Redrawing Australia's next National Health Reform Agreement: confronting the wickedest of wicked problems

Next year will conclude the current (2020–25) National Health Reform Agreement (NHRA) and work is progressing rapidly to develop the next addendum. Established in 2011, the NHRA is an enduring agreement, describing how the Commonwealth, states and territories will "cooperate to achieve a sustainable, connected, and equitable health system that delivers the best outcomes for Australians".[1] The agreement represents the ultimate accord — binding all jurisdictions to cooperate on providing and expending $60 billion per year in health funding to the nation's best advantage.

As the historical focus has been primarily on hospital resourcing, recent addenda have struggled to deliver the broad reform and improved intergovernmental efficiency initially sought. In an environment of national public outcry around health delivery shortcomings,[2] a mid-term review was commissioned in 2023 to "consider whether the addendums' health funding, planning and governance architecture remains fit-for-purpose, given the shared priorities for better integrated care and more seamless interface".[3] The review, released in late 2023, is comprehensive and makes 45 recommendations to address the flaws in the concluding agreement and overcome ongoing dysfunction in our national health system.

"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', … the level of enduring reform that was anticipated has not been achieved."

The review made ten key thematic recommendations (the Box).[3]

This perspective article comprehensively supports the review recommendations as critical building blocks to both the success of the next NHRA, and the very sustainability of Australia's traditionally equitable, affordable and accessible health system. However, success will rest on overcoming seven major policy barriers that have long impeded such essential reform. These "wicked problems" have undermined previous attempts at significant reform, and must be confronted and addressed if the new addendum is to succeed. The seven policy barriers are discussed below.

Acceptance that the fundamental Medicare principles of equitable access on the basis of clinical need and being free of charge, can no longer only apply to hospital care

The review leans heavily on the nation's Medicare principles. However, although the criticality of access to primary care prevention, early intervention and effective chronic disease management is unquestioned globally,[4] our national principles carry no such requirement. Without the inclusion of access to primary care within them, interjurisdictional strategy

Consistent themes identified in the review

Source: Mid-term review of the National Health Reform Agreement Addendum 2020-2025 final report.[3]

1. Whole of system agreement. Establishing the National Health Reform Agreement (NHRA) as a strategic reform agreement, with the remit and governance to take a whole of health system view. **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 health care 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 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. Coronavirus disease 2019 (COVID-19).** Providing flexibility in the agreement to respond to large external shocks and major disruptions to the system, such as COVID-19. ◆

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development will continue to be largely hospital-focused, and the opportunity to maximise good health care in the most appropriate setting lost. The review suggests incentivising "the provision of safe quality care in the most effective setting, such as primary care, … where there is evidence of reduced demand for expensive hospital settings." Although under the current agreement, state governments receive an annual funding increase capped at 6.5% to maintain free public hospital access,[5] no such Medicare principle applies to the sector best placed to avoid such contact. Following a ten-year funding freeze, Australians currently receive a devalued Medicare contribution towards non-hospital care,[6] with general practice services now increasingly dependent on a user-pays basis to remain viable.[7] The Medicare principles of health equity based on clinical need and being free of charge to those who require it must be expanded to apply to all essential care: community and hospital-based. This important national policy debate is long overdue and must be addressed before our next agreement.

Creating infrastructure to effectively link Commonwealth and state-funded service delivery

This outcome has long eluded the NHRAs, and the dual nature of health funding and consequent concern regarding intergovernmental cost shift remains our health system's greatest source of inefficiency and service gap.[8,9] Given the reality of ongoing dual governance complexity within our health system, a linkage between sectors can only realistically occur locally, within engagement rules potentially set nationally by the agreement. This would legitimatise the integration of existing geographical service delivery across sectors, recognising specific local strengths and challenges, and using evidence-based approaches, workforce restructure and digital exchange to optimise patient-centred care. Although mentioned in both the current agreement and the review, such approaches will not occur without recognition of the plethora of individual delivery organisations currently serving communities. Alliance governance arrangements[10] have worked internationally to deliver tangible benefits in such environments. They respect the established history and governance of existing local service providers but bind them together via ongoing relationships, memoranda and service agreements to collectively fund and address shared problems across the community and hospital sectors. At a minimum, such arrangements should include representation and commitment from major service provider groups and consumers locally, with defined resourcing, responsibility, outcomes, terms of agreement and key performance indicators (KPIs) clearly agreed and measured.[11]

Establishing continuity of care arrangements between sectors with the patient at the centre

International literature demonstrates the sizeable positive impact of care continuity on hospital use, care cost and patient experience.[12] Therefore, the new agreement should prioritise the delivery, measurement and incentivisation of continuity of care as a key deliverable. This undertaking could minimise fragmentation and workforce duplication, improve patient partnership and provide the framework for the review's planned bundled payments across sectors.

This work should include exploration of the interface between the public and private health systems; a topic touched on briefly on page 34 of the review. The private health care sector accounts for over 50% of elective surgery; most medical, diagnostic and specialist community care; and in some states is a reliable backup for unmet surgical demand. Over 50% of Australians have private health insurance,[13] but paradoxically are only able to use it for in-hospital or limited community allied health care, creating perverse incentives for hospital options at the expense of more efficient community care of equivalent quality.[14] Intersectoral models of care that bridge the public and private sectors to address patient care deficits should be actively explored in the next addendum.

Mandating relevant key performance indicators and evaluation

A documented flaw in previous agreements has been the absence of measures specific enough to guide and prioritise the desired intersectoral activity and accountability.[3] To achieve change, such KPIs are a priority. At a minimum, they should include evidence of effective data sharing across settings, such as the New South Wales Lumos program,[15] which linked general practitioner post-discharge visits with reduced re-admission. Consumer and provider experience measures,[16] comparative evaluation of new models with traditional care, efficiency assessments and continuity of care mapping are also fundamental but currently absent. Such KPIs align with the outcomes sought by the review and operate at the level where real change is required.

Recognising and supporting the sizeable, ongoing and system-wide change management required

Incorporating even a small number of the review recommendations into the new agreement represents enormous cultural and structural change, and the challenge faced by current jurisdictional stakeholders cannot be underestimated.[17] Support and direction from those who have effectively championed and delivered such change will be essential to supporting our health workforce in new ways of working, creating an all-of-system health culture, and overcoming the inevitable challenges involved.[18] Such leadership should be intersectoral and resourced at both strategic and local levels throughout the life of the new agreement.

Incentivising prevention

A prime opportunity for improved health and reduced mortality lies in effective, population-based health promotion and disease prevention,

recently documented by England's National Health Service Health Check,[19] which lowered risk across all multiorgan disease outcomes over a decade. Obesity remains central to our accelerating chronic disease burden — driving the increased prevalence of diabetes, cardiovascular disease, osteoarthritis, chronic kidney disease and many cancers. We remain one of the heaviest nations on earth, particularly in regional Australia. Our National Obesity Strategy 2022–32[20] explains the importance of immediate action. Coordinated evidence-based prevention activity should be explicitly prioritised in the next addendum, incentivising existing supports within our communities, and measuring access and impact over time.

The avoidance of new bureaucracies in an already crowded field

Despite identifying numerous current oversight bodies, the review suggests creating a new national entity, the Innovation and Reform Agency, to take responsibility for driving and reviewing the system-wide innovation required. The danger in this is the significant time taken to establish such bodies, their track record of defunding,[3] and the risk that the hard work to create and maintain change becomes someone else's responsibility. The review wisely envisages "a small group of experts, rather than a large government 'agency', working with all jurisdictions and national bodies" as the preferred approach. Such an arrangement would allow rapid establishment, strong skill transfer, and the opportunity to immediately influence existing structures, roles and relationships.

Conclusion

As the review acknowledges, the stakes are escalating rapidly for the next agreement. The review rightly calls out the deficits in our current intergovernmental arrangements, and makes important recommendations for the ongoing funding and performance reform of our state and federal jurisdictions. As the agreement covers the largest parcel of national health resourcing, it is important that there is broad discussion about what outcomes the NHRA should prioritise, what interventions are most critical, and how they should be measured and rewarded. Appropriately valuing, supporting and integrating primary care into the agreement — a key recommendation of the review — will be as challenging as it is critical and must not be allowed to again fall through the cracks. The new NHRA should ensure that we use limited health resources optimally, work much more effectively as all-of-system players, and take constant heed of our community's pain points in delivering equitable health care.

The review offers a brave and considered assessment of the best way forward to safeguard an accessible, high quality health system. We must now honestly acknowledge the sizeable structural barriers to implementation, and promote the national discussion and policy reform required for success.

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