health and Aged Care. Stronger Rural Health Strategy. Available from: <https://www.health.gov.au/topics/rural-health-workforce/stronger-rural-health-strategy>

5.6.1.3 Implement models of care within the infrastructure and workforce limitations in rural and remote areas

Effective urban healthcare models may not work in rural and remote areas due to infrastructure and workforce limitations. Rural and remote areas have fewer hospitals, clinics, and primary care services than urban areas, which means that patients may have to travel long distances to access basic health services. In many remote areas, the lack of well-maintained roads and public transport can make it difficult for patients to reach healthcare facilities. Healthcare workforce distribution across Australia is uneven, especially in rural and remote areas. While Australia has a high doctor-to-population ratio¹⁵², the distribution remains imbalanced across geographic locations and specialisations, leading to workforce shortages, especially in specialist and GP roles^{153,154}. There are also shortages of nurses, midwives, and allied health professionals in remote and rural areas^{155,156}.

To tackle these challenges, models of care should leverage the full capacity of the rural health workforce, not just doctors, to deliver safe, high-quality services. Infrastructure and workforce limitations require a shift from relying solely on consultant specialists to focusing on rural generalists, nurses, and allied health professionals who can provide integrated primary, secondary and emergency care in both primary care and hospital settings. The Review identified several initiatives to support the delivery of models of care within rural and remote settings, including:

- Joint planning, development, and implementation of health services between PHNs, LHNs, ACCHOs, and local health service providers, together with enhanced community engagement in influencing what services are needed and where health resources need to be focused (see Case Study: Primary care Rural Integrated Multidisciplinary Health Services).
- Flexible work arrangements and clearer blended funding models in rural and regional areas to support shared workforces and purchasing between sectors to reduce duplication and competition for scarce resources.
- Supporting collaboration between PHNs, LHNs, ACCHOs, and health providers to integrate specialist and hospital services with primary care, and integrate primary care with mental health, aged care, community and disability services.
- Expanding the existing role of Rural Generalists (RGs) in rural and remote communities to facilitate better access to locally based primary mental health care.
- Broadening the scope of practice and care responsibilities for the broader health workforce such as nurse practitioners, paramedics, pharmacists and allied health practitioners.
- Connecting health data across the health system and enhancing the use of telehealth and digital technologies.

Support mechanisms for rural and remote care models should be coordinated at national, State and Territory levels through collaborative efforts.



Case study: Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS)

PRIM-HS is a model of care and funding for providing primary healthcare in rural areas. PRIM-HS involves non-profit, community-based organisations offering a wide range of affordable primary healthcare services to meet the primary health care needs of local communities in flexible and responsive ways.

PRIM-HS has the following unique features that make it a viable and scalable solution for primary health care in rural Australia:

- Employs various primary healthcare providers, including RGs, nurses, nurse practitioners, midwives, dentists and allied health professionals, depending on each community's specific needs and where appropriate working collaboratively with ACCHOs.
- Addresses the challenges of attracting and retaining rural healthcare workers by offering stable employment, attractive conditions, and job security. It does not rely on health practitioners committing to establish their own practice in what are generally thin markets.
- Supports work–life balance through peer support from a multidisciplinary team, overcoming negative perceptions of rural practice, continuous professional development and specific accreditation requirements and ready connection to the local community.
- Potential to provide in-reach services across care settings for RACF, NDIS and DVA recipients, as well as for rural people with chronic disease (management).

The PRIM-HS is an example of an evidence-based model of care that could be supported and enabled by the future NHRA. It was co-developed with Rural Health Alliance members, as well as rural primary care organisations and individuals who work on the ground in rural communities. Critically, it can be tailored to fit the specific health needs of rural and remote communities, using and augmenting the services and infrastructure already in existence.

¹⁵² Commonwealth Department of Health. National Medical Workforce Strategy: 2021-31 Investing in our medical workforce to meet Australia's health needs, 2021. Available from: <https://www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf>

¹⁵³ Australian Institute of Health and Welfare. <https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health>

¹⁵⁴ Australian Medical Association. The general practitioner workforce: why the neglect must end, 2022.

¹⁵⁵ National Skills Commission. Projecting employment to 2026 [Insights], 2022. Available from: <https://labourmarketinsights.gov.au/industries/industry-details?IndustryCode=Q>

¹⁵⁶ National Skills Commission. Care Workforce Labour Market Study, 2021. Available from: <https://www.nationalskillscommission.gov.au/sites/default/files/2022-10/Care%20Workforce%20Labour%20Market%20Study.pdf>



5.6.1.4 Develop a sustainable rural health workforce

In addition to the development of health workforce KPIs across rural and remote areas, all levels of government should be accountable for ensuring that the future rural health workforce has sufficient capacity and capability. The NHRA should detail the funding streams and governance mechanisms to build a future rural workforce that is fit-for-purpose. The Review identified several initiatives in this regard:

- Reviewing the current funding arrangement with the Australian College of Rural and Remote Medicine (ACRRM) to expand the training capacity of GP positions in the Australian General Practice Training Program (AGPT)
- Planning for and funding early career health care jobs in rural and remote settings that reflect local community needs.
- Continuing to invest in innovative models of primary health care for rural and remote locations, such as the Primary Care Rural Innovative Multidisciplinary Models (PRIMM) and the Innovative Models of Care (IMOC) grant opportunities.
- Implementing rural health workforce training programs, such as the single employer model, with a focus on GP Registrars, that address disincentives and provide access to fair pay and healthy working conditions, and expands the use of workplace-based assessments where appropriate, including exploring collaborative models to support international medical graduates with GP and public health services.
- Developing a range of employment options available to RG registrars that are suitable for the different contexts in which RG training occurs and the various training paths they may pursue.
- Ensuring that employment conditions and pay rates are equitable across the health system, avoiding competition between different parts of the system, especially in rural communities with limited healthcare workforce resources.
- Supporting non-health system enablers such as staff accommodation and provision of childcare.
- Establishing a central repository of documentation for identification, assessment, and credentialing information which is accessible to health districts. This streamlines administrative processes and reduces bureaucratic burdens, making it easier for senior medical staff to provide services in rural and remote areas.

It is crucial for all levels of government to commit additional funding to ensure rural access to a wide range of healthcare professionals, including doctors, nurses, midwives, allied health, dental, paramedics, and pharmacists.

5.6.1.5 Review regionality weighting to ensure rural and remote hospitals are funded fairly

Concerns were raised with the Review that the national funding model, despite accounting for rural and remote patient needs, fails to adequately consider regional differences. As noted earlier, data from the NHFB shows that the average cost per NWAU is significantly higher in smaller jurisdictions (South Australia, Western Australia, Tasmania, the Northern Territory, and the Australian Capital Territory) than in larger States (New South Wales, Victoria, and Queensland). The wide distribution of essential hospital services in rural areas inherently leads to cost inefficiencies compared to more concentrated service models, with the potential that rural and remote areas are underfunded.

As noted at Recommendation 18, the effectiveness of rural and remote adjustments to the NWAU should be reviewed with a view to more accurately reflecting the true cost of providing services in these locations.

5.6.1.6 Ensure accountable and equitable TTR funding to rural hospitals

The block funding model for small rural hospitals does not include teaching and training funding, which is currently only available for tertiary and larger regional hospitals. This model does not acknowledge the important role that small rural hospitals play in providing teaching and training for various healthcare professions, including medical students and registrars, especially in the field of RG medicine and other medical specialties. In rural hospitals where teaching occurs, there are additional challenges related to GP Visiting Medical Officer (GP VMO) arrangements. For instance, in New South Wales and Victoria, where hospital inpatient services are contracted to GP VMOs, the current system pays one fee for services when a registrar is on-call. Under these arrangements, there is no compensation provided for supervisors providing training or assistance to the on-call registrar. This reduces the incentive to maximise teaching opportunities and may discourage supervisors from providing help when needed.

To enhance teaching opportunities and create a supportive environment in rural hospitals, supervision of registrars should have a separate budget allocation, distinct from fee-for-service arrangements. Investing in supervision has a substantial positive impact on retaining these doctors in rural and remote areas beyond their training period.

Commonwealth-funded training programs, like the Specialist Training Program and State-administered John Flynn Prevocational Doctor Program, support medical training in rural and remote settings to build the rural training pipeline. Funding for these training programs is allocated to the supplying hospital (typically metropolitan or regional) rather than to the rural hospital where the trainee doctor is placed. While this funding approach may be efficient, rural hospitals have limited control over rural placements. If the supplying hospital recalls or fails to provide the doctor for their rotation/term, the rural hospital has no means to secure a replacement in the future.

Additionally, the allocation of funding and hospital placements for RG trainees presents various issues. Block funding arrangements often do not prioritise training placements, and the funding is not always used appropriately for this purpose. RG trainees seeking hospital placements for their Advanced Skills Training (AST) may find themselves in competition with trainees from other non-GP specialties who are funded through the Specialist Training Program or other initiatives. This results in RG trainees being unfairly disadvantaged, as the current system disproportionately benefits non-RG trainees.

The future NHRA should ensure an accountable, equitable distribution of the TTR funding pool to regional and rural hospitals to support sustainable health workforce training. For Commonwealth funded positions that are allocated based on rotation to a



rural hospital, the rural hospital should have a budget line item for that position's salary, as well as human resource records to align with the staff providing services in that hospital.



Recommendation 36: The importance of improving equitable access to health care services in **rural and remote areas should be reflected in a new and dedicated Schedule in a future Agreement**, with priority actions and milestones incorporated. The Schedule should include:

- a) Establishing **consistent national datasets and minimum standards of access** to primary, disability, aged, and hospital services to ensure maintenance of services across rural and remote areas.
- b) Implementing **models of care** within the infrastructure and workforce limitations in rural and remote areas.
- c) Developing a **sustainable health workforce** in rural and remote areas.
- d) Reviewing **regionality weighting** to ensure rural and remote hospitals are funded fairly.
- e) Ensuring an **accountable and equitable distribution of the TTR funding pool** to regional and rural hospitals to underpin sustainable health workforce training.

5.6.2 Expand 19(2) exemption arrangements to improve access to bulk-billed primary health care



Observation: What is the COAG Section 19(2) Exemptions Initiative?

The COAG Section 19(2) Exemptions Initiative (the Initiative) aims to improve access to bulk-billed primary health care by giving approval for States and Territories to bulk-bill the MBS for primary health care at public hospitals and multipurpose services. The *Health Insurance Act 1973* (subsection 19(2)) allows the Minister to make directions for this Initiative.

The Initiative recognises that in rural and remote communities, people have limited access to primary health care and many public hospitals and health services have employed medical officers to provide this care.

How does the Initiative work?

The Commonwealth government provides access to MBS funding through memorandums of understanding (MoUs) with the States and the Northern Territory. The current MoUs are for the period 2022-2025. At least 70% of the Initiative funding must be used to improve access to primary care. This can include purchasing new equipment.

As of 1 June 2023, there are over 120 approved sites under the Initiative. The States and the Northern Territory can propose sites for the Commonwealth government to consider. They must consult with and seek support from local primary health care providers and other relevant stakeholders and submit a site operational plan. This can create long lead times to have exemptions approved.

Approved sites must review their operational plan annually, provide site annual reports, and provide summary statistics every financial year.

The COAG Section 19(2) Exemptions Initiative supports the provision of primary care in rural and remote hospitals (including aged care and NDIS clients who regularly require primary care services) and serves as a mechanism for sharing the responsibility between the Commonwealth, State and Territory governments for primary health care provision in rural and remote communities.

There is an opportunity to expand the COAG Section 19(2) Exemptions to include additional sites recognising that the only option available for many regions without access to primary health services within a reasonable distance, is to receive primary health care in an ED or outpatient clinic. Alternatively, 19(2) exemption arrangements may be tied to health practitioners (e.g., RG) in rural and remote locations, rather than assigned to a specific practice or facility, to increase the flexibility of providing health care services across different settings. In either case the process of approval needs to be streamlined and simplified so that communities can act more quickly to fill service gaps.

Ensure patients who attend the ED in rural hospitals are not charged out-of-pocket fees

Some Urgent Care Centres (UCCs) have gained approval under the COAG Section 19(2) Exemption Initiative to provide urgent, but non-life threatening, care to patients in rural hospital emergency departments. However, this had led to some States and Territories billing rural and remote emergency services on an MBS billing arrangement.

UCCs are the equivalent of emergency departments in small rural hospitals and are regularly signed as 'Emergency'. These facilities require the treating medical practitioner, usually an RG or specialist GP working under VMO arrangements to bill the presenting patients. The fixed MBS item fee often does not align with the level of care delivered at these facilities, and this care can span several hours, depending on the patient's condition. Consequently, patients may be charged gap fees or providers can be inadequately compensated through the MBS rebate. Stakeholders have informed the Review that these practices have been implemented by Victorian Rural Hospital Urgent Care Centres and South Australian rural hospital emergency departments.

These small rural hospital urgent care services are physically located within the hospital, use hospital nursing staff and clinical supplies, and require doctors staffing them to possess emergency skills and undergo medical education to maintain their proficiency. As such, there should be appropriate remuneration and supportive contractual employment arrangements for GP VMOs providing services to rural and remote hospitals and health care facilities. Governance mechanisms for the application of the COAG Section 19(2) Exemption Initiative should be reviewed to ensure that doctors providing rural hospital emergency services are appropriately remunerated and patients who attend the ED are not charged out-of-pocket fees.



Recommendation 37: The process for the **application and approval of exemptions from Section 19(2) Health Insurance Act 1973** should be **reviewed, simplified and expanded** to improve access to bulk-billed primary health care (MBS-eligible GP, nursing and allied health services) in rural and remote areas and where there are thin and failing markets. This work should:

- a) Explore opportunities to **include further sites and increase the number of exemptions** for areas without access to primary health services (including thin and failing markets) within a reasonable distance.
- b) **Simplify and streamline approval** processes to enable timely establishment of services in areas where there is limited access to primary care.
- c) Ensure that doctors providing rural hospital emergency services are appropriately remunerated and patients who attend the ED are **not charged out-of-pocket fees**.

5.7 Clear commitment to closing the gap for First Nations' people



While the Addendum recognises ongoing barriers to improving health equity for priority population groups, such as First Nations' people, it falls short of fulfilling the obligations outlined in the *National Agreement for Closing the Gap*¹⁵⁷. As a result, there is opportunity to further strengthen the focus on First Nations' perspectives in a future NHRA.

Priority actions are not specifically identified or driven through the NHRA, with little evidence that current funding and governance mechanisms are addressing issues of access and equity for First Nations' people.

There is a significant gap in life expectancy, health care access and health outcomes between the Indigenous and non-Indigenous population. It is important that these differences are explicitly recognised in the Agreement with specific actions agreed, accountabilities assigned and milestones incorporated.



Observation: Closing the Health Gap – major health outcome differences¹⁵⁸

Major health outcome differences for Indigenous people compared to non-Indigenous people are:

- A burden of disease more than twice the rate of the non-Indigenous population.
- Chronic diseases are responsible for more than two-thirds of the total health gap, and 64% of the total disease burden among Aboriginal and Torres Strait Islander people.
- 2.6 times more likely to have a preventable hospitalisation.
- 1 in 25 Aboriginal and Torres Strait Islander people are ending care early (higher in remote regions).
- Can expect to live 8–9 years less.
- Avoidable deaths are 4 times higher in remote areas and 2 times higher in urban and regional areas.
- The additional expenditure required to achieve equitable health spending based on need for Aboriginal and Torres Strait Islander people has been estimated at around \$4.4 billion per year¹⁵⁹.

5.7.1 Governance and funding arrangements

The NHRA lacks specific governance arrangements to drive First Nations' health delivery and reform and identify and map the interventions required to meet *Closing the Gap* commitments to achieve sustainable health gains. This includes a lack of clear roles and responsibilities in the NHRA for ACCHOs, which detracts from the ability of community-controlled organisations to participate in local commissioning and service design. ACCHOs are critical to effectively engaging First Nations' communities with health services where mainstream services are not adequately tailored, as shown in the case study below.

A greater emphasis should be placed on PHNs and LHNs (identified in section 5.2.1) being required to work more closely with ACCHOs to implement programs and data sharing, moving beyond the current GP-centric approach. Co-design of health care services will be key to addressing the shortcomings in existing arrangements.



Case study: Aboriginal Medical Services delivering aged care transition services - Western Australia

The Western Australia Department of Health partnered with Western Australia-based ACCHOs to build capacity to deliver locally led, place-based, culturally appropriate aged care transition care services through the Transition Care Program (TCP).

The program enabled Broome Regional Medical Service (BRAMS), Southwest Aboriginal Medical Service and Geraldton Regional Aboriginal Medical Service to become the first ACCHOs to expand their services to deliver culturally appropriate transition care for Elders. The initiative was embraced by local Aboriginal communities.

The program addresses the low numbers of First Nations' people accessing TCP and aged care nationally. It has supported more older First Nations' people to access TCP services and has achieved positive outcomes reflected through client testimonials and clinical measurements assessing a client's level of independent living, with 90% of clients maintaining or improving their independence.

The program has had a big impact, especially in the Kimberley region where BRAMS has become the first and only service provider of TCP in the region. During April 2022, BRAMS was the only discharge pathway for older people in Broome Hospital to aged care with all other aged care providers in Broome closed for admissions, demonstrating the strength and resilience of Aboriginal Medical Services in the region.

¹⁵⁷ Closing The Gap. National Agreement on Closing The Gap, 2020. Available from: <https://www.closingthegap.gov.au/national-agreement>

¹⁵⁸ National Aboriginal Community Controlled Health Organisation. Key Facts. Available from: https://www.naccho.org.au/app/uploads/2022/11/NACCHO_KeyFacts_infographics_A4_221115.pdf

¹⁵⁹ National Aboriginal Community Controlled Health Organisation and Equity Economics. Measuring the Gap in Health Expenditure: Aboriginal and Torres Strait Islander Australians. May 2022

The Pilot strategically aligns with the NHRA long-term reform agenda and received one-off funding through the NHRA's Health Innovation Fund, with the capacity building and support work for these pilots now fully funded by the State.

The NHRA funding model adjusts the NEP for Indigeneity, rurality and other markers of disadvantage/inequity, as per the IHACPA National Pricing Model Technical Specifications¹⁶⁰. A shortcoming in the operation of the adjustment mechanism relates to the way in which the NEP is set. As the input data is drawn from services delivered to all First Nations' people (generating a broadly based average), the actual cost of providing these services in rural and remote communities, where there are higher numbers of First Nations' people and their health needs are more acute, are likely to be understated, even after the location of the service and resident is incorporated. These adjustments are determined separately, so there may not be an appropriate adjustment when services are delivered both in a remote area and to an Indigenous patient. As a result, activity adjustments for Indigeneity (and remoteness) may not be sufficient or equitable to adequately reflect the cost of care for these communities.

“The Indigenous and remoteness adjustments are determined as separate adjustments and applied in an additive way. While the adjustments consider both remoteness and Indigenous status, there is potential that the combined effect of these factors, when they interact, might not be fully captured and may result in understatement of costs.”

Further, these legitimate and unavoidable costs are reflected in the data after the service has been delivered rather than front-loading appropriate investment in health, including prevention services. This is particularly relevant for First Nations' people who have high rates of chronic and preventable diseases, with the burden of disease more than twice the rate of the non-Indigenous population and 2.6 times more likely to have a preventable hospitalisation¹⁶¹. Further, a considerable gap in life expectancy remains, with mortality rates consistently higher among Indigenous Australians across most causes of death. Recent data spanning 2016 to 2020, reveal an age-standardised mortality rate for Indigenous Australians nearly twice that of their non-Indigenous counterparts (960 versus 522 deaths per 100,000 population respectively)¹⁶².

There is a place for the national funding model to better resource the services required to address the gap between Indigenous and non-Indigenous health outcomes. A focus on co-design of services with First Nations' organisations, outcome-based funding that puts the onus on the health service to ensure completion of care, and a greater emphasis on preventative health could better align with *Closing the Gap* and improve access and equity for First Nations' people accessing care.

Sections 5.3 includes further information on optimal models of care at the interface of acute and primary care settings for chronic disease management and other priority areas.

5.7.2 Performance indicators

Health Ministers agreed the Australian Health Performance Framework (AHPF) as the single framework to support system-wide reporting on Australia's health and health care performance. However, the AHPF does not include indicators that capture First Nations' people's experiences of the health system.

To understand the differences in health outcomes for First Nations' people, culturally relevant data metrics need to be included, as western and biomedical models of health tracking may be insufficient or inappropriate in First Nations' cultural contexts. A lack of cultural safety in hospitals affects both treatment outcomes and the likelihood of accessing care when it is needed.

An Interim Quantitative NHRA Performance Framework was developed as part of this Review (refer to section 5.9) and includes proxy indicators for cultural safety in hospitals:

- The proportion of First Nations' people who left or were discharged from hospital against medical advice in 2020-21 was 4.4 times higher than for non-Indigenous Australians.
- The difference in median waiting time for elective surgery between First Nations' people and non-Indigenous Australians has increased from 4 days in 2012-13 to 11 days in 2021-22.

Both the *National Agreement on Closing the Gap* and the *National Aboriginal and Torres Strait Islander Health Plan 2021-2031* emphasise the importance of First Nations' people having access to, and ownership of, the data that involves and impacts them. Indigenous Data Sovereignty principles should be appropriately embedded in the design, collection, use and dissemination of Aboriginal and Torres Strait Islander data in the NHRA.

¹⁶⁰ Independent Health and Aged Care Pricing Authority. National Pricing Model 2023-24, 2023. Available from:

https://www.ihacpa.gov.au/sites/default/files/2023-03/national_pricing_model_technical_specifications_2032-24.pdf

¹⁶¹ National Aboriginal Community Controlled Health Organisation. Key Facts. Available from:

https://www.naccho.org.au/app/uploads/2022/11/NACCHO_KeyFacts_infographics_A4_221115.pdf

¹⁶² Australian Institute of Health and Welfare (2023). Deaths in Australia. Available from: <https://www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia/contents/summary>

5.7.3 Focus of a future Agreement

A future Agreement should have a greater focus on First Nations' people's health. A specific Schedule in a future Agreement would assist with consolidation and clear articulation of government commitments and provide an opportunity to jointly agree tangible milestones and improvements. This Schedule should include or reference the following:

- Specific indicators within the NHRA, aimed at improving First Nations' health outcomes aligned to the four cross cutting priority reforms in the *National Agreement for Closing the Gap* including to:
 - Strengthen and establish formal partnerships and shared decision-making
 - Build the Aboriginal and Torres Strait Islander community-controlled sector, including transitioning services and the associated funding to community controlled organisations
 - Transform government organisations so they work better for First Nations' people
 - Improve and share access to data and information to enable Aboriginal and Torres Strait Islander communities to make informed decisions.
- The role of ACCHOs should be articulated with greater clarity and be brought more systematically into health system governance. Additionally, the NHRA should ensure that First Nations' people are in the leadership of all planning and commissioning and ensuring the market, including ACCHOs, is prepared in understanding what commissioning is and how they can rightfully bid for funding.
- Review the calculation of weightings for Indigenous status, residential location and treatment location to ensure the purpose of these weightings, and how they interact, are being met, particularly in rural and remote settings.
- Include more targeted attention to Aboriginal and Torres Strait Islander health matters via an additional set of Aboriginal and Torres Strait Islander health-specific indicators to cover gaps in health-related *Closing the Gap* reporting and bring greater attention on improving Aboriginal and Torres Strait Islander health outcomes (e.g. measuring cultural safety in the health system). It is important to have agreed indicators and consistent collection of data relating to these priority groups for monitoring improvements in the cultural safety and accessibility of healthcare, developed with First Nations' representatives.
- Work together and leverage State and Territory First Nations' frameworks and knowledge to develop a relevant national perspective for the NHRA. Many jurisdictions have implemented solutions, frameworks and initiatives to prioritise *Closing the Gap* and promote equity. These success factors should be drawn on to develop a nationwide perspective.



Recommendation 38: The critical importance of improving the health of First Nations' people through the *National Agreement on Closing the Gap* should be reflected in a future Agreement as an additional Schedule. The Schedule should reflect at least the following:

- a) A shared commitment to *Closing the Gap*, working in partnership with First Nations' people.
- b) Specific actions to close the health gap with accountabilities assigned and performance assessed against agreed milestones, including cross-cutting targets.
- c) A shared commitment and requirement to **work with ACCHOs** and local communities in the design and commissioning of services and transitioning of services to community-control.
- d) A shared commitment to **Cultural Safety** in health service delivery with agreed measurement and reporting, including patient experience indicators.
- e) A shared commitment to embed appropriate **governance of Indigenous data holdings** held by all levels of government.

5.8 Embedding workforce and digital health as key enablers of the health system



Both digital health and workforce are key enablers of health system efficiency and effectiveness and are current gaps in the NHRA. As such, a future Agreement should include a national focus on ensuring a sufficient health workforce as well as seamless, safe and secure digital health services and technologies.

5.8.1 Workforce

A future NHRA provides an opportunity to help address the identified challenges of Australia's health workforce which include:

- Maldistribution in some professions and specialties (including Aboriginal and Torres Strait Islander Health, Primary Care, Aged Care, Allied Health, Mental Health) and compounded in rural and remote areas.
 - The specialist-to-population ratio in remote areas is seven times lower than that in major cities¹⁶³.
- Ageing populations and increased rates of chronic disease generate increased demand for primary care.
 - Approximately 25% of GPs intend to retire in the next five years¹⁶⁴ and, concurrently, there is a fall in the proportion of doctors training as GPs. Nationally, the proportion of final-year medical students listing GP as their first preference speciality was only 13.1% in 2022¹⁶⁵.
- Barriers to enabling clinicians working to the top of scope and across care systems include restrictive regulations, resistance to diverge from existing/current traditional roles, funding arrangements and training gaps.

In anticipation of a future Agreement, all jurisdictions should collaborate to address these workforce challenges through:

- a) Alignment to relevant national workforce strategies
- b) Ensuring a collaborative Commonwealth, State and Territory focus on an agreed set of strategic priorities and actions (including in regard to professional scope of practice)
- c) Dedicated national medical workforce planning governance oversight
- d) A commitment to the role of the Australian Health Practitioner Regulation Authority (AHPRA).

5.8.1.1 Alignment with national workforce strategies

The NHRA's limited reference to workforce and its lack of alignment with national workforce strategies requires attention.

A future Agreement should strengthen partnerships between the Commonwealth and States and Territories, and between health services and education providers to further develop, support and sustain those working in the overarching health system.

Alignment to relevant workforce strategies should explicitly drive a sense of national purpose, strategies and outcomes through shared effort in the NHRA. This may cover workforce planning (recruitment and retention), reforming career paths, prioritising Teaching, Training and Research (TTR), enabling TTR support within the primary and community-based health sectors, and monitoring and evaluation.

Some of the key national workforce strategies in place or planned that a future Agreement should incorporate or refer to include:

- *National Medical Workforce Strategy 2021-2031*¹⁶⁶ - With endorsement from Health Ministers in December 2021, the strategy aims to structure and support sustainable medical workforce planning and reform in Australia, improving access to health care by supporting the right people to have the right skills, where needed the most.
- *National Nursing Workforce Strategy*¹⁶⁷ (NNWS) - The Commonwealth together with Victoria and in collaboration with all States and Territories is developing this strategy. The NNWS will provide a national-level strategic approach to nursing policy, seeking to realise the value of nurses, with the need to ensure that this highly qualified and skilled workforce is supported in Australia.
- *Nurse Practitioner Workforce Plan* – The Commonwealth released the Plan in May 2023 and highlights the significant opportunity to increase utilisation of nurse practitioners to meet consumer needs. It details how to remove the barriers currently facing the workforce and build the nurse practitioner workforce, while increasing access to care for all Australian communities.
- *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031*¹⁶⁸ - Developed in partnership with Aboriginal and Torres Strait Islander people, and endorsed by all Commonwealth,

¹⁶³ Department of Health and Aged Care. Australia's rural health workforce. Available from: <https://www.health.gov.au/topics/rural-health-workforce/about>

¹⁶⁴ Royal Australian College of General Practitioners. General Practice Health of the nation, 2022.

¹⁶⁵ Medical Deans Australia and New Zealand – Medical Schools Outcomes Database National Data Report, July 2023

¹⁶⁶ Department of Health and Aged Care. National Medical Workforce Strategy 2021-2031. Available from: <https://www.health.gov.au/resources/publications/national-medical-workforce-strategy-2021-2031?language=en>

¹⁶⁷ Department of Health and Aged Care. National Nursing Workforce Strategy. Available from: <https://www.health.gov.au/our-work/national-nursing-workforce-strategy>

¹⁶⁸ Department of Health and Aged Care. National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031. Available from: <https://www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-health-workforce-strategic-framework-and-implementation-plan-2021-2031?language=en>

State and Territory departments with a responsibility for health and education, this strategic framework and implementation plan aims to grow the Aboriginal and Torres Strait Islander health workforce across all roles, levels and locations, to reach population parity by 2031. It is guided by six overarching strategic directions to attract, recruit and retain First Nations health workers across the health sector.

5.8.1.2 Collaborative Commonwealth, State and Territory focus

Collaborative planning and implementation across the Commonwealth, State and Territories are key to developing a sustainable national health workforce. This involves the co-development of a clear vision for the health workforce, aligned to the national workforce strategies outlined above, with a concise set of strategic initiatives. Collaborative planning and implementation would synchronise efforts to ensure that scarce resources are allocated efficiently. Development of the health workforce vision and strategic initiatives should consider the following elements:

- **Using TTR funding as a key lever to drive change:** TTR funding allocation should be aligned with strategic workforce initiatives with sufficient accountability and transparency. Further information on the transparency of TTR funding is at section 5.4.4.1.
- **Addressing rural and remote workforce challenges:** Rural and remote areas experience a shortage of doctors, nurses, Aboriginal and Torres Strait Islander health professionals, and allied health providers. A joint commitment and funding of workforce capacity-building should cover health service commissioning, explore innovative workforce models (along the lines of the Single Employer Model for GP Registrars referenced below) and potential new roles to support better care coordination. Additionally, health professions should be enabled to operate across the full scope of practice to support the local delivery of high-quality care. Further information on developing a sustainable rural workforce is at section 5.6.1.4.
- **Closing the Gap:** The NHRA should address the relevant priorities outlined in the *National Agreement on Closing the Gap*, the *National Medical Workforce Strategy*, and the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031*, which call for improving the capacity of the health workforce to create and maintain culturally safe environments for the Aboriginal and Torres Strait Islander workforce and patients. This includes cultural awareness and competence through governance, equitable funding arrangements, service delivery and workforce development, across all health care settings.
- **Improving workforce health and wellbeing:** The Agreement should outline a shared commitment to health workforce wellbeing, ensuring supportive workplace cultures and practices are in place that address psychosocial safety, bullying, harassment, discrimination, racism, ensure cultural safety, improve workplace flexibility, and implement career-sustaining reforms for health professionals. This may include investing in supporting multi-faceted careers and pathways and addressing issues of burnout to reduce the consequences of supply and retention.



Case study: Single Employer Model (SEM) as a potential strategic initiative

Single Employer Model (SEM) trials explore new approaches to employment arrangements for GP trainees, with the aim to address key barriers to attracting and retaining the next generation of GPs.

The model allows GP trainees to be employed by one employer throughout their training rotations, providing increased ease of accruing and accessing employment entitlements (such as personal leave, recreation leave and parental leave), and greater certainty of training arrangements. It will bridge the gap between hospital-based and community-based training placements.

Expected benefits of the SEM trials include improved access to GP services for local communities, both in the immediate term through increased numbers of GP trainees, and in the longer term by encouraging those GP trainees to build local connections in the communities in which they train.

The initiative makes it more attractive for junior doctors to enter a GP training pathway (via salary and entitlement incentives), while supporting the delivery of services across hospitals and GPs.

Early feedback from the small number of GP trainees and GPs who have participated in trials has been positive. Further trials will test these findings with a larger cohort across a number of localities, and over a longer period of time. A comprehensive evaluation of the trials will commence in the first half of 2024 to assess if the trials are achieving the desired outcomes. Interim evaluation results will inform ongoing implementation plans. The SEM is a potential strategic initiative that could be enabled and supported through joint commitment from the Commonwealth, States and Territories.

5.8.1.3 Dedicated governance oversight

A national focus on ensuring a sufficient and quality health workforce should be recognised in the NHRA, through a dedicated national health workforce planning body, either within the NHRA or referenced by it, along the lines of the previous Health Workforce Australia. This focus would provide a vehicle to drive collaborative reform on workforce priorities.

Functions of a national health workforce planning body could include ensuring national and jurisdictional health workforce planning and analysis, acting as the source of truth for data on health workforce, and guiding health workforce training numbers aligned to community need and vulnerable populations, across sectors, across specialisations, and geographical location. An

example identified in consultation was the operation of the *Health and Care (Staffing) (Scotland) Act 2019*¹⁶⁹ which sets out the vision and strategy for the National Health Service (NHS) Scotland workforce to deliver a resilient, efficient and high-quality healthcare service (refer case study below).



Case study: The *Health and Care (Staffing) (Scotland) Act 2019*

The *Health and Care (Staffing) (Scotland) Act 2019* provides a statutory basis for the provision of appropriate staffing in health and care service settings, enabling safe and high-quality care and improved outcomes for service users. It does this by ensuring that the right people with the right skills are in the right place at the right time creating better outcomes for patients and service users and supporting the wellbeing of staff.

The effective application of this legislation:

- Provides assurance that staffing is appropriate to support high quality care, identify where improvements in quality are required and determine where staffing has impacted on quality of care.
- Supports an open and honest culture where clinical/professional staff are engaged in relevant processes and informed about decisions relating to staffing requirements.
- Enables further improvements in workforce planning by strengthening and enhancing arrangements already in place to support transparency in staffing and employment practice.
- Ensures the clinical voice is heard at all levels by ensuring arrangements are in place to seek and take appropriate clinical advice in making decisions and putting in place arrangements in relation to staffing.

5.8.1.4 Working to full scope of practice

A key element of workforce effectiveness is to use the medical workforce at its full scope or practice across all professions. There is a need for a national consensus on what this means, establishing methods to ensure safe practice standards, developing more career progression opportunities, and systematically identifying and removing barriers that currently exist. There are a variety of examples of progress in this area which were presented to the Review, but what is lacking is a systematic and connected approach, with a particular focus on current and emerging areas of workforce shortage.



Case study: Paramedics working at their full scope of practice in the community

Innovative models of care are being developed and implemented to maximise the benefits of paramedics within their local communities. Community Paramedicine is a new and evolving model of care in which paramedics receive specialist training and operate with an expanded scope of practice to provide public health, primary healthcare, and preventive care to underserved populations within the community.

Better utilisation of paramedics, through increased scope of practice and clinical expansion, would help address workforce shortages across the broader health system, including in rural, regional, and remote locations, and assessing and treating patients at home, where possible, and avoiding the need for emergency medical transport.

While increasing the scope of practice of paramedics can have several potential benefits, there are risks and considerations that need to be carefully managed, including patient safety, adequate training and education, clinical governance, and collaboration with other healthcare professionals.

5.8.1.5 Commitment to the role of the Australian Health Practitioner Regulation Authority (AHPRA)

AHPRA has five core regulatory functions that seek to ensure the community has access to a safe health workforce across all professions registered under the National Registration and Accreditation Scheme:

- Providing policy advice to the National Boards about registration standards, codes and guidelines for health practitioners
- Ensuring that only health practitioners with the skills and qualifications to provide competent and ethical care are registered to practise
- Managing complaints and concerns raised about the health, performance and conduct of individual health practitioners on behalf of the National Boards
- Monitoring and audit of registered health practitioners to make sure they are complying with Board requirements
- Working with accreditation authorities and committees to ensure graduating students are suitably qualified and skilled to apply to register as a health practitioner.

The NHRA does not currently reference AHPRA. A future Agreement should explicitly reference the role that AHPRA performs and include a commitment to the continued development of the national regulation scheme.

¹⁶⁹ Scottish Government. Health workforce. Available from: <https://www.gov.scot/policies/health-workforce/>

Considerations of how AHPRA's role can be expanded and embedded in the NHRA include:

- Regulation of health professionals that are not currently regulated by AHPRA including Aboriginal and Torres Strait Islander Health Workers for consolidation.
- Monitoring and management to ensure minimum training standards are met in collaboration with peak bodies.
- Provision of data in relation to the health workforce.



Recommendation 39: A future Agreement should **explicitly recognise the role of the health workforce** in the delivery of quality health services as an additional Schedule. The Schedule should:

- Align to relevant national workforce strategies by reflecting the current work being progressed to support, grow, shape, and deliver a health workforce to achieve the goals of the Agreement.
- Ensure a collaborative Commonwealth, State and Territory focus encompassing a concise set of strategic priorities and actions, including those related to operating at full scope of practice, to be delivered through the Agreement.
- Consider **dedicated national health workforce planning governance oversight** (either within the Agreement or as an adjunct to it) along the lines of the previous Health Workforce Australia. This, together with a shared Commonwealth, State and Territory commitment, would provide a vehicle to drive collaborative reform on workforce priorities.
- Include a commitment to the continued development of the national regulation scheme through the Australian Health Practitioner Regulation Authority (AHPRA).

5.8.2 Digital health

5.8.2.1 Support for a healthcare system enabled by digital infrastructure

Digital health infrastructure will play an increasingly important role in the delivery of health care services, given technological advances, consumer demand and the need to operate within a constrained resource (workforce and budget) environment. The effective use of digital health can support consumers as they navigate the health system, empowering them to be at the centre of their own care, connecting healthcare providers, facilitating communication and simplifying and expanding information sharing. This requires digitally enabled models of care that improve accessibility, quality, safety and efficiency, such as:

- More integrated management of chronic illness
- New digital services that support the health of babies and young children
- Digital services for advanced care planning
- Information sharing in urgent and emergency care
- Expanded access to telehealth services, especially in rural and remote Australia.

Digital technologies have the potential to ease the pressure on hospitals and, through the sharing of quality data, help to inform service demand and subsequently workforce supply. When used successfully they enable improved clinical decision-making for health care providers and consumers and can support the transition of care between healthcare settings. However, the value and impact of digital health has not been explicitly recognised in the NHRA.

A future Agreement should incentivise the adoption of digital health solutions in supporting patient-centred care. It should also encourage appropriate data collection, curation and analysis of health data assets to make the health system more efficient and enhance equity and patient outcomes.



Case study: Northern Health - using The Clinician's digital health platform to expand the Victorian Virtual Emergency Department (VVED) statewide¹⁷⁰

In response to the growing demand for virtual emergency care, The Clinician, a digital health innovator, embarked on a collaborative journey with Northern Health to develop an innovative patient registration and intake platform. This initiative is part of the state-wide expansion of the VVED aimed at providing non-critical emergency care to patients in the comfort of their homes.

Through the deployment of The Clinician's digital health platform, ZEDOC, Northern Health sought to revolutionise patient intake procedures and enhance clinical tracking capabilities, ensuring timely access to virtual emergency care.

Notable features included:

- **Multilingual Support:** The registration form is accessible in 22 different languages, ensuring inclusivity and accessibility for diverse patient populations.
- **SMS Verification:** A secure SMS verification process enhances data accuracy and security.

¹⁷⁰ Australian Institute of Digital Health. Northern health using The Clinician's digital health platform to expand their Victorian Virtual Emergency Department statewide, 2022. Available from: <https://digitalhealth.org.au/blog/northern-health-using-the-clinicians-digital-health-platform/>

- Automated Clinical Tracking: Streamlined processes for real-time tracking of patient progress, reducing administrative overhead.
- Integration with HealthDirect's Telehealth Service: A seamless integration with HealthDirect's telehealth service facilitated smooth transitions between virtual emergency care and additional medical services.

As of the implementation date, over 200 clinical and clerical staff members are actively utilising the ZEDOC platform, both onsite and remotely. The VVED's capacity has increased significantly, from serving 50-60 patients per day to 250 patients per day.

This case study demonstrates how a digitally enabled health solution can play a role in managing demand for virtual emergency care, ensuring that patients receive timely attention and care. It highlights the importance of agile collaboration and the potential of digital health solutions to make Australia's health care system more accessible, safe, and efficient.

5.8.2.2 The role of the Australian Digital Health Agency (ADHA) and the Intergovernmental Agreement (IGA) on National Digital Health

ADHA's purpose is to achieve 'better health for all Australians enabled by seamless, safe, secure digital health services and technologies that provide a range of innovative, easy-to-use tools for both patients and providers'. The role of ADHA should be recognised within the Agreement as a national body, noting the significance of its work in supporting the delivery of a future health system.

Funded by the Commonwealth and the States and Territories in recognition of digital health as a national enterprise, the ADHA has a key role in connecting Australians to a modern healthcare system that ensures they can access the care they need, when and where they need it.

Despite a clear purpose, there is a need for their role and focus to be reinforced in a future Agreement, with the following priorities:

- Commitment to putting patients at the centre of healthcare, empowered with timely, accurate and comprehensive information necessary to participate in their own healthcare
- Recognition of the role of digital health solutions in supporting patient-centred care and advancing the objectives of the NHRA – improving health outcomes, access and innovation
- Acknowledgement and support for the *National Digital Health Strategy* and the *IGA on National Digital Health*, where they advance the objectives and outcomes of the NHRA.
- Commitment to strengthen public hospital support of Commonwealth and cross-jurisdictional digital health initiatives, including the use of My Health Record and Healthcare Identifiers.
- Commitment to implementing the *Interoperability Plan* to achieve a more interoperable Australian health system and support implementation of digitally enabled models of care.

The ADHA regularly interacts with all jurisdictions to achieve a national approach in digital health, including implementing national infrastructure funded under the *IGA on National Digital Health*, and to help harmonise jurisdictional digital health strategies and investments. Incorporating ADHA into the NHRA could leverage its partnerships with jurisdictions to support the digital solutions that will help the Addendum achieve its objectives.

5.8.2.3 Shared commitment to progressing digital health and data sharing

Readily available data informs decision making at the individual, community and national level, contributing to a sustainable health system. The COVID-19 pandemic highlighted the importance of timely and comprehensive data sharing and linkage to manage both crisis situations and ongoing health challenges, including increased demand for data by policy makers, researchers, and the public.

States and Territories hold hospital and many other relevant datasets while the Commonwealth holds MBS and PBS data, together with the Census and other data collections. It is not common practice for these datasets to be linked outside of their individual and specific pricing, costing and compliance functions. Consistent implementation of a unique patient identifier (see Case Study: Health Identifiers Framework) would assist in facilitating agreed and appropriate data linkages across the health system, with benefits for transparency, informed health policy and decision-making and research.



Case study: Health Identifiers Framework

The Commonwealth Government is currently engaged in a project aimed at identifying opportunities for modifications within the Healthcare Identifiers Framework, which encompasses the *Healthcare Identifiers Act 2010*, the *Healthcare Identifiers Regulations 2020*, and the essential policy parameters governing the Healthcare Identifiers Services.

Healthcare Identifiers (HIs) have proven effective in implementing initiatives like My Health Record (MHR) and more recent digital advancements such as electronic prescribing. However, the adoption of HIs in contexts beyond these services has been slow, partially due to legal and operational challenges.

The primary objective of this project is to align the Act and the HI Service to align with Australia's modern healthcare environment. This alignment will facilitate the provision of safe, high-quality healthcare services and enable the fulfilment of current and emerging strategic, policy, program, and operational objectives.

The project seeks to expedite the integration of Australia's health information systems by ensuring that HIs can serve as universal identifiers across healthcare programs and services. This will empower healthcare providers to accurately identify recipients of healthcare and securely transmit health information between healthcare facilities. This transformation is expected to:

- Alleviate the burden on healthcare recipients, as they will no longer need to repeatedly provide crucial health information.
- Provide healthcare providers with access to more comprehensive patient information at the point of care, ultimately enhancing patient outcomes.
- Enhance researchers' capacity to connect and analyse large volumes of de-identified health data regarding outcomes and usage. The outcomes of this research will inform planning and funding decisions, benefiting all Australians.

The HI Framework project is an example of a critical health data initiative that requires national collaboration, coordination, and commitment to overcoming the legal and operational challenges associated with digital health and data sharing.

'Enhanced health data' is a long-term reform (LTR) priority area in the Agreement. This stream aims to ensure that the data generated by Australia's health system drives better health outcomes and delivers effective, safe and efficient health care for all Australians. The *IGA on National Digital Health* is a shared investment commitment between the Commonwealth and the States and Territories that progresses this LTR stream. This commitment and work to date (see Case Study: IGA on National Digital Health) should be reflected in a future Agreement.



Case study: IGA on National Digital Health

The IGA on National Digital Health's purpose is to enable interoperability and connected data across Australia's health care settings to support high quality patient care and improve the efficiency and sustainability of the health care system. It comprises the governance, funding arrangements, and roles and responsibilities of relevant parties to guide future investment, development and implementation of a national approach to digital health, including innovative and technological advances.

The IGA was renewed for four years from 2023-24 to support existing national health infrastructure and commitment by all governments to support the development of national health information exchange (HIE) capabilities that support patients as they transition through care settings. This allows the secure, safe and seamless sharing of health information between all jurisdictions where it is required for healthcare delivery.

A national HIE network of interconnected health information systems will increase access to new and existing sources of health information for a complete picture of an individual to enable the right care, in the right place, through seamless data exchange. The key benefits of a national HIE, being tested through scoping activity, include reduced time spent looking for information, improved continuity of care through a reduction in duplication of tests, potential avoidance of unnecessary hospital admissions, and swifter interventions where the complete data picture is available. These will all lead to improved clinical outcomes and system efficiencies.

The health data landscape and interactions with privacy regimes is complex within jurisdictions and, by extension, across jurisdictions. While there are legislative means that enable data sharing to occur, inconsistencies in legal terminology, organisation culture and risk frameworks often impact the ability to readily share data. Breaches of government and non-government data impact on public trust and the social licence for data sharing. In addition, while data processing in healthcare remains manual and paper-based, the use of robust and up to date data to inform decisions will be impeded.

The *Strengthening Medicare Taskforce* emphasised the need to continue to invest in infrastructure that improves interoperability between systems, simplifies data sharing and access, improves the security and resilience of the health system, and accelerates progress towards a consumer driven health system. These reforms include modernising My Health Record to increase its utilisation and impact, improving health system data connection underpinned by robust national governance and legislation, regulation of clinical software and improved technology, and investing in better health data for research/evaluation of models of care and to support planning.

First Nations' data

Both the *National Agreement on Closing the Gap* and the *National Aboriginal and Torres Strait Islander Health Plan 2021-2031*¹⁷¹ emphasise the importance of First Nations' people having access to, and ownership of, the data that involves and impacts them. Indigenous Data Sovereignty principles should be embedded in the NHRA for the design, collection, use and dissemination of Aboriginal and Torres Strait Islander data.

¹⁷¹ <https://www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-health-plan-2021-2031>

Workforce data

There is an opportunity to initiate structural reform to the way the health workforce is planned and managed through a comprehensive approach to workforce intelligence and governance.

For example, requiring States and Territories to report on the Australian Teaching and Training Classification (ATTC) as a national minimum dataset where current reporting is only on a “best endeavours” basis, would improve transparency and enable improved workforce planning. Agreement across jurisdictions on data, sharing data, and mandatory reporting (as is law in New Zealand) would enable a greater understanding of the TTR environment to make appropriate policy decisions.



Recommendation 40: A future Agreement should include an explicit **commitment to progress digital health as a key enabler to improving the health system**, as an additional Schedule. The Schedule should reflect:

- a) Support and incentivisation for a digitally enabled healthcare system, including integrated funding for evolving models of care.
- b) The role of the Australian Digital Health Agency (ADHA) in progressing digital health.
- c) The *Intergovernmental Agreement (IGA) on National Digital Health 2023-27* and *Connecting Australian Healthcare - National Healthcare Interoperability Plan 2023-28*.
- d) Agreed priorities, roles and responsibilities, and actions to progress digital health, data sharing and data linkage as a foundation to advance effective co-commissioning and optimal models of care.

5.9 Measuring the success of the Agreement

5.9.1 The need for a health system performance framework

The objectives, priorities and shared Commonwealth, State and Territory responsibilities of the NHRA and the Addendum include commitments to improve safety and quality, access, equity, sustainability and efficiency. An existing objective of the Agreement is that all jurisdictions “work in partnership to implement arrangements” to “improve accountability and performance reporting on the health system through the Australian Health Performance Framework (AHPF) and supporting national performance indicators” (clauses 7f and D5a).

In undertaking the Mid-Term Review of the NHRA, it proved very difficult to access a concise set of data able to inform the Review and Governments on how effectively the Agreement was delivering against its objectives. Stakeholders concurred that the absence of a single clear performance framework, an underpinning nationally consistent dataset to support performance reporting and governance and clear lines of accountability, reporting and alignment with decision-making processes, detracted from the effective operation of the Agreement.

5.9.1.1 History

The commitment to a performance and accountability framework able to provide Australians “with information about the performance of their health and hospital services in a way that is nationally consistent and locally relevant”¹⁷² was a feature of the original NHRA. While this commitment has been retained in some form in the Addenda that have followed, there have been changes to roles and responsibilities and governance associated with its delivery that have detracted from achieving its purpose.

Two factors have particularly impacted this:

- Firstly, the 2011 Agreement established and charged the NHPA as an independent Commonwealth statutory authority to provide quarterly reporting on hospital and health system performance, monitor the performance of LHNs, Medicare Locals (now PHNs), develop additional performance indicators as appropriate and maintain the My Hospitals website. The NHPA was further charged with providing comparative analysis and identifying best practice. The NHPA was abolished in 2015 with its functions transferred to the AIHW, ACSQHC and the Commonwealth Department of Health and Aged Care. With this, clarity of roles and responsibilities and lines of accountability were lost.
- Secondly, with the changes to the Commonwealth commitment to funding share and the introduction of a 6.5% national growth cap, the collection and reporting of performance indicators and performance benchmarks, as set out in the *National Health Reform Act 2011*, faltered.

The absence of clear lines of accountability and shared commitment to specific performance indicators and benchmarks, regular reporting and examination of progress against these in a way that can inform policy, and continual refinement and development of indicators to align with health system challenges is detracting from the effective operation of the Agreement.

5.9.1.2 Why does it matter?

An evidence-based, effective way of understanding, monitoring and responding to the performance of Australia’s health system provides the strategic framework in which the NHRA sits. Existing gaps in performance measurement and reporting means there are insufficient mechanisms to measure the implementation and success of the Agreement at both national and jurisdictional levels.

Current performance metrics included in the AHPF for the health system are largely focused on hospital activity, with insufficient reporting on system outcomes, activity and outcomes at the interface between health sectors, and the consumer experience, including for vulnerable populations.

A future Agreement should seek to reinstate the intended purpose of the original Agreement and *National Health Reform Act 2011*, namely to establish a broadly based health system performance framework incorporating quantitative and qualitative indicators that accurately report nationally consistent and locally relevant data on the performance of the Agreement against its objectives and the performance of the health system. This will enable an assessment by Ministers, system managers and the broader public of whether the NHRA is meeting its objectives and is prepared for future challenges.

To be effective this will require the right governance and capabilities, robust business rules and principles, sufficient resourcing, and clear lines of accountability as well as appropriate data linkage and data sharing. Data requirements should be a core element of planning and service development, to ensure that activity and outcomes can be measured, reported and evaluated.

Establishing a health system performance framework along these lines will:

- Support a shared vision and understanding of NHRA and health system performance through development and reporting against nationally consistent performance measures.
- Drive improved performance through collection and analysis of measures and progress towards improvement goals, including mapping progress against the accountabilities of the parties (individual and shared) and those of the national bodies.

¹⁷² Council of Australian Governments. National Health Reform Agreement. Available from: <https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-08/national-agreement.pdf>, page 44



- Potentially reduce low-value care that does not contribute to improved patient outcomes and better manage patient transitions by highlighting variations in practice and outcomes.
- Serve as a basis for comparison and benchmarking for regional differences and inequalities.
- Provide a multifunctional tool that allows monitoring of health system performance, transformation and data to support decision making.

Recommended areas of responsibility for developing the new health system performance framework and reporting against it are:

- As part of negotiating the next Agreement and as a priority, all Health Ministers and their officials should work together to develop a health system performance framework, comprising quantitative and qualitative measures and outcome measures, aligned to the objectives of the new broadly based Health System Agreement. Advice should be sought from the national bodies on measures relevant to their areas of expertise.
- The AIHW would have the primary responsibility for the collection and reporting of national health system performance framework data, including the development of nationally consistent data standards to ensure comparability and consistency of data. IHACPA would retain responsibility for data standards, collection and reporting in relation to cost and cost-related activity data.
- The new National Innovation and Reform Agency would have primary responsibility for advising Health Ministers on the system implications of the reported data and developing innovation and reform ideas in response, for consideration by the parties to the Agreement.

Health performance reporting should be considered at least annually by Health Ministers and should inform a program of shared action and future work. Performance indicators should be implemented in an objective, transparent, and consistent manner, including quality assurance mechanisms, such as stakeholder review and consultation.



Recommendation 41: A broadly based **health system performance framework incorporating quantitative and qualitative indicators and outcome measures** that accurately report against the objectives of the Agreement should be developed as a priority, with clear governance drawing on the expertise of the NHRA national bodies, and with at least annual reporting to Health Ministers on system performance and improvement strategies.



Recommendation 42: The AIHW should be primarily responsible for the development of nationally consistent data standards, data collection and reporting for the health system performance framework, working with jurisdictions and the national bodies, with the new **Innovation and Reform Agency to advise Ministers on potential innovation and reform responses** to the system implications of reported data.

5.9.2 Elements of a Performance Framework

In the absence of an agreed dataset on the performance of the NHRA, an Interim Quantitative NHRA Performance Framework was developed by the Review, as a means of assessing the progress of the Agreement to date against its objectives. This interim framework drew on existing data sourced primarily from AIHW, the Productivity Commission, ACSQHC, IHACPA, NHFB and the Commonwealth Department of Health and Aged Care.

Measures were derived against the six NHRA themes identified in Figure 37.

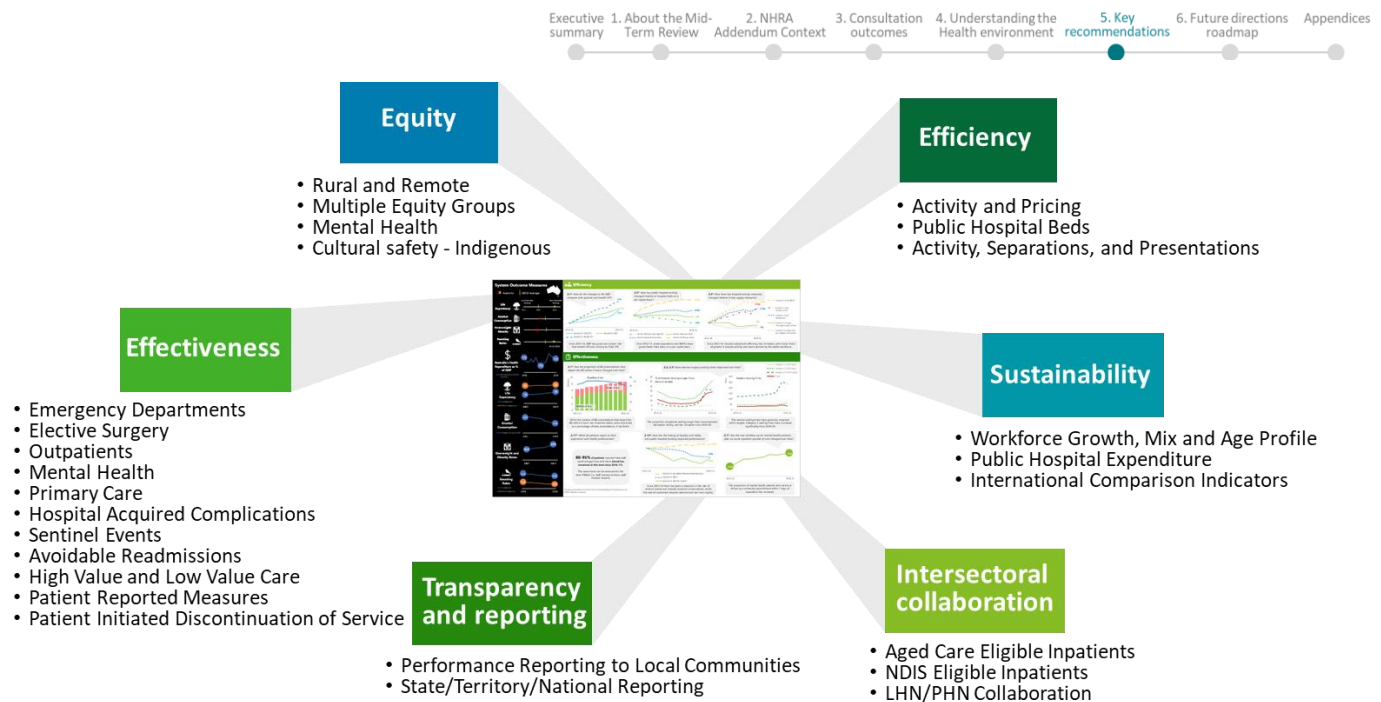


Figure 37: NHRA Interim Quantitative Performance Framework – NHRA objectives and indicator measures

This framework culminated in a two-page Data Placemat developed as part of the Review – refer to Figure 38 below and Appendix I. The Data Placemat sought to provide a snapshot of today's health system performance against the objectives of the NHRA. This performance framework architecture and monitoring is a starting point and should be further built upon and refined to form the health system performance framework described at Recommendation 41, underpinned by readily accessible and shared national data collections.

In developing the Data Placemat, gaps were identified that should be addressed in a future health system performance framework as follows:

- **Outcome Measures:** Much of the data that has been used to measure and report on the health system relates to system inputs and outputs, generally with an activity focus. Measures that capture the outcomes that this activity generates enables greater sophistication in understanding how effectively the system is operating and whether it is achieving the highest value.
- **PREMs / PROMs:** These measures begin to incorporate the importance of patient outcomes in any assessment of health system performance (see Case Study: Patient Reported Indicator Survey). Collecting this data in a more consistent manner will help with continual monitoring of public hospital systems.

Case study: Patient Reported Indicator Survey (PaRIS)

PaRIS is an OECD-led initiative aimed at strengthening the measurement of outcomes and experiences of healthcare services for people living with chronic conditions in primary care. ACSQHC, on behalf of the Commonwealth Department of Health and Aged Care, is the National Program Manager for PaRIS in Australia.

The survey focuses on PREMs, which measure how patients experience health care and refers to practical aspects of care; and PROMs, which measure how patients assess the results of the care they receive. One of the critical dimensions that PaRIS assesses is the coordination of care from the patients' perspective, providing insights to policy makers on integrated care. PaRIS is being rolled out Australia-wide between mid-May 2023 to 31 October 2023, aligned with the OECD timeframe.

- **Quality and Safety:** While there is data available in this area (some of which are included in the Data Placemat), capturing this consistently over time and in a way that enables comparison is important. Clear and consistent guidelines will promote consistent identification of quality and safety events (e.g. Sentinel events).
- **Access block:** A consistent national dataset on the incidence of long stay older and NDIS patients in hospitals by region and cause would assist in establishing baseline measurement and monitoring for interventions designed to reduce access block. Some jurisdictions consider that Hospital Access Targets (HAT) may be a more nuanced set of time-based targets for ED performance. HAT has been adopted by Western Australia, trialled in the Australian Capital Territory, and Tasmania has committed to implementing it by 2023.
- **Workforce:** Whilst there are sources of workforce data, the collection varies by profession and timing. More specific data fields could be collected to better identify changes in public hospital workforce trends. Key workforce data that should be collected consistently include specifying the number of hours or proportion of time a worker spends in the public hospital system, workforce data by age, profession (medical practitioners, nurses, allied health), and rurality. In the process of



developing the Data Placemat, discrepancies were identified between data collections held by AIHW and the Commonwealth Department of Health and Aged Care. These differences should be reconciled in a future health system performance framework.

- **Primary care:** Measures of access to primary care enable a clearer understanding at national and local levels of health system performance. ABS data on reported reasons why people do not access a GP provides an important insight to perceived access barriers and should be collected and reported consistently. In addition, the following data was requested in the development of the Data Placemat. Continued collection of this data as part of the new health system performance framework would be beneficial:
 - Bulk billing rates
 - by age (0 to 16, 16-64, 65+)
 - by State, Territory and National
 - Out of pocket costs (age)
 - by age (0 to 16, 16-64, 65+)
 - by State, Territory and National
 - Out of pocket costs (telehealth)
 - by State, Territory and National
- **Population Health:** Agreeing a consistent national collection to track population health trends and outcomes over time would assist to create stronger understanding of health system challenges.

To establish a common and consistent health system performance framework, some existing challenges need to be accounted for and overcome, for example:

- Consistent definition of inputs (e.g. data type).
- Recognition that the scope of indicators should relate not only to public hospitals but also to intersectoral collaboration such as primary care, aged care, disability support, *Closing the Gap* and other priority groups with lower access.
- Agreement of performance measurement business rules.
- Agreement of reporting structures.
- Consistent application of reporting at jurisdictional and national levels (e.g. the jurisdictions agree that their submitted data to national bodies has been interpreted and applied correctly).
- Agreement on the reporting turnaround timeframe between service delivered and data available (to reduce any potential reporting time lag).

A future health system performance framework (within a new Agreement) should also drive and measure innovation.

Country comparisons of Performance, Monitoring, and Improvement Systems are provided in Appendix J.



Case study: OECD Health System Performance Assessment (HSPA) Frameworks – establishment and implementation in Estonia

HSPA frameworks have been developed and used increasingly across countries and regions, to bring together stakeholders in the health sector to share common objectives and to support their work towards better health system performance. The OECD HSPA framework states that this type of Framework should:

- Be comprehensive, encompassing all aspects of the system and its performance.
- Incorporate both quantitative and qualitative indicators.
- Be able to serve as a basis for comparison and benchmarking, as well as for monitoring regional differences and inequalities.
- Be regularly updated to reflect the latest research, data and methodology, which requires an iterative process to ensure the right indicators are reported.
- Be flexible enough to adapt to changing circumstances, such as technological advances and changing population and health needs.
- Be implemented in an objective, transparent, and consistent manner.
- Include quality assurance mechanisms, such as stakeholder review and consultation.

In 2021, the Ministry of Social Affairs of Estonia, alongside key representatives within the Estonian health system, the OECD, and European Commission, embarked on a process of developing a national HSPA framework.

The Estonian HSPA framework is composed of 18 domains grouped into 5 areas of health status, outcomes, processes, structures, and cross-cutting themes. The framework highlights the main policy direction of the Estonian health system to become more person-centred, and embeds equity, efficiency, and resilience into all domains.

The selection process of indicators assessed both their fitness-for-use (data availability and readiness), and fitness-for-purpose (relevance for policy priorities and for HSPA purpose), along with their benchmarking possibilities for international and regional comparison.

The implementation and daily use of HSPA will be facilitated by a three-part governance structure, with clearly assigned roles and responsibilities to the key organisations. The HSPA Advisory Board involves main health system stakeholders and is

tasked with the overall oversight and HSPA stewardship role. The Co-ordination Board, led by the Ministry of Social Affairs, will be complemented by Task Force, led by the National Institute for Health Development.



Recommendation 43: The health system performance framework should be accompanied with a shared commitment to:

- a) Being developed as an **immediate priority**, in order to take effect from the start of a new Agreement, with an agreed timeframe to move to nationally consistent measurement and reporting as soon as possible.
- b) Include indicators that focus not only on quantitative and qualitative performance of public hospitals, but also on the outcomes that are achieved, the interface with the broader health system such as prevention/health promotion, primary care access, aged care transition, disability support transition, Closing the Gap indicators, rural and remote access, and adequacy and distribution of the health workforce as well as patient experience and reported outcome measures.

NHRA MTR and NHRA Interim Quantitative Performance Framework Data Placemat (double-sided)

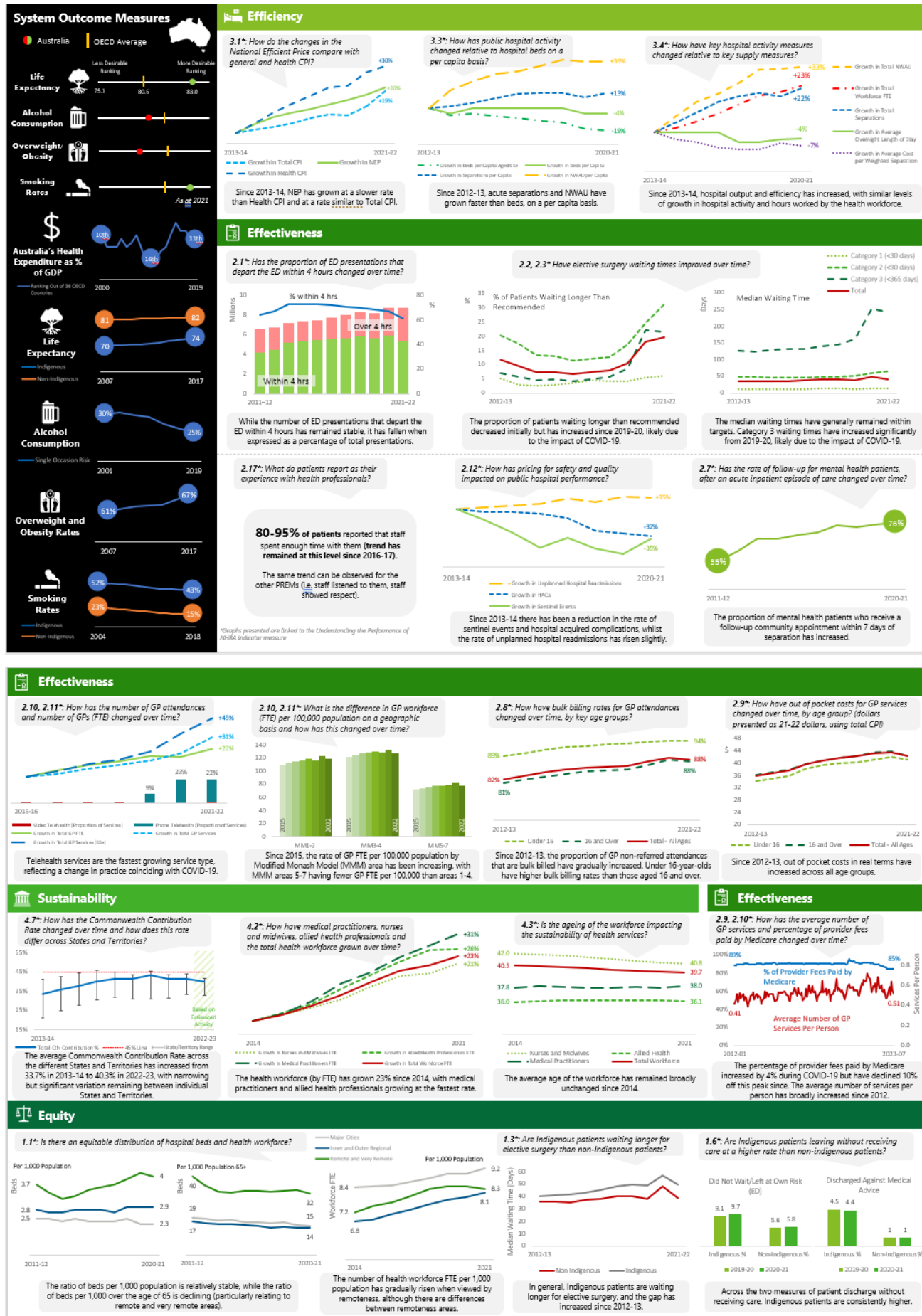


Figure 38: NHRA Interim Quantitative Performance Framework Data Placemat

5.10 Learning from COVID-19 and preparing for future events



The COVID-19 pandemic highlighted a lack of flexibility and agility in the NHRA to manage major disruptions to the health system, requiring bespoke arrangements to be put in place. That said, these arrangements were put in place quickly at the start of the pandemic and supported the continued operation of the health system during that period.

The pandemic significantly increased volatility in public hospital activity attributed to the direct effects of COVID-19 on healthcare demand, the need to maintain standby capability for COVID-19 cases, and workforce limitations caused by staff being furloughed. The average daily ED presentations categorised as resuscitation, urgent, and emergency have slightly increased since 2019-20¹⁷³, and there are reported backlogs in elective surgery¹⁷⁴ and specialist outpatient services, though underlying volatility in the data during the periods of COVID-19 lockdowns makes it hard to identify long-term trends.

As noted, the NHRA could not adapt easily to the change in the volume and nature of public hospital activity related to COVID-19 and required separate agreements to be put in place. In particular, the current base plus growth model is not sufficiently responsive to accommodate periods of rapid volatility in the system. The three-year lag in cost data underpinning the NEP and NEC means that real-time cost increases related to COVID-19, inflationary pressure, supply chain costs and wages growth, are not reflected for some time in the price/funding provided through the NHRA, putting significant pressure on State and Territory budgets. Section 5.4.2.2 details recommendations for improving the responsiveness of the NEP determination.

States and Territories noted in consultation the substantial and enduring costs of COVID-19 related to increases in health service costs, additional expenses for personal protective equipment, more extensive cleaning protocols, and COVID-19 testing and screening for patients and visitors. In addition, many jurisdictions and health practitioner groups cited increased demand for elective surgery and an increase in the acuity of patients when they present, related to deferred care. These demand and cost factors have increased pressure on public hospitals, with many stakeholders of the view that this is unlikely to change in the foreseeable future.



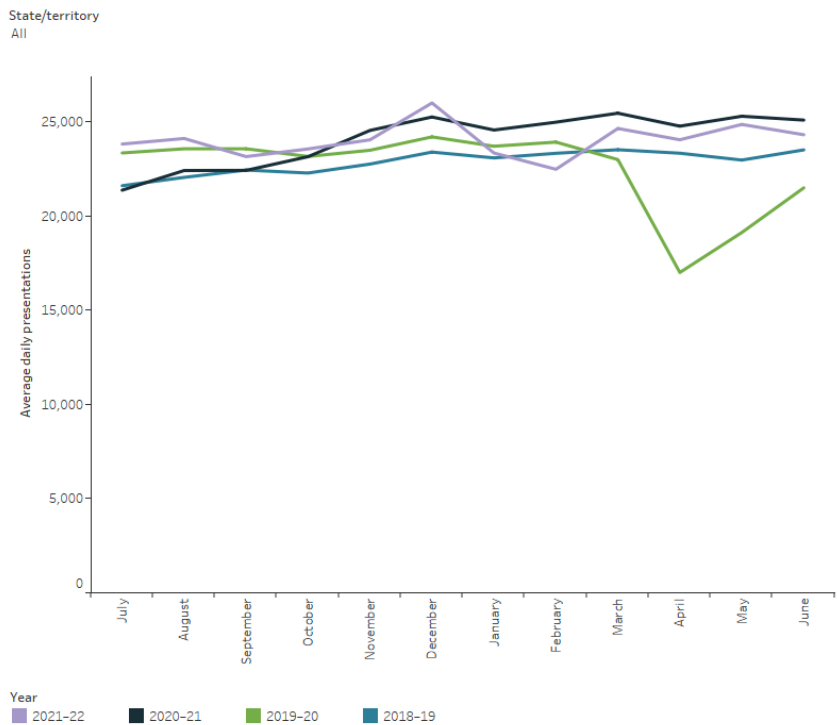
Case study: COVID-19 impact on ED activity

In 2019–20, 2020–21 and 2021–22, ED activity was influenced by COVID-19 restrictions and changes in healthcare provision starting in February 2020. Some jurisdictions established COVID-19 fever clinics within EDs during 2020–21, contributing to significant increases in ED activity observed between 2019–20 and 2020–21¹⁷⁵.

Before COVID-19, from 2014–15 to 2018–19, there was an average annual increase of 3.2% in ED presentations. With the initial outbreak of COVID-19 in 2019–20, ED presentations decreased by 1.4% compared to 2018–19¹⁷⁵. Between 2019–20 and 2020–21, ED presentations rebounded with a 6.9% increase. ED presentations remained relatively stable between 2020–21 and 2021–22, decreasing by only 0.2%. From February 2022, there was a steady increase in daily ED presentations to the end of June 2022.

Refer to Figure 39.¹⁷⁶

Average daily presentations to emergency departments, by month, all states and territories, 2018-19 to 2021-22



Source: AIHW National Non-admitted Patient Emergency Department Care Database

Figure 39: Average daily presentations to ED, by month, all States and Territories, 2018-19 to 2021-22

¹⁷³ Australian Institute of Health and Welfare. Emergency department care activity, 2023. Available from: <https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/ed>

¹⁷⁴ Australian Institute of Health and Welfare. Elective surgery activity, 2023. Available from: <https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/eswt>

¹⁷⁵ Australian Institute of Health and Welfare. Emergency department care activity, 2023. Available from: <https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/ed>

¹⁷⁶ <https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/ed>

5.10.1 Increase flexibility in funding arrangements to enable rapid response to future system disruptions

Despite a lack of flexibility in the NHRA to respond to major system disruptions, governments moved quickly at the onset of COVID-19 to establish two funding arrangements:

- The **Minimum Funding Guarantee (MFG)** (\$1.23 billion provided) guaranteed a baseline Commonwealth public hospital funding amount even if the usual amount and complexity of hospital activity decreased due to the pandemic; and
- The **COVID-19 NPA** (\$14.7 billion provided) provided additional Commonwealth funding, generally matched on a 50:50 basis by the States and Territories, for targeted COVID-19 response programs including but not limited to public hospitals (refer to section 2.8 for further information).

The COVID-19 NPA gave States and Territories flexibility to fund various models of care and made it easier to coordinate initiatives that crossed traditional boundaries between acute care and primary care, aged care and disability sectors. Additionally, the COVID-19 NPA supported States and Territories in contracting private hospitals to increase capacity to respond to the pandemic. This flexibility in using hospital capacity across the entire system helped meet demand and optimise the workforce, medical equipment and bed capacity.

While the existing NHRA architecture supported delivery of new funding arrangements in response to the pandemic, there were challenges in operationalising and managing them. This included issues with:

- the requirement for quarterly reconciliation of NPA payments
- quarantine and border control costs
- determining the level of contribution for the Vaccination Dose Delivery Payment
- differing interpretations of activity reporting requirements across jurisdictions.

A number of jurisdictions have raised the importance of fully understanding the way in which the NHRA, the MFG and COVID-19 NPA were developed and implemented, including any long term impacts to the NHRA funding model when the MFG and COVID-19 NPA ceased.



Case study: Impact of the Minimum Funding Guarantee (MFG) on ABF base funding

The Commonwealth established the MFG from 2019-20 to 2021-22 to underwrite hospital funding during the COVID-19 pandemic, effectively guaranteeing funding equivalent to pre-pandemic forecasts of activity for those years.

The way in which the MFG was applied was to create an artificial level of activity for 2019-20, 2020-21 and 2021-22, equivalent to the level of the funding guarantee. \$1.23 billion in funding was distributed to the States and Territories through the MFG.

For 2022-23, the first year after the end of the MFG, the artificial level of activity created by the MFG for 2021-22 has been used to calculate the growth in activity that occurred in that year, driving the level of Commonwealth funding. Some State and Territories have identified that this could result in a reduction in funding compared to an alternative potential scenario where their actual (lower) activity in 2021-22 was used as the base for calculating growth purposes. Should it occur, this reduction in funding would negatively impact a State or Territory's financial sustainability and is an example of how a sensible short term arrangement may have, or be seen to have, unanticipated long term impacts.

There is value in the Commonwealth, States and Territories collaboratively identifying the lessons from COVID-19 funding arrangements and agreeing how a future NHRA can be more responsive to future system disruptions and more effectively manage the transition back to normalised arrangements. This work, drawing on the submissions and case studies provided to this Review, should occur as part of negotiating a future Agreement, in order to inform future preparedness. These lessons should also be informed by the forthcoming Independent Inquiry into Australia's response to the COVID-19 pandemic.¹⁷⁷

A future NHRA should clarify the roles of Commonwealth, State and Territory governments in managing major health system disruptions. It should establish principles for expanding surge capacity and determining cost-sharing arrangements. Pre-agreed principles and processes for funding public health responses to future disruptions will enable more rapid establishment and smoother implementation. Refer to section 5.4.4.2 for further information on the transparency of public health funding.

Furthermore, the Australian government's commitment to establish an Australian Centre for Disease Control (CDC) presents an opportunity to streamline funding for public health activities. The CDC's scope will include preventive health elements that may be relevant to Clauses 21(a) and (b) of the NHRA. It is also likely there will be additional Commonwealth-State and Territory arrangements negotiated in line with the CDC establishment that may impact the NHRA. The commitment of all jurisdictions to the CDC presents an opportunity to ensure that funding for public health activities, including health protection, health promotion and preventive health initiatives, is used efficiently and is transparent. The CDC's role in addressing emerging issues, including both communicable and non-communicable disease, in the health system should be reflected in a future NHRA.

¹⁷⁷ Prime Minister of Australia. Improving Future Preparedness: Inquiry Into The Response To The COVID-19 Pandemic. Available from: <https://www.pm.gov.au/media/improving-future-preparedness-inquiry-response-covid-19-pandemic>



Recommendation 44: In relation to **future system disruptions**, a future NHRA should:

- a) Set out the principles and processes to establish **time-limited funding arrangements to respond to short-term national emergencies**, the circumstances in which these would be triggered and map the transition back to usual arrangements. These principles, processes and transitions should be informed by coordinated Commonwealth, State and Territory consideration of the experience and lessons of the COVID-19 pandemic including the Independent Inquiry into Australia’s Response to the COVID-19 Pandemic.
- b) Be informed by the Australian Centre for Disease Control and other related national bodies’ advice and guidance regarding public health actions aimed at addressing disruptions to the health care system.

5.10.2 Support health system recovery from the ongoing impacts of COVID-19

The longer-term effects of COVID-19 require monitoring and consideration, including management of increased mental health demand, the impact of delayed diagnosis both on demand and acuity, emerging effects of long-COVID and any backlogs in planned surgery. The NHRA currently lacks the capacity to accelerate activity in response to system demand. The operation of the growth cap is a constraint, as is available workforce.

While the COVID-19 NPA was extended several times, when it did expire on 31 December 2022, there were no transitional arrangements put in place. Consequently, activities that were previously funded under the COVID-19 NPA are currently funded through the NHRA (at a Commonwealth Contribution Rate of 45%) and count towards the 6.5% growth cap. As noted, the NEP lags behind the current costs of providing services due to the time it takes for cost data to translate to the NEP (refer to section 5.4.2.2).

States and Territories have reported that the cessation of the MFG from 2022-23 has shifted a significant financial burden onto them, given the 6.5% cap on national funding growth remains in place but the ongoing COVID-19 impacts have not dissipated.

The acuity of ED presentations due to delayed care and any backlog in elective surgeries will place additional demand on the health care system. As the costs related to increased ED presentations rise, States and Territories have advised that the only area where can limit their activity is elective surgery.

The Agreement should outline a shared commitment to collaborative strategies to address the ongoing impacts of COVID-19 on workforce availability, increased health service costs, increasing disease burden and the effects of delayed care on ED and elective surgery performance.

“COVID-19 has resulted in increased cost of service provision that is expected to endure. Hospitals have adapted to COVID-19 by changing patient movement and journeys, the use of PPE, cleaning procedures and how patients are grouped together.”



Case study: Increasing wait times for elective surgery

From 2019-2022, wait times for elective surgery increased significantly due to the COVID-19 restrictions on performing elective surgery and the resultant elective surgery backlog. The average proportion of patients waiting longer than the clinically recommended time for elective surgery, across all categories, doubled in 2021-22 with an increase to 19.5% (refer to Figure 40¹⁷⁸).

Enduring impacts are hard to forecast. However, based on the data in Figure 40, there was an upward trend in Category 2 and 3 patients and in the average wait time.

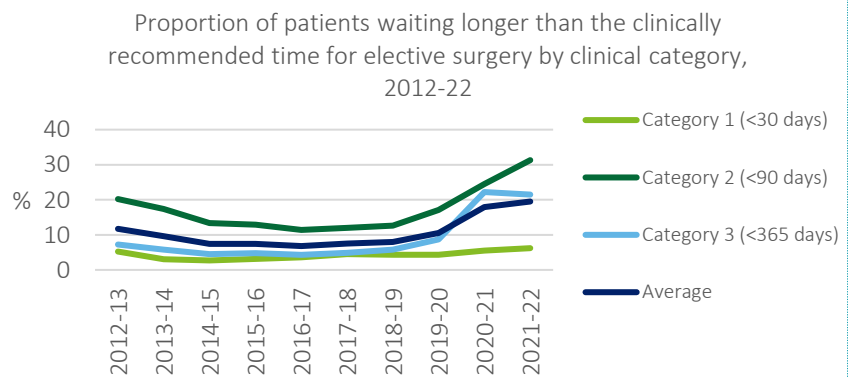


Figure 40: Proportion of patients waiting longer than the clinically recommended time for elective surgery by clinical category, 2012-22

¹⁷⁸ Australian Institute of Health and Welfare. Elective surgery waiting times, 2022. Available from: <https://myhospitalsapi.aihw.gov.au/api/v1/measure-downloads/myh-es>



Recommendation 45: A recovery plan should be agreed for the remainder of the 2020-25 Addendum to address the ongoing impacts of COVID-19 on workforce availability, cost escalation, increased disease burden and the backlog of delayed care. An option that should be considered is to exempt elective surgery activity (all or part) from the growth cap for the period to the end of the current Agreement, to reduce elective surgery backlogs.

5.11 Technical amendments of the Agreement (not addressed elsewhere)

There are a range of technical amendments required to the Agreement in the future that are not addressed elsewhere in the report, provided in Table 5.

Table 5: Technical amendments of the Agreement (not addressed elsewhere in the report)

Issue	Comment
'Grandfathering' of services at particular hospitals	Clause A24 in conjunction with Clause A17 enables 'grandfathering' of services at particular hospitals so they are eligible for Commonwealth funding. This is because of pre-NHRA arrangements that permitted them to be funded as public hospital services. This embeds a level of inequity between jurisdictions and between LHNs within jurisdictions. A review of its application and consistency is required (links to Recommendation 12).
Nationally Funded Centres (NFCs)	Clause A187 and NFCs was not identified as a high priority concern by stakeholders (among the other items identified), however some stakeholders stated its operation and arrangements remained unresolved many years later despite significant investigation of the issue. Services such as NFCs are at risk of systematic under-pricing through the existing national pricing model. It may require additional data collections and feasibility studies to assess and determine an agreed way forward, in which case obligations on Parties to support and enable development of new models would be required.
People who do not reside in one of the eight self-governing States or Territories	Review the incomplete and inconsistent categorisation of some cohorts of patients, such as people who do not reside in one of the eight self-governing States or Territories. Further understanding is needed of how many patients this relates to, their circumstances and impact to public hospital services.
Consistent definition of compensable patients	"Compensable patients" is not defined in Commonwealth legislation but instead there are State and Territory-specific definitions (for example, some States and Territories consider Australian Defence Force personnel to be compensable patients). Consistency and clarity is required for a national funding basis.
Patient policies	Given the legacy of differing policy interpretation and practice, consideration could be given to how the NHRA and its Business Rules, could better reflect a shared understanding of the intent of the operation of certain items such as the circumstances under which patient charges can be levied and the operation of Clause G21 (non-admitted services provided by GPs to private patients).

6 Future directions roadmap

This chapter provides a pathway to reform with a horizon timeframe of next steps.

The Review, conducted at the mid-point of the 2020-2025 NHRA Addendum, has developed a set of recommendations intended both to inform and guide the remainder of the Addendum period as well as present options for future reform and Agreements.

At a broad level, the Review's forty-five recommendations can be grouped into five streams of activity as detailed in Figure 41, spanning governance, models of care, funding reform, performance and enablers.

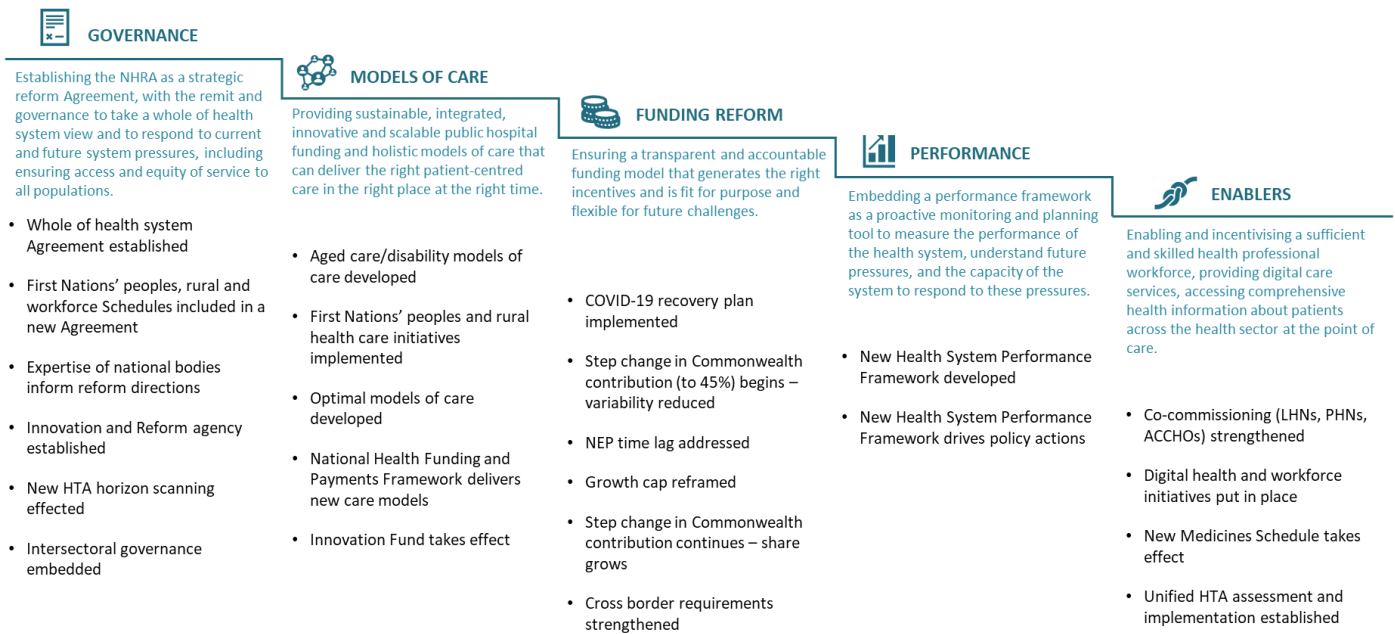


Figure 41: Overarching strategic implementation

While initiatives across each of these streams will take time to develop and implement, it is important that this work begins as soon as possible, to enable a new Agreement to be fully operational from its commencement date, in particular:

- establishing the governance settings and framing of a new whole of Health System Agreement
- conducting early work on developing new models of care and the National Health Funding and Payments Framework, and
- agreeing a new performance framework that can take effect from the start of a new Agreement.

Further, there are recommendations that would enhance the operation of the current Agreement while negotiations are underway, notably:

- agreeing a recovery plan for ongoing impacts of COVID-19, and
- putting in place short term arrangements to expedite transition of older patients and NDIS participants from the acute setting once their clinical episode is complete.

Figure 42 on the following page sets out a proposed implementation roadmap for all recommendations across these five work streams in three time horizons: to the end of the current Addendum where there is potential for quick wins and preparatory work; and two tranches of a new Agreement (early and later). The roadmap differentiates between the requirement for development work and proposed timing of implementation.



(D) = Development (I) = Implementation (IS) = Initial Step

	1 QUICK WINS/PREPARATION (to end of current Addendum)	2 NEW AGREEMENT (Years 1-3)	3 NEW AGREEMENT (Years 3-5)
Governance	<ul style="list-style-type: none"> 2 Audit of existing health related agreements (Cwlth and S&Ts) 3 Mental health actions 29 Horizon scanning for high-cost, highly specialised therapies 32 Program of action on long-term health reform areas 33 Renewed focus on prevention activities 34 (D) Innovation and reform agency and Innovation Fund 37 Section 19(2) Exemptions simplified and expanded 	<ul style="list-style-type: none"> 1 Single collaborative health system Agreement 4 Medicare principles – processes and reporting 5 Update governance references in NHRA 6 Architecture of national bodies 34 (I) Innovation and reform agency and Innovation Fund 35 Roles and responsibilities of rural and remote health care provision 36 Rural and remote reflected in new Schedule 38 First Nations' peoples through Closing the Gap reflected in new Schedule 	
Models of care	<ul style="list-style-type: none"> 9 (D) Collaboration between Aged Care and public hospitals – early actions 10 Transition out of hospital to home of people with a disability 11 (IS) Development of optimal models of care 12 (D) Scope of public hospital services reviewed and broadened 16 (D) 10-year National Health Funding and Payments Framework 	<ul style="list-style-type: none"> 9 (I) Collaboration between Aged Care and public hospitals 11 (D) Development of optimal models of care 12 (I) Scope of public hospital services reviewed and broadened 13 Develop and implement bundled payments (initial focus on maternity care) 14 (D) Pricing approaches that reward high value care and penalise low value care 15 Retaining and strengthening safety and quality reforms 16 (I) 10-year National Health Funding and Payments Framework 	<ul style="list-style-type: none"> 11 (I) Development of optimal models of care 14 (I) Pricing approaches that reward high value care and penalise low value care
Funding reform	<ul style="list-style-type: none"> 17 Retain ABF 18 Review NEP calculation to reduce complexity 19 Identify options for use of more recent activity / cost data 25 Retain block funding arrangements 44 Future system disruption planning 45 Recovery plan for ongoing impacts of COVID-19 	<ul style="list-style-type: none"> 20 Cross-border principles augmented 21 Determining funding neutrality for private patients in public hospitals 22 (IS) New funding model to increase Cwlth contribution to 45% of nationally efficient public hospital activity 23 (D) Freed up State funds redirected to innovation 24 Reframe 6.5% national funding cap to activity cap alone 	<ul style="list-style-type: none"> 22 (I) New funding model to increase Cwlth contribution to 45% of nationally efficient public hospital activity 23 (I) Freed up State funds redirected to innovation 26 Transparency in Teaching and Training funding and investments 27 Transparency and reporting on Public Health funding
Performance	<ul style="list-style-type: none"> 41 (D) Health System Performance Framework 	<ul style="list-style-type: none"> 41 (I) Health System Performance Framework 42 Framework responsibility with AIHW & new Innovation and Reform Agency 43 (D) Framework shared commitment for development and indicators 	<ul style="list-style-type: none"> 40 (I) Framework shared commitment for development and indicators
Enablers	<ul style="list-style-type: none"> 7 (D) Intersectoral architecture (PHNs, LHNs and ACCHOs) 8 (D) Primary care interface 	<ul style="list-style-type: none"> 7 (I) Intersectoral architecture (PHNs, LHNs and ACCHOs) 8 (I) Primary care interface 28 Nationally consistent access to medicines 30 (D) Unified national HTA process for high-cost, highly specialised therapies 31 (D) Cost consistency & cross-model approach for unified HTA framework 39 Role of the health workforce reflected in new Schedule 40 Digital Health reflected in new Schedule 	<ul style="list-style-type: none"> 30 (I) Unified national HTA process for high-cost, highly specialised therapies 31 (I) Cost consistency & cross-model approach for unified HTA framework

Figure 42: Recommendation implementation timeline

Appendix A Glossary

Table 6: Glossary

Acronym	Full name	Acronym	Full name
ABF	Activity Based Funding	HAC	Hospital Acquired Complications
ABS	Australian Bureau of Statistics	HAT	Hospital Access Target
ACAT	Aged Care Assessment Team	HCEF	Health Chief Executives Forum
ACCHO	Aboriginal Community Controlled Health Organisation	HIE	Health Information Exchange
ACCPA	Aged and Community Care Providers Association	HIV	Human Immunodeficiency Virus
ACRRM	Australian College of Rural and Remote Medicine	HMM	Health Ministers Meeting
ACSQHC	Australian Commission on Safety and Quality in Health Care	HSD	Highly Specialised Drugs
Administrator	Administrator of the National Health Funding Pool	HSPA	Health System Performance Assessment
AGPT	Australian General Practice Training Program	HTA	Health Technology Assessment
Agreement	National Health Reform Agreement	ICT	Information and communications technology
AHDA	The Australian Digital Health Agency	IDEAS	Integrated Diabetes Education and Assessment Service
AHMAC	Australian Health Ministers Advisory Committee	IGA	Intergovernmental Agreement
AHPF	Australian Health Performance Framework	IHACPA	Independent Hospital and Aged Care Pricing Authority
AHPRA	Australian Health Practitioner Regulation Agency	IHPA	Independent Hospital Pricing Authority (now IHACPA)
AIHW	Australian Institute of Health and Welfare	IMOC	Innovative Models of Care
AIR	Australian Immunisation Register	KPI	Key Performance Indicator
AN-ACC	Australian National Aged Care Classification	LHD	Local Hospital District
ANAO	Australian National Audit Office	LHN	Local Hospital Network
APRA	Australian Prudential Regulation Authority	LSOP	Long stay older patients
ATTC	Australian Teaching and Training Classification	LTR	Long Term (Health) Reform
BEACH	Bettering the Evaluation and Care or Health	MABEL	Medicine in Australia – Balancing Employment and Life
BRAMS	Broome Regional Medical Service	MADIP	Multi-Agency Data Integration Project
CALD	Culturally and linguistically diverse	MBS	Medicare Benefits Schedule
CCM	Commonwealth Contribution Model	MFG	Minimum Funding Guarantee
CCR	Commonwealth Contribution Rate	MSAC	Medical Services Advisory Committee
CDC	Centre for Disease Control	NDIS	National Disability Insurance Scheme
CEO	Chief Executive Officer	NEC	National Efficient Cost
CHC	COAG Health Council	NEP	National Efficient Price
COAG	Council of Australian Governments	NFC	Nationally Funded Centre
COPD	chronic obstructive pulmonary disease	NHCDC	National Hospital Cost Data Collection
CQRs	Clinical quality registries	NHFB	National Health Funding Body
ED	Emergency Department	NHFP	National Health Funding Pool
EMR	Electronic Medical Records	NHPA	National Health Performance Authority
GDP	Gross Domestic Product	NHRA	National Health Reform Agreement
GP	General Practice	NHS	National Health Service

Acronym	Full name	Acronym	Full name
NMP	National Medicines Policy	RADAR RR	Residential Aged Care District Assessment and Referral Rapid Response
NPA	National Partnership Agreement	Review	Mid-Term Review
NWAU	National Weighted Activity Unit	RG	Rural Generalist
OECD	Organisation for Economic Co-operation and Development	RIG	Reform Implementation Group
OTDA	Organ and Tissue Donation Authority	RWA	Rural Workforce Agencies
PaRIS	Patient Reported Indicator Survey	SAVCS	South Australian Virtual Care Services
PBAC	Pharmaceutical Benefits Advisory Committee	SEM	Single Employer Model
PBS	Pharmaceutical Benefits Scheme	SMF	State Managed Fund
PHC	Primary Health Care	SPP	Specific Purpose Payment
PHI	Private Health Insurance	TCP	Transition Care Program
PHN	Primary Health Network	TGA	Therapeutic Goods Administration
Pool	National Health Funding Pool	ToR	Terms of reference
PPH	Potentially preventable hospitalisation	TORCH	Torres and Cape Health Care
PRA	Pharmaceutical Reform Arrangement	TTR	Teaching, Training and Research
PRIMM	Primary Care Rural Innovative Multidisciplinary Models	VC-RPM	Virtual Care – Remote Patient Monitoring
PROMs	Patient Reported Outcome Measures	VMO	Visiting Medical Officer
QAS	Queensland Ambulance Service	VVED	Victorian Virtual Emergency Department
RACF	Residential Aged Care Facilities	WAVED	WA Virtual Emergency Department
RADAR	Residential Aged Care District Assessment and Referral		

Appendix B Terms of Reference

Table 7: Review's Terms of Reference

Preliminary clause	Inclusions
21.a) implementation of the long-term reforms and other governance and funding arrangements, and whether practice and policy in place delivers on the objectives of the Addendum	<ul style="list-style-type: none"> Whether health and emergency services delivered through the public hospital system are being provided consistent with the Medicare Principles of: <ul style="list-style-type: none"> Eligible persons must be given the choice to receive public hospitals services free of charge as public patients; Access to public hospital services is to be on the basis of clinical need and within a clinically appropriate period; Arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic locations Focus and progress of the long-term reforms and systems interface reforms, including: <ul style="list-style-type: none"> changes to scope and the impact of COVID-19 on progress and reform priorities interactions with other reforms and agreements in mental health, aged care, primary care, and disability systems, and opportunities to recontextualise reform priorities promoting equitable access to high quality health care and reducing disadvantage for all Australians, including for Aboriginal and Torres Strait Islander people and those living in regional and remote areas Changes to national governance and the impact on governance and decision-making related to Addendum oversight and implementation Impact and effectiveness of policy changes implemented through the Addendum Implementation of funding arrangements including: <ul style="list-style-type: none"> NEP, NEC, ABF price and volume setting, the national cap, data matching and the interaction with S19(2) adjustments to the funding model implemented in the Addendum (including private patient neutrality), including whether adjustments added over time have enabled policy intent to be met or have otherwise impacted the purpose of each added signal administrative requirements on jurisdictions to meet obligations of the funding model over time compared to impacts on efficiency and outcomes Implementation of safety and quality pricing adjustments and whether they have achieved the policy intent, including whether they have a material impact on the ground, and whether there are other opportunities to achieve the policy intent The effectiveness of existing reporting metrics in measuring whether the Addendum is meeting its objectives, including the timeliness, transparency, and national consistency of these metrics The effectiveness of mechanisms supporting PHNs and LHNs to collaborate to improve responsiveness to local community needs in accordance with the objectives of the Addendum.
21.b) the impact of external factors on the demand for hospital services and the flow-on effects on Addendum parameters	<ul style="list-style-type: none"> Impact of COVID-19 on hospital demand and flow-on effects to the funding model under the Addendum, including impact on long-term trends (including transition to 'COVID-normal'), NEP, NPCR, funding guarantee, and how flexibility and agility could be incorporated into the model and future agreements Flow-on effect of COVID-19 on Addendum public health funding Availability of services and supports outside the hospital system that impact on ongoing demand and the ability to appropriately discharge in a timely manner Impact of remoteness and isolation on demand for hospital services Changes in primary care reform and with primary care demand, capacity and capability over time, and any impact on the Addendum meetings its objectives Changes in the aged care and disability sectors over time, and any impact on the Addendum meetings its objectives Changes in the health workforce over time, and any impact on the Addendum meetings its objectives Changes in other parts of the health care sector, such as public health and mental health, or other sectors that may impact on the Addendum meetings its objectives Consideration of risk sharing between the Commonwealth, States and Territories when volatility occurs in the health system
21.c) for small rural and small regional hospitals, whether they continue to meet the block funding criteria determined by the IHPA	<ul style="list-style-type: none"> Challenges faced by these hospitals with volatility in volume due to COVID Any alternatives to block funding that may better meet the needs of small rural and small regional hospitals, with consideration given to the reporting requirements associated with any alternatives



Preliminary clause	Inclusions
21.d) whether any unintended consequences such as cost-shifting, perverse incentives or other inefficiencies that impact on patient outcomes have arisen, and the capacity of Parties to adopt and deliver innovative models, as a result of financial and other arrangements in this Addendum	<ul style="list-style-type: none"> Any impact from the 6.5% cap on the Addendum meeting its objectives Changes in demand, capacity, and capability in the wider health system and any impact on the Addendum meeting its objectives The suitability of the definition of public hospital services under the Addendum and the way in which decisions are made regarding what meets the definition The extent to which private patient election is made on the basis of informed financial consent
21.e) the performance of the national bodies against their functions, roles and responsibilities	<ul style="list-style-type: none"> Any impact from the 6.5% cap on the Addendum meeting its objectives Changes in demand, capacity, and capability in the wider health system and any impact on the Addendum meeting its objectives The suitability of the definition of public hospital services under the Addendum and the way in which decisions are made regarding what meets the definition The extent to which private patient election is made on the basis of informed financial consent
21.f) arrangements for approval and funding of high cost therapies offered in public hospitals, as outlined in Schedule C (Clauses C11 and C12) and Appendix B	<ul style="list-style-type: none"> Review of implementation of high-cost therapies and MSAC decision making as it applies to the Addendum, including treatment setting, and whether this has resulted in any unintended consequences
21.g) other matters as agreed by HMM (formerly CHC) or National Cabinet (formerly COAG)	<ul style="list-style-type: none"> In addition to matters that may be referred by HMM or National Cabinet, consideration will be given to the First Secretaries Group Improving Care Pathways project which is focused on the practical improvements to aspects of health system interfaces occurring over the next 12 months, rather than the longer term, funding, and reform arrangements for health systems interface issues in the Addendum. The Review should acknowledge this work and avoid duplicate recommendations.

Appendix C Reference documents

Some of the documents that were referred to and utilised during the Review include:

- Administrator National Health Funding Pool. Annual Report 2021-22. Available from: <https://www.publichospitalfunding.gov.au/publications/national-health-funding-pool-annual-report-2021-22>
- Administrator National Health Funding Pool. National Health Reform Funding by source. Available from: <https://www.publichospitalfunding.gov.au/public-hospital-funding-reports>
- Australian Bureau of Statistics. Consumer Price Index (Health CPI, Total CPI series). Available from: <https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia>
- Australian Commission on Safety and Quality in Health Care. Annual Report 2021-22. Available from: <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/acsqhc-annual-report-2021-22>
- Australian Commission on Safety and Quality in Health Care. The Fourth Atlas. Available from: https://www.safetyandquality.gov.au/sites/default/files/2021-04/The%20Fourth%20Australian%20Atlas%20of%20Healthcare%20Variation%202021_Full%20publication.pdf
- Australian Institute of Health and Welfare. Annual Report. Available from: <https://www.aihw.gov.au/reports/corporate-publications/annual-report-2021-22/contents/summary>
- Australian Institute of Health and Welfare. Health Performance Framework. Available from: <https://www.aihw.gov.au/reports-data/indicators/australias-health-performance-framework>
- Australian Institute of Health and Welfare. Health workforce. Available from: <https://www.aihw.gov.au/reports/workforce/health-workforce>
- Australian Institute of Health and Welfare. Australia's hospitals at a glance, Hospital activity. Available from: <https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance/contents/hospital-activity>
- Australian Institute of Health and Welfare. Health Expenditure Australia 2020-21. Available from: <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2020-21/contents/about>
- Australian Institute of Health and Welfare. Admitted patient safety and quality. Available from: <https://www.aihw.gov.au/reports-data/myhospitals/intersection/quality/apc>
- Australian Institute of Health and Welfare. Elective Surgery Waiting Times. Available from: <https://www.aihw.gov.au/reports-data/myhospitals/sectors/elective-surgery>
- Australian Institute of Health and Welfare. Emergency Department Data Extract. Available from: <https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care>
- Australian Institute of Health and Welfare. Hospital Acquired Complications (not publicly available)
- Bilateral Agreement between the Commonwealth and Tasmania for minimum funding for public hospital services:
 - https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-08/Tas_bilateral_signed.pdf
 - https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-09/Tas_bilateral_extension_signed.PDF
- Bilateral Agreement between the Commonwealth and the ACT for minimum funding for public hospital services:
 - https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/ACT_bilateral_signed.pdf
 - https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/ACT_bilateral_extension_signed.pdf
- Bilateral Agreement between the Commonwealth and the Northern Territory for minimum funding for public hospital services:
 - https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NT_bilateral_signed.pdf
 - https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NT_bilateral_extension_signed.pdf
- Bilateral agreements on co-ordinated care reforms with all States and Territories - <https://federalfinancialrelations.gov.au/agreements/national-health-reform-agreement>
- Commonwealth Government of Australia. *National Health Reform Act 2011*. Available from: <https://www.legislation.gov.au/Details/C2012C00746>
- Commonwealth Government of Australia. *National Health Reform Agreement 2011*. Available from: <https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-08/national-agreement.pdf>
- Commonwealth Government of Australia. 2020-25 Addendum to the National Health Reform Agreement. Available from: https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NHRA_2020-25_Addendum_consolidated.pdf
- Commonwealth Government of Australia. National Health Reform Agreement Long Term Reforms Roadmap. Available from: <https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-10/NHRA-longterm-reforms-roadmap.PDF>
- Commonwealth Government of Australia. National Healthcare Agreement (agreed by COAG in 2008 and amended in 2011). Available from: [National Healthcare Agreement 2012 - effective 25 July 2012 \(federalfinancialrelations.gov.au\)](https://www.nationalhealthcareagreement.gov.au)
- Commonwealth Government of Australia. National Agreement on Closing the Gap. Available from: https://www.closingthegap.gov.au/sites/default/files/2022-09/ctg-national-agreement_apr-21-comm-infra-targets-updated-24-august-2022_0.pdf



- Commonwealth Government of Australia. National Partnership on COVID-19 Response. Available from: <https://federalfinancialrelations.gov.au/agreements/covid-19-response>
- Commonwealth Report on Government Services, 2023. Available from: <https://www.pc.gov.au/ongoing/report-on-government-services>
- Commonwealth Government of Australia. 2023 Intergenerational Report. Available from: <https://treasury.gov.au/publication/2023-intergenerational-report>
- Commonwealth Government of Australia. Minimum Funding Guarantee for States and Territories 2019-20 to 2021-22 correspondence
- Commonwealth Government of Australia. Federal Budget, Budget Strategy and Outlook, Budget Paper No. 1. Available from: https://budget.gov.au/content/bp1/download/bp1_2023-24_230727.pdf
- Department of Health and Aged Care. National Medical Workforce Strategy: 2021-31 Investing in our medical workforce to meet Australia's health needs, 2021. Available from: <https://www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf>
- Department of Health and Aged Care. National Medicines Policy, 2022. Available from: <https://www.health.gov.au/sites/default/files/2022-12/national-medicines-policy.pdf>
- Department of Health and Aged Care. Workforce Full Time Equivalents (not publicly available)
- Department of Health and Aged Care. GP Services and Full Time Equivalents (not publicly available)
- Department of Health and Aged Care. Commonwealth Contribution Rates (not publicly available)
- Department of Health and Aged Care. General Practice Workforce. Available from: <https://hwd.health.gov.au/resources/data/gp-primarycare.html>
- Independent Health and Aged Care Pricing Authority. NEP and NEC Explanatory documents 2022-23 and (where relevant) 2023-24 including:
 - Pricing Framework, National Efficient Price and National Efficient Cost Determination Graphic
 - National Efficient Price and National Efficient Cost Determinations Online Glossary
 - Understanding the NEP and NEC Determinations
- Independent Health and Aged Care Pricing Authority. National Efficient Price Determination 2022-23 and 2023-24. Available from: <https://www.ihacpa.gov.au/health-care/pricing/national-efficient-price-determination>
- Independent Health and Aged Care Pricing Authority. National Efficient Cost Determination 2022-23 and 2023-24. Available from: <https://www.ihacpa.gov.au/health-care/pricing/national-efficient-cost-determination>
- Independent Health and Aged Care Pricing Authority. National Pricing Model 2023-24. Available from: https://www.ihacpa.gov.au/sites/default/files/2023-03/national_pricing_model_technical_specifications_2032-24.pdf
- Independent Health and Aged Care Pricing Authority. Pricing framework for Australian Public Hospital Services 2023-24. Available from: <https://www.ihacpa.gov.au/resources/pricing-framework-australian-public-hospital-services-2023-24>
- Independent Health and Aged Care Pricing Authority. Annual Report 2021-22. Available from: <https://www.ihacpa.gov.au/resources/ihpa-annual-report-2021-22>
- Productivity Commission Shifting the Dial report. Available from: <https://www.pc.gov.au/inquiries/completed/productivity-review/report>
- The Auditor-General Report. Australian Government Funding of Public Hospital Services – Risk Management, Data Monitoring and Reporting Arrangements. Available from: https://www.anao.gov.au/sites/default/files/Auditor-General_Report_2018-2019_26.PDF
- The Commonwealth Fund. Mirror, Mirror: Reflecting Poorly. Available from: <https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly>

Appendix D Stakeholders consulted

Table 8: Stakeholders consulted

Type	Stakeholder / organisation	Date
National Body consultation	Australian Commission on Safety and Quality in Health Care (ACSQHC)	7 March and 16 August
National Body consultation	Independent Hospital and Aged Care Pricing Authority (IHACPA)	7 March and throughout
National Body consultation	Australian Institute of Health and Welfare (AIHW)	8 March and throughout
National Body consultation	Administrator of the National Health Funding Pool (Administrator)	22 March and throughout
National Body consultation	National Health Funding Body (NHFB)	22 March and throughout
Jurisdictional workshops	South Australia	3-4 April
Targeted interview	Australian Healthcare and Hospitals Association (AHHA)	11 April
Targeted interview	National Aboriginal Community Controlled Health Organisation (NACCHO)	11 April
Targeted interview	Pharmaceutical Benefits Advisory Committee (PBAC)	11 April
Jurisdictional workshops	Commonwealth	12-13 April
Targeted interview	Consumer Health Forum (CHF)	14 April
Jurisdictional workshops	Victoria	17-18 April
Targeted interview	Australian Diagnostic Imaging Association (ADIA)	19 April
Targeted interview	Australian Nursing and Midwifery Federation (ANMF)	20 April
Targeted interview	Australian Private Hospitals Association (APHA)	20 April
Targeted interview	National Mental Health Commission (NMHC)	20 April
Targeted interview	Royal Australian College of General Practitioners (RACGP)	20 April
Targeted interview	Australian Medical Association (AMA)	21 April and 20 July
Targeted interview	National Aged Care Advisory Council (NACAC)	21 April
Targeted interview	Australasian College for Emergency Medicine (ACEM)	24 April
Targeted interview	National Disability Insurance Agency (NDIA)	24 April
Targeted interview	Aged and Community Care Providers Association (ACCPA)	4 May
Targeted interview	Australian College of Nurse Practitioners (ACNP)	4 May
Targeted interview	Rural Doctors Association of Australia (RDAA)	8 May
Jurisdictional workshops	Western Australia	9-10 May
Targeted interview	Ramsay Health Care	18 May
Targeted interview	Royal Australasian College of Surgeons (RACS)	18 May
Jurisdictional workshops	New South Wales	23-24 May
Targeted interview	Private Healthcare Australia (PHA)	25 May
Targeted interview	National Rural Health Alliance (NRHA)	26 May
Targeted interview	Australian College of Midwives (ACM)	29 May
Jurisdictional workshops	Australian Capital Territory	30-31 May
Targeted interview	Department of Social Services (DSS)	1 June
Targeted interview	Medical Services Advisory Committee (MSAC)	1 June
Targeted interview	Pharmaceutical Society of Australia (PSA)	1 June
Targeted interview	Australian College of Rural and Remote Medicine (ACRRM)	2 June



Type	Stakeholder / organisation	Date
Targeted interview	Australian Digital Health Agency (ADHA)	2 June
Targeted interview	Australian Health Practitioner Regulation Agency (AHPRA)	2 June
Targeted interview	Council on the Ageing (COTA)	2 June
Targeted interview	Dementia Australia	2 June
Targeted interview	Royal Australasian College of Physicians (RACP)	2 June
Jurisdictional workshops	Northern Territory	5-6 June
Jurisdictional workshops	Tasmania	13-14 June
Jurisdictional workshops	Queensland	20-21 June
Targeted interview	Society of Hospital Pharmacists Australia (SHPA)	11 Jul
Targeted interview	HTA Review Reference Committee	7 September

Appendix E

Written submissions received

Table 9: Written submissions received

No.	Organisation	No.	Organisation
1	ACT Health Directorate	34	Medicines Australia
2	Aged Care Council of Elders	35	Mental Health and Suicide Prevention Senior Officials Group
3	Australasian College for Emergency Medicine	36	National Blood Authority
4	Australian College of Midwives	37	National Health Funding Body and Administrator of the National Health Funding Pool
5	Australian College of Nursing	38	National Mental Health Commission
6	Australian College of Rural and Remote Medicine	39	National Rural Health Alliance
7	Australian Council on Healthcare Standards	40	Network of Alcohol and Other Drugs Agencies
8	Australian Diagnostic Imaging Association	41	Northern Territory Department of Health
9	Australian Digital Health Agency	42	NSW Health
10	Australian Health Economics Society	43	Palliative Care Australia
11	Australian Healthcare and Hospitals Association	44	PHN Cooperative
12	Australian Institute of Health and Welfare	45	Private Healthcare Australia
13	Australian Medical Association	46	Public Pathology Australia joint with the Royal College of Pathologists of Australasia
14	Australian Nursing and Midwifery Federation	47	Queensland Health
15	Australian Physiotherapy Association	48	Ramsay Health Care
16	Australian Psychological Society	49	Royal Australian College of General Practitioners
17	Australian Rheumatology Association	50	Royal Australian College of Physicians
18	Australian Nursing and Midwifery Federation	51	Rural Doctors Association Australia
19	The Health Alliance: Brisbane North Primary Health Network and Metro North Health	52	Rural Health Commissioner
20	Catholic Health Australia	53	SA Health
21	Department of Health and Aged Care	54	NSW Primary Health Networks
22	Department of Social Services	55	Tasmanian Department of Health
23	Victorian Tasmanian PHN Alliance	56	The Society of Hospital Pharmacists of Australia
24	Flinders Medical Centre	57	The University of Melbourne
25	Government Affairs at Gilead	58	Victoria Department of Health
26	Grattan Institute	59	Victorian Healthcare Association
27	Health Consumers' Council of WA	60	WA Department of Health
28	Health Technology Assessment Review Reference Committee	61	Department of Immunology, Flinders University
29	Inclusion Australia	62	Lymphoma Australia
30	Independent Health and Aged Care Pricing Authority	63	Epworth Healthcare
31	Leukaemia Foundation	64	Cell Therapies
32	Macquarie University	65	Peter MacCallum Cancer Centre
33	Medical Workforce Reform Advisory Committee		

Appendix F NHRA Addendum 2020-2025 contents

This appendix includes two tables:

- Table 10: NHRA Addendum 2020-2025 Schedules and key contents
- Table 11: Key changes introduced through the 2020-2025 Addendum (sourced from Commonwealth Department of Health and Aged Care).

Table 10: NHRA Addendum 2020-2025 Schedule contents

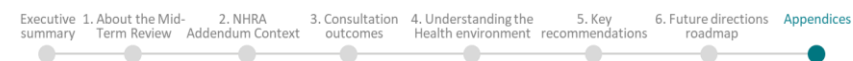
Schedule	Key content	Schedule	Key content
Preliminaries - Principles, objectives, roles and responsibilities	<ul style="list-style-type: none"> • Shared intent, purpose and responsibility for the health system • Re-affirms commitment to National Healthcare Agreement principles and objectives, Medicare Principles, financial arrangements including ABF, and shared commitments to closing the gap and improving mental health outcomes for Australians • 2020-2025 four strategic priorities (includes long term reform focus) • Nationally unified/locally controlled architecture with broad set of objectives • Breakdown of roles and responsibilities • Implementation mechanisms, principles and artefacts and reform commitments • Mid-Term independent review • Process to amend and resolve disputes 	Schedule E - Local governance structures and reforms	<ul style="list-style-type: none"> • LHNs: purpose, responsibilities, specification of LHN Service Agreements, structure/governance • PHNs: purpose, responsibilities, Commonwealth, State and Territory engagements around local and primary care service delivery, and Commonwealth commitment to primary care reforms
Schedule A - Funding elements, funding data reporting and sustainability	<ul style="list-style-type: none"> • Funding arrangement principles • Commonwealth funding parameters • Public health funding arrangements • Public hospital services scope • ABF arrangements, including principle of financial neutrality between public and private patients • Objectives and principles of the NEP • Block funded services • National funding cap, including operation of the soft cap, and adjustments for HACs, sentinel events, and avoidable readmissions • Calculating Commonwealth funding, including in-year and annual adjustments • Determining State and Territory funding contributions • Innovation: process of funding innovation through trials and impact on block or ABF funding • Maintenance of effort • Data provision and service level agreements • Principles for State and Territory cross-border arrangements, including funding flows through, and operation of the Pool, Cross-border Agreements between jurisdictions and pricing • Cost-shifting: process for submissions and assessment • Pool operation • Data quality and integrity • Pricing and funding for Quality and Safety: Sentinel events, HACs, avoidable readmissions • Private provision of public hospital services 	Schedule F - Health, disability and aged care interfaces	<ul style="list-style-type: none"> • Acknowledge system links across health, disability, aged care, primary care systems are collective responsibility including with ACCHOs • Breakdown of roles and responsibilities, and intersection with NDIS, aged care, primary care and related bodies • Commitment to develop health, primary, aged care and disability interface performance indicators • Governance to manage interface issues



Schedule	Key content	Schedule	Key content
	<ul style="list-style-type: none"> • Veteran entitlements • Nationally funded centres 		
Schedule B - National Bodies: purpose and data	<ul style="list-style-type: none"> • Outline of the four NHRA national bodies • Three national funding bodies: establishment, business rules and dispute resolution • IHPA: functions, governance, consultation • Administrator: functions, governance, consultation • ACSQHC: functions, governance, consultation • AIHW: functions, consultation • Data requirements for national bodies • Statements of assurance on data integrity across system 	Schedule G - Business rules: charging, complaints, private patients	<ul style="list-style-type: none"> • Public patient charges • Charges for patients other than public patients • Patient arrangements, including public/private election process and informed financial consent • Data provision on private patients in public hospitals and processes • Minimum requirements for admitted patient election forms
Schedule C - Long-term reform principles	<ul style="list-style-type: none"> • Commit to shared action on four strategic priorities, with six long-term reform areas: <ul style="list-style-type: none"> • Nationally cohesive health technology assessment • Paying for value and outcomes • Joint planning and funding at local level • Health literacy • Prevention and wellbeing • Enhanced health data 	Appendix A - Definitions	Definitions
Schedule D - Transparency and performance reporting	<ul style="list-style-type: none"> • AHPF is single reporting framework for healthcare reporting • Four agreed actions for this Addendum: <ul style="list-style-type: none"> • Whole-of-system performance indicators • Revised performance benchmarks • Mechanism for governance • Proposed approach for measuring value in the health system 	Appendix B - Highly specialised therapies governance	Governance arrangements for new highly specialised therapy

Table 11: 2020-2025 Addendum changes (sourced from Commonwealth Department of Health and Aged Care)

Key area of change	Description of change	NHRA reference
Equitable access to highly specialised therapies	<p>Strengthens funding arrangements to ensure Australians with some of the rarest conditions have access to new, lifesaving highly specialised therapies in public hospitals. This includes:</p> <ul style="list-style-type: none"> • Equal sharing of costs between the Commonwealth, States and Territories for high costs therapies (which exceed \$200,000 per patient). • Greater transparency and improved consultation processes so all jurisdictions can engage and be informed in the Medical Services Advisory Committee (MSAC) decision making process, which recommends new high cost treatments that are suitable for delivery in public hospitals. 	C11-C12, Appendix B
Private patients in public hospitals	All Governments agreed to the principle that their funding models will be financially neutral, regardless of whether a patient elects to be private or public in a public hospital.	A13, A43-A44
Compliance	States and Territories agreed to improved collection, sharing and matching of data to ensure the Australian Government pays appropriately for services. If data matching validates that hospital activity has been paid for twice, the Administrator can provide the information required for the Commonwealth to recover these amounts, or for the States and Territories to repay the owed amounts.	A11-A12, B75



Key area of change	Description of change	NHRA reference
Role of national bodies	Provides increased clarity on the processes for national bodies to follow in ensuring consultation and consideration of all Parties' views with respect to changes in the funding system. Also includes a new section on the functions of AIHW in relation to implementing the NHRA.	Schedule B
Long-term health reforms	All Governments committed to working together on long-term system-wide reforms, which aim to provide person-centred care in the most appropriate setting, reduce avoidable hospitalisations, and improve system sustainability. The six LTRs are identified in section 2.1. This includes: <ul style="list-style-type: none"> • Governments being supported to trial, evaluate, and refine different models of care at increasing levels of ambition. • States and Territories encouraged to identify opportunities to scale-up initiatives where appropriate for implementation on a broader scale. • Collaboration between Governments to agree what works and identify how successful features are incorporated into the system as a whole (particularly around planning, funding arrangements and data collection/reporting). • Improvements in health data and streamlined health technology assessment (HTA) processes. • Governments working with the health sector to better understand and remove systemic barriers to improving health care. 	Schedule C
Innovative models of care	Enabled States and Territories to trial new models of care to improve the health of Australians, while reducing demand on hospitals. This supports the delivery of programs that provide care more flexibly, to give patients care where and when they need it.	A96 –A101
Aboriginal and Torres Strait Islander peoples' health outcomes	Includes specific reference to efforts that demonstrate the commitment of all Governments to working with communities to closing the gap in disadvantage and life expectancy of Aboriginal and Torres Strait Islander peoples. This includes: <ul style="list-style-type: none"> • Working in partnership with Aboriginal and Torres Strait Islander communities to co-design approaches tailored to their needs through a shared decision making approach, recognising and enabling Aboriginal and Torres Strait Islander leadership and local decision making processes. • Working in partnership with Aboriginal and Torres Strait Islander people to co-develop and co-deliver culturally safe and secure health services across the whole health system. • Developing a National Aboriginal and Torres Strait Islander Health Workforce Plan. • Monitoring the impact of the reforms through Aboriginal and Torres Strait Islander led evaluation to ensure they remain appropriate. 	Preliminaries 9 (g)
Mental health	Includes a commitment to improving mental health outcomes and preventing suicides by reforming the provision of mental health care across the key areas of prevention, diagnosis, treatment and recovery.	Preliminaries 1 (j), 6 Schedule E - E40 (b)
Rural and regional health	Clarifies that the Commonwealth, States and Territories will be jointly responsible for identifying rural and remote areas where there is limited access to health and related services with a view to developing new models of care to address equity of access and improve outcomes.	Preliminaries 9(h)
Local governance	Reiterates the roles and responsibilities of LHNs and contemporises references to the PHNs.	Schedule E
Aged care, disability and primary care interface issues – Aged care and disability	Contemporises the shared and individual responsibilities of the Commonwealth, States and Territories with respect to health, disability and aged care services. This includes: <ul style="list-style-type: none"> • Provisions for the development of new data collections and performance indicators to monitor the impact of interface performance on client outcomes. • New clauses to support exploration of the impact of housing security, provision and assistance on people's health outcomes. • Clearer governance arrangements to provide an oversight mechanism to monitor and address issues. 	E37 – 40, Schedule F Roles and responsibilities (F3-F9) Activities and governance (F10 –F16)
Aged care, disability and primary care interface issues – Primary care	Includes stronger references to integrated care and better articulates all parties' commitment to reducing ED demand, avoidable hospital admissions and extended stays.	
Transparency and reporting	Includes a contemporised reference to the AHPF as the agreed single framework to support system-wide reporting on Australia's health and health care performance. A national monitoring and reporting framework will improve the measurement of impact and build the case for greater investment in prevention over time.	Schedule D (D1 – D11)

Appendix G Health related national Agreements¹⁷⁹

- National Mental Health and Suicide Prevention Agreement
- Organ and Tissue National Program
- National Blood Arrangements
- Pharmaceutical Reform Agreement
- National Partnership on Public Dental Services for Adults
- IGA on National Digital Health
- First Nations people Agreements/Strategies:
 - National Agreement on Closing the Gap
 - National Aboriginal and Torres Strait Islander Health Plan 2021 - 2031
 - National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021 - 2031
- Health Innovation Fund Agreements
- National Workforce Plan
- National Medical Workforce Strategy
- Strengthening Medicare Taskforce
- NDIS
- Commonwealth Support to South Australia Home Quarantine Application
- Community Health and Hospitals Program - QLD
- Achieving Better Health Outcomes
- Addressing blood-borne viruses and sexually transmissible infections in the Torres Strait
- Child Development Assessment Service in the Macarthur region: temporary 4-year multidisciplinary enhancement
- Communicable diseases of public health concern - Access to HIV treatment for people who are not eligible for Medicare
- Community Health and Hospital Program for Tasmania, ACT and VIC
- Community Health and Hospitals Program and Other Initiatives – SA and NT
- Community Health and Hospitals Program NSW Eating Disorder Initiative
- Community Health and Hospitals Program Queensland 2018-19 Initiatives
- Community Health and Hospitals Program Remote Point of Care Pathology Testing NT Initiative
- Community Health and Hospitals Program South Australia Hospital Discharge Pilot
- Community Health and Hospitals Program Tasmanian 2019-20 and 2020-21 Initiatives
- Community Health and Hospitals Program VIC's Eating Disorder Initiative
- Community Health and Hospitals Program Victoria's Children's Colorectal Service
- Community Health and Hospitals Program Western Australian Initiatives
- Comprehensive Children's Cancer Centre (CCCC) at Sydney Children's Hospital, Randwick
- Comprehensive Palliative Care in Aged Care
- Construction of the Launceston Hospice
- Construction of Western Australian Children's Hospice
- COVID-19 Response
- Dengue and Other Disease Mitigation through Mosquito Control in Tennant Creek
- Elimination of Trachoma in Indigenous Communities
- Essential Vaccines
- Expansion of Clare Holland House
- Extension of Encouraging More Clinical Trials in Australia
- Fighting Cancer - Regional Cancer Treatment Centres for Radiation Therapy
- Health Infrastructure Projects in Western Australia
- Home for the Matildas - high performance facility
- Japanese Encephalitis Virus Mitigation through Mosquito Surveillance and Control
- Japanese Encephalitis virus vaccines - intradermal administration clinical trial
- John Flynn Prevocational Doctor Program
- Kangaroo Island Community Health Outreach Program
- Lymphoedema Compression Garment Scheme
- Managing Torres Strait/Papua New Guinea Cross Border Health Issues in the Torres Strait Islands
- Medicare Urgent Care Clinics
- Mental Health Emergency Supports for NSW
- Mosquito Control in the Torres Strait Protected Zone
- National Bowel Cancer Screening Program - Participant Follow up Function
- Operation of Hummingbird House
- OzFoodNet Program
- Palliative Care Services Navigation Pilot
- Prevention of Avoidable Hospital Admissions, Obesity and Chronic Disease
- Primary Care Pilot
- Project Agreement for National Coronial Information System (NCIS)
- Proton Beam Facility
- Public Dental Services for Adults - 2022-23
- Queensland 2032 Olympic and Paralympic Games Candidature
- Rheumatic Fever Strategy
- Royal Darwin National Critical Care and Trauma Response Centre
- South Australia Cancer Genomics Laboratory Establishment
- South Australian Adult Mental Health Centre
- Specialist Dementia Care Program - Phase One
- Stillbirth autopsies and Investigations
- Surge Capacity for BreastScreen Australia
- The Provision of COVID-19 Quarantine Arrangements at the Northern Territory Centre for National Resilience for Organised National Repatriation of Australians
- Transfer of the Mersey Community Hospital
- Vaccine Preventable Diseases Surveillance
- Western Australia Comprehensive Cancer Centre
- Western Australian Hospital Infrastructure Package
- Worker Screening Design Support

¹⁷⁹ As at 30 August 2023, sourced from the Commonwealth Department of Health and Aged Care

Appendix H Summary of international developments on high value care and integrated funding systems

Table 12: High-level summary of international developments on high value care and integrated funding systems

Country	High-level summary
Denmark	<ul style="list-style-type: none"> Approximately 6-7 years ago Denmark revised their ABF model to remove unnecessary and low-value care. This approach was informed from the Choosing Wisely construct and materials from Canada. Hospitals are actively incentivised to proactively remove low-value care from their hospitals. This means that they are not financially penalised for avoided procedures or admissions. Their intention is to take a whole of system approach to the management of individual patients. They do acknowledge that they have an impending shortage of GPs in their primary care settings. As such, their focus currently is to embed the changes to low-value care into the established models of care.
USA	<ul style="list-style-type: none"> To maximise population health financial performance and align incentives to deliver both well and sick care, provider organisations are pushing to have 40% of their revenue managed under 'value-based care' contracts. The 40% mark is viewed as the 'tipping point' at which a hospital's value-based care opportunities start to outweigh fee-for-service revenue reductions. Success within value-based care arrangements necessitates alignment of payer contracting and payment reform with care model transformation. Evidence from the US has reported an association between ABF and: 1) shorter length of stays in acute care and 2) greater use of post-acute care.
Netherlands ¹⁸⁰	<ul style="list-style-type: none"> The Dutch embarked upon a reform of their health care system in January 2006. Since then, the Netherlands has functioned as a hybrid system that is both publicly and privately run (before 2006 it was mostly a public system), although strongly regulated by the government, which mandates and determines a basic insurance scheme for all citizens. At Santeon, a collaboration of seven top clinical hospitals focusing on value based healthcare, a pilot program at one of the hospitals has resulted in a model with some, but not all, 'Integrated Patient Units' elements. At this point (at Nov 2020), the pilot involves teams responsible for four medical conditions; they are accountable for the quality outcomes but not for the financial side.
Norway ¹⁸¹	<ul style="list-style-type: none"> In Norway, mandatory bundled payments contracts for dialysis and four high-cost treatment programs were introduced in 2019 on a national level. In 2020, the very first procedure-based bundle for hip replacement was implemented, including surgery, hospital stay, and hospital follow-up visits. Rehabilitation and post-acute care are left out to reduce risk for participants and to secure a controlled implementation within hospital setting. In Norway, to promote the integration of specialty care (managed by the four Regional Health Authorities) and primary care (overseen by municipalities), the national government introduced reforms in 2008 and implemented several national plans. The key element of the reform was to make the municipalities more economically accountable for patients after discharge from specialised care, incentivising shorter hospital stays and a closer follow-up of patients post discharge. The reform has been heavily debated, as municipalities have struggled with capacity and to provide good enough care for high-need, high-cost patients. The Norwegian government has just launched a collaboration program between local hospitals and primary care centers in nearby municipalities.
England ¹⁸²	<ul style="list-style-type: none"> NHS England has not widely introduced bundled payments yet but does work with a payment scheme — known as the best practice tariffs (BPT) — that rewards providers who deliver high-quality care through predefined patient-pathways. The goal of BPT is to reduce clinical variation by promoting the adoption of best practices. In this scheme, the NHS defined a set of criteria for various conditions (so far 22) that are likely to result in improvements in care processes from admission to discharge. Providers who participate in the BPT scheme receive a somewhat lower base rate for a procedure and, if they meet all the criteria, they receive additional funding that, by far, offsets the base rate reduction. There are also fines for breaching indicators of quality of care, e.g., unplanned readmissions within 30 days of previous discharge.

¹⁸⁰ <https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0530>

¹⁸¹ <https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0530>

¹⁸² <https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0530>

Appendix I NHRA Interim Quantitative Performance Framework themes and indicators

Table 13: NHRA Interim Quantitative Performance Framework themes and indicators

Theme	Sub-Theme	Indicator measure	Measure purpose
Equity	Rural and remote	Ratio of hospital beds in rural/regional/metro areas per 1,000 total population and per 1,000 aged 65+ over time	Is there an equitable distribution of hospital beds and health workforce?
		Hospital separations per capita in rural/regional/metro areas over time	Do selected equity groups have similar rates of hospital separations compared to metro areas?
	Multiple equity groups	Median waiting times for Elective Surgery by rural/regional/metro, Indigenous status, CALD status and SEIFA over time	Are Indigenous patients waiting longer for elective surgery than non-Indigenous patients?
	Mental health	Proportion of patients being treated with Mental Health Services in rural/regional/metro areas, per capita – per incidence rate, by Indigenous status, CALD status and SEIFA over time	Do selected equity groups have similar access to mental health services compared to metro areas, when adjusted for the incidence of mental illness within those equity groups?
	Indigenous	Qualitative indicators need to be identified, e.g., surveys	Are there available surveys or other data measures that can be used to indicate the level of cultural safety in the provision of public hospital services?
Number and ratio proportion of patients who did not wait, left or were discharged against medical advice by Indigenous status over time		Are Indigenous patients compared to non-Indigenous Australian patients leaving without receiving care at elevated rates?	
Effectiveness	Emergency departments	Number and proportion of ED presentations that depart within 4 hours over time, compared against the growth in the number of ED presentations	Has the proportion of ED presentations that depart the ED within 4 hours changed over time?
	Elective surgery	Proportion of patients waiting longer than clinically recommended for elective surgery over time	Have elective surgery median waiting times improved over time? What does the relationship between elective surgery median waiting times, inpatient separations, and inpatient activity tell us?
		Median patient waiting time for elective surgery over time	
		Rate of elective surgery waiting list turnover over time	
	Outpatients	Median patient waiting time for outpatient appointments over time	Have outpatient median waiting times improved over time, indicating improved patient access?
		Number of patients on outpatient waiting lists over time	
	Mental health	Proportion who receive follow up community appointments	Has the rate of follow-up for mental health patients, after an acute inpatient episode of care changed over time?
	Primary care	Proportion of Bulk Billed GP services over time	How has bulk billing rates for GP attendances changed over time, by key age groups?
Average out of pocket patient costs for GP services over time		How has out of pocket costs for GP services changed over time?	
Number of GP primary health care services per capita over time		How has the number of GP attendances and number of GPs (FTE) changed over time?	

Theme	Sub-Theme	Indicator measure	Measure purpose
		Number of GP FTE per 100,000 population over time	What is the difference in GP workforce (FTE) per 100,000 population on a geographic basis and how has this changed over time?
	Hospital acquired complications	Proportion of separations with a Hospital Acquired Complications (HAC) over time	How has the linking of Quality and Safety into public hospital funding impacted performance?
	Sentinel events	Rate of Sentinel Events per 1000 separations, over time	
	Avoidable readmissions	Rate of avoidable readmissions per 1000 separations, over time	
	High Value and Low Value Care	Number of knee arthroscopies over time Additional Indicator Measures TBC based on VBHC Framework	Is the number of low value care procedures decreasing and the number of high value care procedures increasing?
	Patient reported measures	Patient Reported Experience Measures (PREMS) over time Patient Reported Outcome Measures (PROMS) over time Evidence of establishment and reporting of PREMS and PROMS measures over time	What do patients report as their experience with health professionals?
	Patient initiated discontinuation of service	Proportion of patients who did not wait, left, or were discharged against medical advice	Are more people completing care, possibly suggesting that services are more effective at engaging patients?
Efficiency	Activity and pricing	Annual National Efficient Price (NEP) over time and growth compared to annual health CPI	How do changes in the NEP compare with general and health CPI
		Average cost per NWAU over time and growth compared to total separations, and by 65+ years separations, annual health CPI, and annual NEP	Is it more or less costly to deliver one standardised unit of activity, as measured by the NWAU?
	Public hospital beds	Ratio of hospital beds per 1,000 population and per 1,000 aged 65+, nationally and by State and Territory, over time, and changes in comparison to changes in hospital separations and total NWAU	How has public hospital activity changed relative to hospital beds on a per capita basis?
	Activity, separations, and presentations	Number and proportion of category four and five ED presentations to total ED presentations over time Number and proportion of total separations with existing comorbidities to total separations over time Number and proportion of separations for patients 65+ with existing comorbidities to total patients with comorbidities over time Ratio of NWAU per occupied bed day over time Average inpatient overnight length of stay over time	How have key hospital activity measures changed relative to key supply measures? A composite graph can be included for a range of measures showing standardised growth rates over time (by commencing from zero) and including the following measures: <ul style="list-style-type: none"> Total number of inpatient separations Total number of NWAU each year LOS each year Cost per weighted separation (brings in funding) Workforce growth rate
Sustainability	Workforce	Growth of the medical, nursing and allied health public hospital workforce over time Comparative growth of medical, nursing and allied health public hospital workforce over time	How have medical practitioners, nurses and midwives, allied health professionals and the total health workforce grown over time?

Theme	Sub-Theme	Indicator measure	Measure purpose
		Age of the workforce	Is the ageing of the workforce impacting the sustainability of health services?
	Public hospital expenditure	Total public hospital expenditure over time by (i) aggregate (ii) Commonwealth, State or Territory	How has the Commonwealth Contribution Rate changed over time and how does this rate differ across States and Territories?
		Relative Growth Rates of Total Public Hospital Expenditure and Total Primary Care Expenditure	How has the Commonwealth versus State and Territory contribution to total funding (within and outside the National Health Funding Pool (NHFP)) changed over time?
		Total health expenditure as a proportion of total tax revenue and total government expenditure over time for (i) aggregate (ii) Commonwealth, State or Territory	
		Funding through the National Funding Pool over time by (i) aggregate (ii) Commonwealth, State or Territory (iii) ABF/Block/Public Health	
		Proportion of Commonwealth to State and Territory ABF funding through the National Funding Pool over time by (i) aggregate (ii) State and Territory	
	International comparison indicators	Comparison of Australia's total and per capita expenditure as a proportion of GDP to OECD countries	Compared to other countries, how much is Australia spending on health care?
Intersectoral Collaboration	Aged Care Eligible Inpatients	Number of Aged Care eligible patients clinically ready for discharge occupying a bed in a public hospital	Is the number of Aged Care eligible patients who are clinically ready for discharge but still an inpatient reducing over time?
	NDIS Eligible Inpatients	Number of NDIS eligible patients clinically ready for discharge occupying a bed in a public hospital	Is the number of NDIS eligible patients who are clinically ready for discharge but still an inpatient reducing over time?
	LHN/PHN Collaboration	Proportion of LHNs and PHNs who have documented collaboration/alliance agreements over time	Is the amount of collaboration between LHNs and PHNs increasing over time?
		Number of category four and five ED presentations over time	Has the number of category four and five ED presentations changed over time and is it possible to link LHN or primary care initiatives to these changes?
Transparency and Reporting	Performance Reporting to Local Communities	Proportion of LHNs public reporting of useful equity, effectiveness and efficiency indicator measures over time	Does the public have easy access to relevant local public hospital data to assist their decision making?
	State / Territory / National Reporting	No indicator measure identified	Does the public have easy access to relevant State, Territory and National public hospital data to assist their decision making?

Appendix J Performance systems - Country comparisons

Table 14: Performance, Monitoring, and Improvement Systems – country comparisons

Country	Health system summary	Performance, Monitoring, and Improvement System
Canada	Universal, decentralised and publicly funded. (Note: There is also currently a national trend toward greater administrative centralisation)	<p>Performance indicators: Continually evolves, Involving collaboration from the Canadian Institute for Health Information (CIHI), other agencies and representatives of other stakeholder groups. CIHI has worked closely with the Federal-Provincial-Territorial governments to develop and publicly report on these performance indicators, thus there is some accountability to the public even if the agreements themselves are not transparent.</p> <p>Reporting and Monitoring:</p> <ul style="list-style-type: none"> • Many provinces have agencies responsible for producing health care system reports and for monitoring system performance e.g., Health Quality Ontario (HQO). • In addition, CIHI produces regular public reports on health system performance, including indicators of hospital and long-term care facility performance. • Healthcare Excellence Canada (HEC) was formed in October 2020, following the amalgamation of two pan-Canadian healthcare organisations – the former Canadian Foundation for Healthcare Improvement (CFHI) and the former Canadian Patient Safety Institute (CPSI). These legacy organisations each reported on the delivery of their outputs and outcomes, performance against accountability targets, and their progress toward strategic objectives on an annual basis.
UK – Spotlight on England	Universal and highly centralised (although is undergoing some decentralisation)	<p>Performance indicators: The National Institute for Health and Clinical Excellence (NICE) is responsible for managing the development process of clinical and public health indicator and also recommends whether the existing indicators should continue to be part of the frameworks. The indicators tend to be developed in a relatively open and transparent way, with input from individuals and stakeholder organisations.</p> <p>Reporting and other: The Care Quality Commission (CQC) is the regulator for all health and social care services in England and Monitor is the regulator for NHS foundation trusts. The Quality and Outcomes Framework provides general practices with financial incentives to improve quality.</p>
Denmark	Universal and decentralised National Government provides Block Grants from tax revenues to the regions and municipalities	<p>Performance Indicators: From 2015, a new system in which regions are responsible for developing schemes that enable them to meet eight national quality targets and related indicators replaced the Danish Healthcare Quality Program (2004-2015). Indicators of health care quality include not only clinical measures but also, increasingly, patient-reported experiences and outcomes.</p> <p>Regulation and Monitoring:</p> <ul style="list-style-type: none"> • The general regulation, planning, and supervision of health services, including overall cost-control mechanisms, take place at the national level through Parliament, the Ministry of Health and governmental agencies. • The Health Authority provides general monitoring and regulation of quality and works in close collaboration with representatives from medical societies. • Regional performance is monitored and published annually by the Ministry of Health.
The Netherlands	Universal coverage ensured – but merges both public and private insurance	<p>Performance Indicators: In 2019, a key policy priority to develop reliable and meaningful quality indicators was established.</p> <p>Monitoring: The Dutch Health Care Inspectorate is responsible for monitoring quality and safety. In 2014, the National Health Care Institute (NHCI) was established to further accelerate the process of quality improvement and evidence-based practice. As part of the NHCI, the National Quality Institute promotes quality measurement and transparency. Most quality assurance is carried out by providers, sometimes in close cooperation with patient and consumer organisations and insurer.</p>

Country	Health system summary	Performance, Monitoring, and Improvement System
New Zealand	Universal, predominantly publicly funded	<p>Performance Indicators: Performance indicators were used in both PHC and secondary care to assess DHB and PHO performance against set targets.</p> <p>Monitoring mainly occurs at the national government level: Ministry monitors the performance of public hospitals and reports annually on the implementation of the New Zealand Health Strategy. Other national agencies have specific monitoring roles e.g., Maori or Nursing. Often, there is no clearly linked reporting on, or monitoring or evaluation of, strategies, and it is particularly difficult to identify the improvements in health and independence gained as a result of key strategies. Inevitably, there are significant gaps in our understanding of how the system performs and there can be long delays in data being reported. Despite being recognized as a problem for many years, there is still no national PHC dataset, while data for community services also remains poor. These gaps make it difficult to form a comprehensive overview of the performance of the New Zealand health system. A particular challenge for the reformed health system will be the availability of data for localities initiatives</p>
Germany	Universal	<p>Reporting: Federal Health Reporting (Gesundheitsberichterstattung, GBE) is carried out by the Robert Koch Institute (RKI) and the Federal Statistical Office, each focusing on different tasks in close consultation. Health reporting in Germany takes place at the federal, state and municipal level. Due to different legal foundations, differences in human and financial resources, and varying data availability, a heterogeneous picture of health reporting results between and within the different levels.</p> <p>Monitoring: The RKI was officially charged with Health Monitoring by the Federal Ministry of Health in 2007. The monitoring system includes three survey components that repeatedly provide comprehensive information on the population's state of health and health behaviour, as well as on healthcare services in Germany. The Health Monitor (Gesundheitsmonitor) was a national initiative of not-for-profit organizations and sickness funds. To assess the performance of the health care system, it regularly conducted studies from the patient perspective. The Health Monitor, which last conducted a study in 2016, ceased to exist after 15 years. A comparable survey on health access has not been provided.</p>
Italy	Highly decentralised	<p>Monitoring: Italy has now established a national system, called the called the New System of Guarantees (Nuovo Sistema di Garanzia) monitor the regions and their organizations with 88 indicators that are collected robustly and reliably.</p>
France	Universal The governance of the health system is strongly centralised	<p>Performance Indicators: CompaqH, a national program of performance indicators, also reports results on selected indicators.</p> <p>Monitoring: Quality assurance and risk management in hospitals are monitored nationally by the Ministry of Social Affairs, Health, and Women's Rights, which posts hospital-acquired infection rates and other information online. However, the absence of a national health system performance assessment framework to monitor and evaluate health system performance in France reduces the capacity to identify problem areas as well as good practices to promote policies aiming to improve care quality and efficiency.</p>