MEMBER BULLETIN

Healthy people, healthy systems

Strategies for outcomes-focused and value-based healthcare: a blueprint for a post-2020 national health agreement

19 December 2017

Background

The Australian Healthcare and Hospitals Association (AHHA) is a national peak body representing public healthcare providers. In response to a request from the Commonwealth Minister for Health, Greg Hunt MP, to provide him with a blueprint for a 10-year health funding agreement, AHHA has published 'Healthy people, healthy systems' (the paper) which details a series of reforms intended to improve the integration, value, cost effectiveness and management of the Australian health system.

This bulletin summarises the reform recommendations that AHHA has submitted to the Minister for Health, as well as the Opposition's health spokesperson, Catherine King MP. If members are seeking to read the paper in full, it can be accessed here.

VHA input and response

With parts of the health system suffering from duplication and structural inefficiencies, the VHA offers its support to the AHHA and its efforts to influence the long-term reform of the system.

If implemented, the recommendations that AHHA puts forward, would result in greater alignment of the acute and primary health sectors, improve the use of data to inform health planning, orient healthcare delivery to focus on accountability against outcomes and re-energise Australia's efforts to improve prevention and health promotion activities. Importantly, these recommendations are based on a comprehensive member and sector engagement process, undertaken throughout 2017, in which the VHA participated.

The paper offers a robust emphasis on a nationally consistent health system, which in the case of standardised datasets and performance benchmarks, is a positive direction for reform. While the role of state governments is not covered in depth, it is important to see the vision for a better-integrated acute and primary care sector involving the PHNs so clearly articulated.

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There is a focus throughout the paper on improving the value of healthcare, both from the perspective of the consumer, and also from the perspective of system funders and planners. This is a worthwhile ambition that must be married with a commensurate focus on equity of access, particularly in instances where healthcare interventions for people experiencing disadvantage might otherwise be categorised as 'low value'. The paper's recommended introduction of a metric to monitor institutional racism is a positive reform and could, in theory, be extended to ensure that all people experiencing social and economic disadvantage continue to experience full access to the public health system.

While the paper has set a 10 year horizon for the full suite of its recommended reforms, implementation, particularly within the two year period, might prove to be ambitious for a health system already grappling with significant change.

The VHA commends the blueprint to its members.

Priorities for recommended reform

The paper sets out four priorities for recommended reform, consisting of a number of short, medium and long-term actions over the next 10 years. These priorities are:

1. a nationally unified and regionally controlled health system that puts patients at the centre;
2. performance information and reporting that is fit-for-purpose;
3. a health workforce that exists to serve and meet population health needs; and
4. funding that is sustainable and appropriate to support a high quality health system.

1. A nationally unified and regionally controlled health system that puts patients at the centre	
Short term (within two years)	Establish an independent national health authority, distinct from the Commonwealth, and state and territory health departments, guided by a skills-based board with multi-jurisdictional representation and consumer and professional expertise, reporting directly to COAG (or the COAG Health Council). The authority would assume responsibility for functions currently led by the Independent Hospital Pricing Authority (IHPA), the Administrator of the National Health Funding Pool, the Australian Institute of Health and Welfare (AIHW), the Australian Digital Health Agency and the Australian Commission on Safety and Quality in Healthcare (ASQHC). The authority would assume responsibility for coordinating improvements in primary and dental care and cross-sector integration, including: • providing independent oversight of regional needs assessments, and identification of priorities in primary healthcare and prevention

	• ensuring coordination and integration between states and territories, local health networks (LHNs) and primary health networks (PHNs) (including processes for distribution of pooled funding at a regional level) • distributing Commonwealth funding to PHNs • financial management and audit of PHNs • performance monitoring and reporting for PHNs • providing advice on optimal use of existing capacity and evolving opportunities within general practice and primary healthcare services.
	Secure agreements between the Commonwealth and PHNs, and the states and territories with LHNs, establish consistent governance arrangements for regional needs assessments, priority setting and funding, aimed at a coordinated and integrated approach to reducing preventable hospital admissions and presentations.
Medium term (within five years)	The independent national health authority would report annually to the Commonwealth, and state and territory parliaments on its key performance indicators. Reporting would support regional needs assessments. Reporting would replace existing reporting, including the abolishment of: • the biennial report by AIHW to the Australian Parliament on Australia's Health • the Report on Government Services • National Health Performance Framework reports.
	The independent national health authority would support alignment of all agreements established by the Commonwealth that impact on shared health objectives, including reporting on their value to the overall health system. Examples include the National Indigenous Reform Agreement, the Community Pharmacy Agreement, the National Mental Health Agreement and Commonwealth budget investment in associated 'independent' entities such as NPS MedicineWise.

2. Performance information and reporting that is fit-for-purpose	
Data standards	
Short term (within two years)	All providers receiving government funding would be required to supply data on patient outcomes and other service provision dimensions to better inform system performance. Relevant data from the private sector (hospitals, general practitioners, allied

	health, private health insurers, etc) would be captured, with the requirements for public reporting of healthcare quality and safety also applying to private facilities and service providers.
	A national minimum dataset and data dictionary for primary healthcare would be developed and include: • alignment with acute care national minimum datasets to support data linkage and development of outcomes data reporting; and • data submission a requirement for those receiving an Medicare Benefit Scheme (MBS) provider number, practice incentive payments, or other government funding.
	A whole-of-system framework would be developed for a consistent and coordinated approach to the collection and use of patient-reported experience and outcome measures (PREMs and PROMs) across the health system, with standardised national definitions and descriptors.
	The matrix for identifying, measuring and monitoring institutional racism would be validated in hospitals and health services.
ICT architecture	
Short term (within two years)	Business plans for the Australian Digital Health Agency would include development and implementation of interoperability standards to support information sharing across the health system, with this work being fast-tracked for achievement within two years.
	Work currently underway considering secondary use of My Health Record data includes using outcomes data to support better stewardship and governance of the health sector, with these data being made available to the proposed independent national authority for public reporting purposes.
Medium term (within five years)	Standards for general practices' electronic health records would be developed and implemented. Elements addressed include: **1.** A defined electronic health record data model that links related data elements **2.** Consistent data element labels and definitions **3.** Use of standardised clinical terminologies and classifications **4.** Accreditation of general practices in terms of electronic health record capability and processes.
Analytical and reporting capability	
Short term (within 2 years)	A strategy would be developed for a standardised national approach to measuring value-based patient-centred outcomes, and is reported at different levels of the healthcare sector, and to different audiences.

	This includes setting clear objectives, defining target audiences, developing transparent principles and methodology through broad consultation, and timely monitoring and evaluation of unintended consequences.
	The *Choosing Wisely Initiative* would be extended to provide individualised feedback to professionals who continue to provide services identified by the initiative. Similarly, the work being led by the ACSQHC mapping variation in care would include a feedback loop to professionals where significant variation is identified. The *Choosing Wisely Initiative* would be integrated with the work being undertaken by the ACSQHC to ensure alignment of activity and to reduce duplicated effort and investment of public funds.
	Stakeholders are given financial and non-financial incentives to cooperate in introducing standardised tracking of health outcomes and costs of care.
Medium term (within 5 years)	Performance would be benchmarked against standardised sets of value-based patient-centred outcomes, with: • anonymous public reporting across and within health systems, but with reporting back to providers of their relative performance, with a focus on learning and continuous improvement • validating methodologies for outcomes tracking and risk-adjustment.
	A matrix for identifying, measuring and monitoring institutional racism would be incorporated into performance information and reporting requirements across the health system.
	Regional needs assessments will be used to determine projected needs of the population 5–10 years into the future to inform investment in prevention.
Long-term (within 7–10 years)	Outcomes data would be published to empower patients to make informed choices about treatment options and providers.
	Stakeholders would be given financial and non-financial incentives to improve healthcare value, based on standardised high quality outcomes data.

3. A health workforce that exists to serve and meet population health needs	
Short term (within two years)	A national workforce reform strategy would be developed, including action plans for medium term (within 5 years) and longer term (within 7–10 years) reforms. This strategy would extend beyond the adequacy, quality and distribution of the workforce as it currently exists, to pursue outcomes-focused and value-

	based changes in scopes of practice and models of care to meet public need, with coordination of education, regulation and funding (at the Commonwealth, state and territory, and regional service levels) for both regulated and unregulated practitioners. This strategy is linked with regional needs assessments and strategies.

4. Funding that is sustainable and appropriate to support a high quality health system	
Short term (within two years)	Current Commonwealth funding levels for public hospitals, including the growth formula, would be maintained for seven years with a review commencing at year five, to determine funding which could be quarantined as pooled PHN/LHN regional funding for cross-sector care coordination and delivery.
	Health services would be funded on a regional basis, with: • shared needs assessments between primary and hospital sectors, and regional planning, informing the distribution of funding • shared needs assessments at a regional level informing investment in prevention • continued investment in mechanisms to integrate healthcare across sectors (e.g. through HealthPathways) • the architecture of agreements being centred on patient needs, not individual sector needs, while still recognising that models of care must be sustainable and attractive to health service providers as well as patients.
	To support the movement to a value-based approach to healthcare funding, stakeholders would be given financial incentives to cooperate in introducing standardised tracking of health outcomes and costs of care.
	A funding formula with a 25% component for performance relating to the top four chronic diseases, risk factors or determinants would be trialled for two years. This would expand to cover the top 10 chronic diseases, risk factors or determinants within five years, and all health conditions within 10 years. Conditions would be set, based on available data, by the proposed independent national health authority.
Medium term (within five years)	Funds would be dedicated to prevention activities based on the regional needs assessments determining projected needs of the population over 5–10 years. These funds would initially target a return to funding levels of around 2.3% of recurrent expenditure on health, and be introduced incrementally over five years. Preventative health measures should be directed to activities that have been demonstrated to be cost-effective and which interpret lifestyle choices

	in the context of the opportunity costs and other incentives faced by individuals.
Long term (within 7–10 years)	Following the measuring and reporting of standardised sets of value-based patient-centred outcomes becoming embedded across the sector, stakeholders would be given financial incentives to improve healthcare value on the basis of outcomes data.

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