

Putting the 'reform' in the National Health Reform Agreement

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Overview

Australia's health system needs structural reform. Rates of chronic disease have risen and will keep rising. As the system strains to meet growing demand, it will also have to change, fixing the mismatch between the system we inherited from the 20th century and the system we need for the future.

The emphasis must shift from hospital care to keeping people healthy. Many people have to manage multiple chronic diseases over decades, so instead of planning and funding individual, fragmented healthcare interventions, the system needs to join up and fit around people's needs.

Neither the federal nor state governments can achieve these changes alone. Service systems run by different levels of government – such as public hospitals and GP clinics – need to work together. The configuration of the system, from the workforce, to infrastructure, to digital systems, needs to be planned as a whole, not in silos. And how funding is divided should be based on population health needs, and the results that services will achieve, not based on turf, precedent, and cost-shifting.

That's why the next version of the National Health Reform Agreement (the Agreement) must be very different from the current one.

Instead of galvanising reform, the Agreement reinforces the status quo. It focuses on hospital care, instead of the whole system. While the cost of hospital care has fallen (technical efficiency), it has failed to shift what care is offered, and where it's offered (allocative efficiency), or increase investment in prevention (dynamic efficiency).

The Agreement gestures at reform, nominating the right themes, but it doesn't go much further. The reform themes are vague and disconnected from the mechanics of change that the Agreement could put in motion: funding, measurement, and accountability.

This submission suggests a new approach that would make the Agreement an engine for reform, with examples of how that approach could be applied.

Chapter 1 explains how the Agreement should be redesigned and restructured. The subsequent chapters outline potential reform themes and how they could be built into the Agreement: Shifting care out of hospitals (Chapter 2), Filling access gaps (Chapter 3), Prevention (Chapter 4), Workforce (Chapter 5), and Measuring what matters (Chapter 6).

Recommendations

Set the destination

- Explain how the health system will change, including the roles and relationships of different parts of the system

Shift care out of hospitals

- Define new 'missing middle' services to keep people out of hospital
- Increase the federal government's share of new public hospital spending, and allocate it to expanding these new 'missing middle' services
- Don't pay for long hospital stays when short stays are better for patients
- Increase funding flexibility for hospitals and primary care to test new ways of working together to care for patients

Fill access gaps

- Define when access to GP care is unacceptably low in a local community, and provide funding for states and Primary Health Networks to jointly fill the gap
- Expand public hospital specialist clinics to cut wait times and fees, and to provide advice to GP clinics to help them do more
- Fund a transition to universal coverage for dental care

Join up local care

- Require joint Local Hospital Network (LHN) and Primary Health Network (PHN) planning for workforce, and digital and physical infrastructure
- Make it simple for LHNs and PHNs to pool their funding and manage the health system together

Fix the workforce crisis

- Explain how workforce roles will change
- Commit to set training numbers based on projections of workforce supply and demand
- Provide funding to scale up new workforce roles

Measure what matters

- Plan a national data collection on the outcomes that matter to patients
- Measure and report healthcare access and outcome gaps between different communities and regions
- Measure virtual and in-home care to support the shift away from care in hospitals
- Measure and set targets for hospital carbon emissions

1 How the National Health Reform Agreement should be redesigned and restructured

The National Health Reform Agreement (the Agreement) between federal and state governments was signed in 2011, rolling out activity-based funding across the nation's public hospitals.

The Agreement has been updated several times since. Most recently, it was extended from 2020 to 2025.¹ The updates since 2011 have tried to spur reform. They added bilateral reform agreements between the federal government and individual states which committed to specific projects. In 2020, long-term reform themes were added.²

But reform progress has been limited. The cost of the average public hospital stay has been contained,³ but the Agreement has not helped Australians get the right care in the right place, or at the right time. It created an incentive to cut the cost of each hospital visit, but also to increase the number of visits. Overall costs have risen dramatically, because the Agreement has done little to slow growing demand for hospital care.

In the early stages of the pandemic, some types of reform weren't possible, but there are other reasons that reform has stalled. The Agreement lacks a clear vision of the future health system that the nation is trying to build. Instead, the long-term reform directions are vague catchphrases, making it difficult to set priorities or expectations for progress.

The long-term reform directions are also disconnected from the incentives and resources that the Agreement provides. That condemns them to be low priorities at best, or tokenistic make-work exercises at worst, particularly when new investment is needed to achieve reform. The bilateral agreements include some good initiatives, but they are too diffuse, uncoordinated, and small-scale to achieve system-level change.

Whatever reform priorities are included in the next version of the Agreement, a different approach to achieving them is clearly needed.

The next version should focus on reform areas where system reform is urgently needed within five years, and where national collaboration is required for success. Each reform area should then be clearly defined and linked to funding and accountability.

Collectively, the reform directions should be clear, concrete, and compelling enough to engage clinicians, patients, and the community.

While the Agreement will go into greater detail for areas of shared responsibility, it should also paint a picture of the system as a whole. It should lay out reform directions that span the whole system. It should explain the role that each part of the system will play and how they will interact. It will take this holistic approach to deliver a health system that is coherent, efficient, and makes sense to patients.

1. Commonwealth of Australia 2020

2. The themes are: Nationally cohesive health technology assessment; Paying for value and outcomes; Joint planning and funding at the local level; Empowering people through health literacy; Prevention and wellbeing; Enhanced health data; Interfaces between health, disability, and aged care systems, *ibid*.

3. Causation is not certain, but activity-based funding provides an incentive to reduce costs, and cost growth slowed after its introduction, falling to a sustained rate of around 2.5%, Independent Hospital Pricing Authority 2023.

To achieve all this, the Agreement should be restructured to include an overarching System Reform Agreement that sets out:

- **A vision** – how the system will change over the life of the Agreement, including changes to the roles of major parts of the system and the roll-out of new models of care and care delivery
- **Accountability** – the roles and obligations of the federal government, states, Local Hospital Networks, and Primary Health Networks in achieving system reform
- **Resources and incentives** – the funding, incentives, and targets that will achieve system reform.

Specific funding agreements and reform action plans could then sit under the overarching strategy, going into greater detail on hospitals, primary prevention, mental health, workforce, digital infrastructure, and so on.⁴

The following chapters suggest reform areas that could be built into both the overarching strategic agreement and the reform plans.

4. This would be similar to the approach proposed in the Draft National Strategy for the Care and Support Economy: DPMC (2023).

2 Shifting care out of hospitals

Why a national plan is needed

There is good evidence that moving some kinds of care out of hospitals can improve quality of care, access to care, and the financial sustainability of the system. It could also reduce infections, helping to reduce spikes of hospital demand in winter and contain future pandemics.

Leading health systems around the world, and many states in Australia, recognise that the balance of health investment must shift away from hospitals and towards community-based care. This is a necessary response to the rising tide of chronic disease and multi-morbidity, which requires more intensive, ongoing management to keep people healthier and reduce the need for hospital stays.

Many models of care that shift all or part of the patient's care into home and community settings can improve patient outcomes and experience.⁵ They can also reduce infrastructure costs over time, making the system more sustainable.

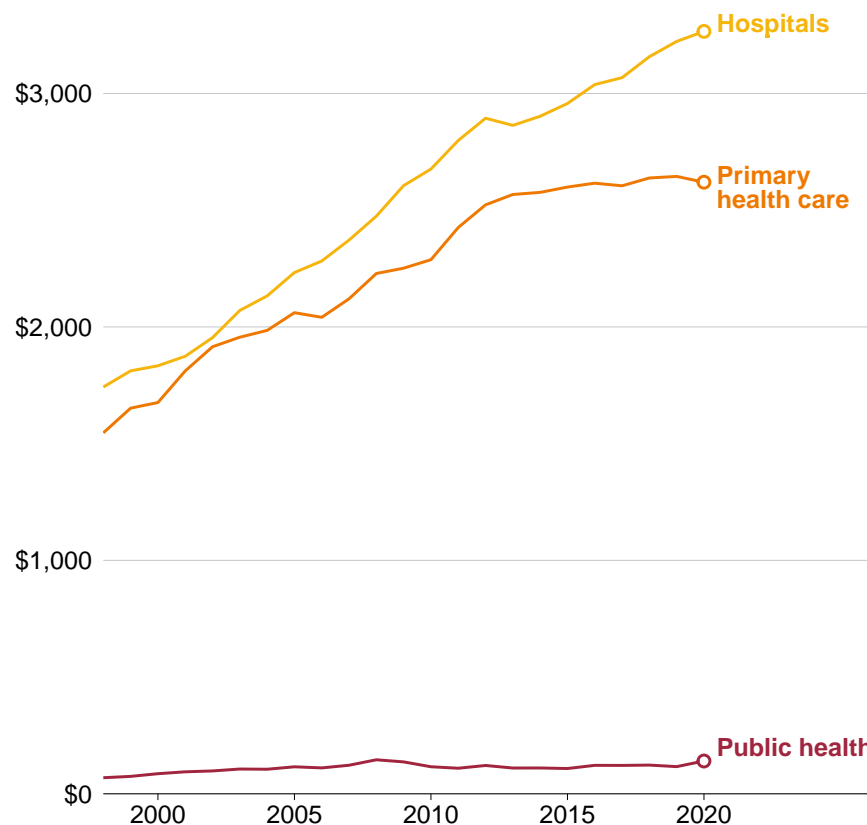
More intensive, multidisciplinary, and integrated models of primary care are also needed, to better manage increasingly complex patient needs and bring down rates of preventable hospitalisation.⁶ It will be difficult to build up these models without constraining hospital spending growth, which will otherwise draw funding and workforce away from other settings.

Reshaping the health system will only succeed if there is a clear plan. It will require collaboration between different levels of governments and across different parts of the health system.

5. Ricauda and Barclay (2012).

6. Breadon et al (2022).

Figure 2.1: Hospital cost growth has outpaced other health expenditure
Total per capita expenditure, by area of spending



Note: Expenditure includes government and non-government spending.

Source: AIHW (2023a).

There is already some momentum, with new programs to move care out of hospitals springing up across the country. State governments have expanded models of care that shift parts of surgical hospital stays into patients' homes. The federal government has funded urgent care clinics,⁷ and states have established their own,⁸ to shift lower-complexity emergency department visits into specialised primary care clinics.

But bigger structural change is needed, similar to what Denmark has achieved (see Box 2 on page 10). In Australia, it will take a sustained effort to reverse the trend of hospital spending rising much faster than investment in primary care (Figure 2.1 on the previous page).

Recent state election platforms have focused on hospital expansion, suggesting that traditional, hospital-centric models loom large in how governments and communities think about the future of the system. The next version of the Agreement could be the engine for changing this, unlike the current version, which reinforces the status quo.

The current version locks funding into established models, including through the strong gravitational pull of activity-based hospital funding, and through rules that enforce siloed responses, such as constraints on Medicare billing by hospitals, or on how and where hospital funding can be spent. New models and platforms often lack a secure funding source. For example, existing urgent care centres lack ongoing funding, and there is no clear pipeline of funding to expand the model.

Many of these new models require sharing information and expertise, and coordination of effort across the system. For example, emergency departments and urgent care centres should be working together to manage patient flow. And hospital specialists should be working with

general practices to support chronic disease management, such as under the new federal initiative, 'MyMedicare', which includes a focus on frequent hospital attenders who often have complex health needs.

What the Agreement could look like

Building new care platforms to divert and prevent hospital care

The Agreement should specify new platforms that will be built up to reshape the system and move care out of hospitals.

One example is urgent care centres, which can move less complex emergency care into primary care settings, as discussed above.

Another could be intensive 'prehabilitation' and respite for older people with complex health needs. It would improve their health, give their carers a break, and give them a chance to try out living in a residential aged care setting. This could reduce the need for hospital stays, and may enable earlier discharge from hospital for patients who cannot yet return home.

The Agreement should outline how these services will be funded, how they will operate, how they will connect with other parts of the system, and how many will be built. It should specify how Local Hospital Networks, Primary Health Networks, and health departments will plan and support the services. Otherwise, there will be too much inconsistency, and no clear plan to reshape the system. The parameters that the Agreement should include are shown in Box 1 on the following page.

Other platforms should be included that might not be jointly funded, but which require collaboration between federal- and state-funded systems to succeed. One example of this is GP practices with enrolled patients participating in the new MyMedicare funding model for people who go to hospital frequently. The Agreement could specify that public

7. Department of Health and Aged Care (2023a).

8. For example, NSW, Victoria, and Queensland have all made recent investments: NSW Health (2022); Department of Health (2022); Queensland Health (2023).

hospitals will provide secondary consultation support to these clinics, and support information sharing and discharge planning.

Committing to build up a small number of new, community-based settings for care would avoid innovations being marooned in pilot stage, with no pathway to expansion. Instead, states and PHNs would have a firm foundation for long-term planning, with clear priorities and certainty about how much funding was coming, and when. It would help form the basis for clearer communication with clinicians, patients, and the community about how the health system will change, gaining support for these reforms.

A deal could be struck to fund these new platforms. States have long argued for the federal government's share of the growth in public hospital spending to increase from 45 per cent to 50 per cent.

The federal government should provide this extra 5 per cent of growth funding, but allocate it to new service models such as those outlined above. This would create a growing slice of health funding to rebalance the health system over time. States should also make financial or in-kind contributions to these models, such as providing workforce, planning, and other support.

Trimming hospital stays

Another funding reform could reduce hospital lengths-of-stay through so-called 'normative pricing'. This refers to paying for what care 'should' cost, in this case based on best practices that reduce the time patients spend in hospital. For many surgeries, the average length of stay is high, as is variation in length of stay across hospitals.

Admissions for total hip replacements average about 5-to-6 days in large and major hospitals, but in many hospitals it is more than 7 or 8 (Figure 2.2 on the next page). In Canada, same-day discharges are increasingly common for this procedure, and a study found that,

Box 1: Defining new service platforms

The Agreement should specify the following aspects of new care platforms.

Funding

How services will be paid, and a five-year plan to build more of them where they are needed most

Workforce

The mix of workforce roles, which will help determine the cost of care

New workforce roles to scale up in these new settings

Planning

Where services are needed, based on the mismatch between supply and demand, and, where relevant, proximity to hospitals or other kinds of care

Partnership roles

What Local Hospital Networks, Primary Health Networks, and health departments will contribute, for example joint planning, sharing workforce and clinical information, and other in-kind support

Accountability

What care should achieve, including estimates of how many hospital visits were avoided

compared to visits spanning two days, same-day discharges had in lower hospital costs, fewer emergency department visits, and less patient time away from work, among other benefits.⁹ Length of stay for procedures like this has been declining. But the decline has been too slow, and the level of variation among hospitals has stayed too high.¹⁰

Adjusting activity-based funding for a shorter length of stay for specific procedures would help shift care out of hospital. Over time, this would mean less investment is needed to expand hospital infrastructure, freeing up funding for primary and community-based care.

Time in hospital may need to be replaced with virtual care or home visits, and in some cases those costs may approach those for a longer hospital stay. To reflect this, and the fact that some frail or complex patients will need longer stays, normative pricing should incorporate costs for out-of-hospital care and be based on appropriate assumptions about patient eligibility for early discharge.

New models of shared care

Shared care refers to multiple healthcare providers collaborating and sharing responsibility for the care and treatment of a patient. It can shorten or prevent hospital admissions, as models of care developed during the pandemic help illustrate.

Several states developed new models of care for COVID patients who were at risk of rapid deterioration, but who were not sick enough to justify a hospital admission.¹¹

Some models used a combination of remote monitoring, regular telehealth check-ups, and rapid escalation to primary, specialist, and

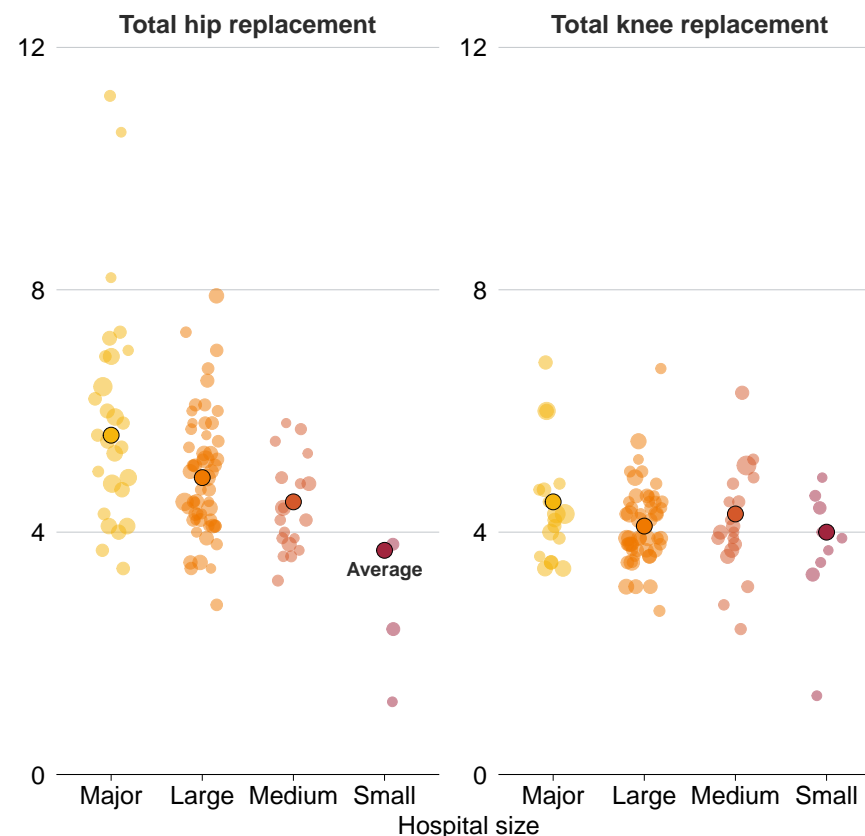
9. Zomar et al (2022).

10. For example, the inter-quintile range (a measure of variation) in the length of stay for knee and hip replacements remained high between 2012 and 2020, with no downward trend AIHW (2023b).

11. Gray et al (2022); and Lim et al (2022).

Figure 2.2: The average time spent in hospital for a hip or knee replacement varies considerably

Average length of stay (days) for knee and hip replacements by hospital and hospital size, 2018



Source: Grattan analysis of AIHW (2023b).

in-hospital care, using agreed pathways developed by Primary Health Networks and hospitals. Using technology, a new type of care was delivered in people's homes, connecting them to the right part of the health system at the right time.

Shared care models have also been developed in Australia and around the world for many other types of care, ranging from maternity to cancer, diabetes and mental health care, and to integrate health and social care services for patients with complex needs.

There should be ongoing experimentation to develop models like this to help keep people at high risk of hospitalisation as healthy as possible. Funding rules can make this difficult, by locking funding into one setting or another. The next version of the Agreement should change this, supporting innovation in shared care.

The Agreement should allow Local Health Networks to apply to 'cash out' existing funding streams and collaborate with Primary Health Networks to develop and evaluate models of shared care.¹² This could be topped-up with funding for design, set-up, and evaluation.

The objectives of pilots should be clear. They should seek to reduce hospital demand and improve patient outcomes. The cost should make it realistic to scale the model if it works. National coordination would help ensure that projects learn from each other and that evaluations span states when they are trialling the same thing.

Only initiatives that require close collaboration across different parts of the health system should be funded, and applications should be submitted jointly by Local Hospital Networks or states and Primary Health Networks, potentially in collaboration with private sector partners.

12. For other ways the Agreement could support collaboration between Local Hospital Networks and Primary Health Networks, see Box 3 on page 14.

Box 2: The Denmark model

Denmark has reconfigured its health system, shifting care away from hospitals and into general practice. There are many differences between Denmark and Australia, but Denmark's experience shows what is possible with committed leadership and a clear plan.

Denmark drastically consolidated hospitals, shutting smaller ones and centralising services in larger centres. Between 2007 and 2016, the number of hospitals in Denmark almost halved.^a This was supported by measures to strengthen primary care, prevention, and digital health tools, including the introduction of electronic patient records.^b

The results are promising: since 2007, hospital costs have been stable, and hospital productivity has increased.^c Waiting times for surgery and length of stay have both decreased, and over the 2007 to 2016 period, Denmark reduced the number of hospital beds per person by almost a third.^d By comparison, the number of hospital beds in Australia remained steady over the same period.^e

Reform is continuing. In 2019, Denmark took new measures to expand the role of primary care, improving continuity of care and care coordination. To achieve this, funding to the regions has been tied to criteria such as hospital admissions, in-hospital treatment for chronic care patients, unnecessary readmissions within 30 days, increased use of telemedicine, and better integration of IT across regional and municipal sectors.^f

a. Floystrup et al (2022); and Christiansen and Vrangbæk (2018).

b. Floystrup et al (2022); and Christiansen and Vrangbæk (2018).

c. Christiansen and Vrangbæk (2018).

d. OECD (2023a).

e. OECD (ibid).

f. The Commonwealth Fund (n.d.).

3 Filling access gaps

Why a national plan is needed

Structural gaps in access to care lead to avoidable illness, avoidable health spending, and a drag on the economy. These problems entrench health inequity, because they affect certain groups much more than others, particularly people with low incomes and people who live in remote areas.

Some of the biggest gaps in access are in:

- General practice
 - In small rural towns, there are half as many full-time equivalent GPs per person, compared to inner areas.¹³
 - People living in outer regional, remote, or very remote areas are about 30 per cent more likely to report waiting too long to see a GP than those living in major cities, and are almost twice as likely to delay or avoid GP care because of cost.¹⁴
- Specialist care
 - In 2021-22, more than a quarter of Australians felt they waited too long to get specialist medical care.¹⁵
 - In Victoria and Queensland, some patients requiring urgent care wait more than two months for an initial specialist appointment in an outpatient clinic.¹⁶
 - In southern Tasmania, patients with an urgent referral wait more than 900 days to see a neurologist.¹⁷
 - Bulk-billing rates for specialist appointments are low, and in some specialties it is common for fees to be more than double the schedule fee.¹⁸
- Dental care
 - In 2021-22, 16 per cent of Australians skipped going to the dentist because of the cost.¹⁹
 - Australians living in areas of most socio-economic disadvantage are more than twice as likely to avoid seeing the dentist because of the cost, and Australians without dental insurance are more than three times as likely to have not seen a dentist for at least five years.²⁰
- Mental health care
 - In 2021-22, 38.9 per cent of people who needed mental health care delayed or did not see a health professional on at least one occasion.²¹
 - An even higher proportion of Australians skipped or delayed needed visits to the psychologist (44.1 per cent) or psychiatrist (43.7 per cent) on at least one occasion. More

13. Department of Health and Aged Care (2023b).

14. ABS (2022a).

15. Ibid.

16. Wait times for urgent care are recommended to be less than 30 days: Duckett (2018).

17. Tasmanian Health Service (2023).

18. Duckett et al (2022, pp. 19–21).

19. ABS (2022a).

20. Brennan et al (2020) and ABS (2022a).

21. Ibid.

than half of the time, care was skipped or delayed because of the cost.²²

- One in three psychologists reports not being able to take on new clients due to high demand.²³

It will take national collaboration and long-term plans to fill these access gaps.

In rural areas with a shortage of general practice care, existing health workforce and infrastructure are split across services funded by federal and state governments. Attracting and retaining workforce will be much easier, and more efficient, if there is a coordinated approach to recruitment, employment and supporting services, and infrastructure.²⁴

Patients across the country are facing high fees for specialist care, and long waits for specialist appointments in public hospitals.²⁵ Again, the most effective solution will come from different parts of the system working together. That is because specialists are employed in both federally-funded clinics and in hospitals managed by state governments. Each should work closely with GP clinics to avoid unnecessary referrals.

There is a structural hole in public dental funding, and dental services are split across levels of government. A national plan and new investment is required to transition to universal coverage.²⁶ The gaps in mental health care could also best be tackled through a coordinated national plan.

22. Ibid.

23. Australian Psychological Society (2022).

24. See, for example, shared employment models in NSW and proposals for integrative community-controlled providers: Davey (2020) and National Rural Health Alliance (2022).

25. Duckett et al (2022).

26. Duckett et al (2019).

What the Agreement could look like

As with shifting care out of hospitals, the Agreement should define funding models, workforce models, an investment trajectory, partnership requirements, and accountability measures to close the worst access gaps.

In areas with too little GP care, federal and state governments should work together to expand existing services, or set up new ones.²⁷ In areas where waits for specialist care are far too long, governments should join forces to expand public hospital specialist clinics.

In both cases, the Agreement should specify a trigger for action. It should define when the amount of GP care per person, or the waiting time for specialists, is unacceptable, unlocking new investment.

While new investment is necessary, national collaboration can do much more, allowing access gaps to be filled in new ways.

Advising and supporting primary care could become a much bigger part of what specialist clinics do. This would help GP clinics to do more, reducing referrals, and slashing wait times and fees.²⁸

Rural gaps in primary care access could be filled by new community-controlled organisations funded by federal and state governments, or by expanding the role of existing rural hospitals into primary care. This is just one example of so-called 'co-commissioning', where different levels of government work together to buy care and manage services. The Agreement should also support co-commissioning much more broadly (see Box 3 on page 14).

Beyond these examples, there are other areas where a national plan is needed to improve access to care, including dental and mental health.

27. Breadon et al 2022.

28. Many clinics already do this, but inconsistently. For more on how secondary consultation can improve access and quality of care, see: Breadon et al (2022) and Duckett et al (2022).

4 Prevention

Why a national plan is needed

A large and growing share of Australia's disease burden is caused by chronic diseases. Over the past three decades, the total burden from chronic diseases has grown by almost 40 per cent.²⁹

But many chronic diseases are preventable. About 38 per cent of the burden of chronic diseases is caused by modifiable risk factors, such as smoking, obesity and overweight, poor nutrition, or social isolation.³⁰ With some key risk factors, including obesity, on the rise, we can expect this trend of rising preventable disease to continue.

There is good evidence that many preventive interventions are effective and excellent value-for-money. But Australia spends much less than the OECD average on prevention, at less than 2 per cent of health spending.

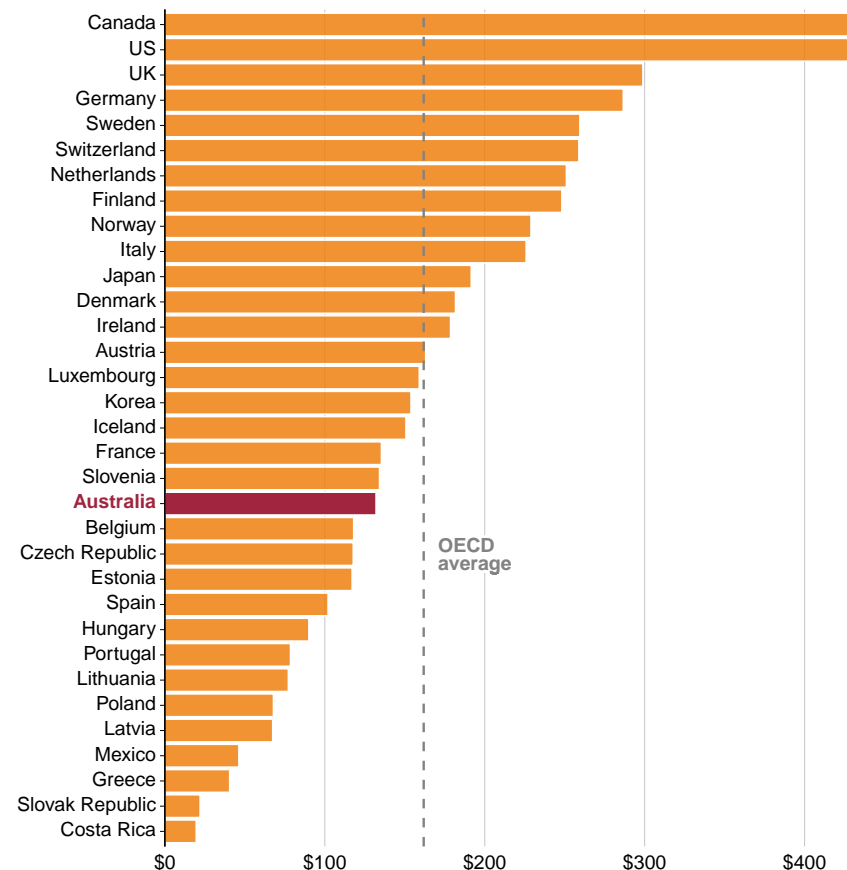
Many government reviews, reports, and strategies have recognised that prevention funding is insufficient, notably the National Preventive Health Strategy agreed by federal and state governments in 2021, which calls for prevention funding to increase to 5 per cent of health spending by 2030. But there is no plan to achieve this, and the last national agreement on prevention funding was abolished in 2014.³¹

Along with a national plan to increase prevention spending, Australia needs better systems to coordinate and prioritise that investment.

In many cases, prevention works best when different policy levers (e.g. regulation, service delivery, and social marketing) and different

Figure 4.1: Australia spends less on prevention than many other OECD countries

Per capita expenditure on public health, PPP adjusted



Source: Grattan analysis of OECD (2023b).

Note: PPP = Purchasing power parity.

29. Breadon et al (2023).

30. AIHW (2021).

31. Parliament of Australia (n.d.).

portfolios (e.g. health, transport, consumer protection, and environmental protection) work together. And in many cases relevant levers sit with different levels of government, requiring further coordination. But prevention is poorly coordinated in Australia and prevention spending doesn't always go to the highest-value investment.

What the Agreement could look like

A recent Grattan Institute report, *ACDC (Australian Centre for Disease Control): Highway to health*, proposed a new approach to prevention funding, which should be part of the next version of the Agreement.³²

There should be a national funding agreement for prevention, with co-investment by federal and state governments at an agreed ratio, increasing over time. Investments should be limited to those recommended by the new ACDC as contributing to the goals of the National Preventive Health Strategy (NPHS) and being highly cost-effective.³³

Rather than setting out a new set of prevention priorities, the Agreement should refer to those in the existing National Preventive Health Strategy, which should be updated every five years. This would ensure that the focus of prevention investment can be updated when new challenges emerge, without requiring changes to the Agreement.

32. Breadon et al (2023).

33. Assuming that this function is part of the ACDC's role, which has not been confirmed. Otherwise, the link to NPHS goals and evidence of cost-effectiveness should be assured another way, for example through a submission process.

Box 3: Joined-up commissioning

When decisions about healthcare are made by one level of government in isolation, it can ignore the shared workforce, infrastructure, health needs, and health risks in a region. The result can be inefficiency, duplication, and services that don't work well together.

The current version of the Agreement encourages Local Health Networks (LHNs) and Primary Health Networks (PHNs) to work together to plan and fund healthcare in their region, but it does not create a clear framework for this, or require it. As a result, the degree of collaboration varies around the country.

The next version of the Agreement should include a co-commissioning funding agreement that supports place-based approaches. It should require joint workforce, healthcare, and digital infrastructure planning as a basic standard for all regions. Then, it should support LHNs and PHNs that want to go beyond joint planning.

As discussed above, there should be standard arrangements for LHNs and PHNs to test new shared care arrangements and to jointly commission GP services where there is a market failure.

The same should apply if LHNs and PHN want to set up a local partnership to improve outcomes through a collective impact approach.^a And in some instances they may want to go even further: pooling their funding for a region to jointly commission care for that community.^b

Template legal, funding, and reporting arrangements should make it easier to break down the silos in the system.

a. Australian Institute of Family Studies (2017).

b. This approach is being trialled in the Torres Strait: QAIHC (2023).

5 Workforce

Why a national plan is needed

There are structural workforce shortages for many different roles in the health system, in many different regions, and in some cases nationwide.

Some of these shortages have been exacerbated by attrition, and disruption of training and migration, caused by the pandemic. But the deeper problem is the absence of a national workforce strategy and implementation plan. The situation can be expected to deteriorate further given growing workforce demand in healthcare, disability care, and aged care in the years and decades ahead.

Limitations on health professionals using all their skills make shortages worse, as do failures to better use proven workforce roles such as nurse practitioners, nurse proceduralists, and physician assistants.

National coordination is critical for workforce reform, because federal and state governments set policy for different parts of the workforce training pipeline and for different workplaces that employ the same professional groups.

What the Agreement could look like

The Agreement should commit governments to actions that will solve the workforce crisis.

They should start by setting out where we are heading. The Agreement should state how workforce roles and the mix of professions will shift. Directions for change could include better supporting and rewarding generalist medical roles, continuing to shift the emphasis of community pharmacy from retail to service delivery, ensuring workers can use all their skills, and greater effort to retain workers.

Many of these directions are already laid out in various policies and plans.³⁴ The Agreement should consolidate those directions and provide a roadmap for change, focusing on areas where coordinated national action is needed.

The Agreement should commit governments to develop a national model for the supply and demand of different professions.³⁵ They should agree to set academic and clinical training positions to resolve current shortages, and avoid future ones.

The Agreement should also feature a short list of workforce roles to scale across the country. There is strong evidence that roles such as nurse proceduralists, nurse practitioners, and physician assistants can increase access, quality, or efficiency.³⁶ These roles exist, but often at a pitifully small scale, primarily due to cultural barriers and inertia, and in some cases regulatory and funding constraints.

The Agreement should help overcome these barriers by specifying which workforce roles should be scaled up, setting targets for employment, and providing tapering financial incentives for achieving widespread adoption of these roles.³⁷

New training approaches could build skills faster and more flexibly. Since training spans federal- and state-managed systems, this is another area where national collaboration is needed. New approaches could include competency-based training that builds new pathways

34. Notably in the National Medical Workforce Strategy, Department of Health 2021.

35. The UK government has recently committed to publishing independent projections for the National Health Service workforce: Kings Fund (2022). The National Medical Workforce Strategy also suggests that population health needs should determine the supply of medical graduates: Department of Health (2021).

36. Duckett and Breadon (2014).

37. *ibid.*

within and between professions,³⁸ and which use technology to provide supervision and training in rural and remote areas.

38. Pertiwi and Hariyati (2019).

6 Measuring what matters

New performance measures will be needed for new care platforms, as outlined above, including estimating reductions in hospital demand, where relevant. But there should also be changes to reporting for existing parts of the system. These changes should provide the information needed for the system to learn and improve over time, getting more effective, fairer, and greener.³⁹

The Agreement should set priorities for expanding outcome measurement using existing clinical registries and making the results more transparent to clinicians, patients, and the community. Where possible, outcomes measurement should align with emerging approaches to measuring wellbeing.⁴⁰

Unacceptable gaps in health access and outcomes are one of the biggest failings of Australia's healthcare system. The most disadvantaged fifth of Australians are about 20 per cent more likely to have at least one chronic condition, and are about twice as likely to have two or more chronic conditions, compared to the most advantaged fifth.⁴¹ They are twice as likely to die before the age of 75.⁴² Life expectancy gaps between Indigenous and non-Indigenous Australians are 8.6 years for males and 7.8 years for females. Targets to close these gaps are not on track.⁴³

Refreshed performance measurement and reporting should show how well the system is working for people that it fails too often, such

as people who live in rural areas, Aboriginal people, poor people, and people with severe mental illness.

Better national data should be collected on virtual and in-home care, to help develop targets and funding models to support the shift away from hospital beds.

Australia is committed to reaching net-zero carbon emissions by 2050. The health system causes significant emissions, particularly public hospitals, which account for around one third of health sector emissions.⁴⁴ The Agreement should draw inspiration from ambitious targets in the UK's NHS and set consistent emissions reporting requirements for public hospitals, along with targets for emissions reduction.⁴⁵

39. Hardie et al (2022); and Zurynski et al (2020).

40. For example, the federal government is consulting on a wellbeing measurement framework: Leigh (2023).

41. ABS (2022b).

42. Adair and Lopez (2021).

43. Australian Government (2020).

44. Duckett et al (2020).

45. The NHS has set a 2040 net-zero target for emissions it directly controls, and a 2024 net-zero target for emissions it can influence, with reporting required in NHS Trust annual reports: NHS England (2022). Measurement in Australia could build on the NABERS rating scheme for public hospitals: NABERS (2023).

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