



Expert Report 1

Resource management in NSW Health

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This Expert Report was undertaken by the Sax Institute for the NSW Special Commission of Inquiry into Healthcare Funding.

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Introduction

1. This expert report for the Special Commission of Inquiry into Healthcare Funding (the Inquiry) focuses on the way NSW Health funds health services delivered in public hospitals and community settings.
2. It is important to emphasise that any changes recommended by the Inquiry to the governance, accountability and scope of functions of NSW Health, which are beyond the brief of this paper, could influence the appropriate funding arrangements. These changes could include, for example, the extent of decentralisation versus centralisation of roles and functions and possible changes to the accountabilities of CEOs to the Secretary vs Board Chairs.
3. The comments below regarding the funding model were primarily drawn from:
 - Research evidence
 - Submissions made to the Inquiry
 - Discussions with local health districts (LHDs)/Ministry/Commonwealth personnel
 - Consideration of arrangements in other jurisdictions.

Background

4. Key obligations of the NSW Health system include 'ensuring the efficient and economic operation of its health services and health support services and use of its resources'.¹
5. Resource management is complex. Many factors must be considered to manage resources in an effective and agile way. Factors include those within NSW Health and those external to it.
6. Resourcing decisions are required across the spectrum of service planning, delivery, and interfaces with other systems. The consideration of resource management and allocation is not linear and needs to take into account the many factors likely to impact demand.
7. Some of the factors influencing resource management include emerging changes in population and demands on the health system. Resources required are impacted by consideration of efforts in prevention, aged care, acute care, other sectors and the interplay between these. Climate change and its impacts (such as heatwaves, droughts and floods) also create demands on the health system and resource allocation.

History

8. Before the introduction of the current activity-based funding (ABF) model, NSW had a two-tiered funding model.² The Resource Distribution Formula (RDF) model, in combination with the governance framework, made Area Health Services (AHSs) responsible for maintaining and improving the health of the population. The RDF was "deliberately neutral on the issue of efficiency",³ but the NSW Health system used other policy instruments such

as Service Agreements and performance reporting to encourage both technical and allocative efficiency (see Glossary).

9. At the highest level, funding was distributed from the centre to regions on the basis that each region should receive a fair share of funding to meet the needs of its catchment population.
10. At the next level, regions distributed funding to hospitals and health services on an expected basis at a set price per activity to achieve a standard 'efficient' cost of service. In fact, most hospitals ran over activity every year without additional activity funding, so the real price was less.
11. The goal was that this two-tiered funding model would have a greater focus on achieving allocative efficiency. As the RDF was never fully applied, however, a significant amount of historical funding (i.e. the same funding received yearly) remained embedded in the system - which is contrary to the goal of achieving equitable funding.
12. With the signing of the National Health Reform Agreement (NHRA) in 2011,⁴ there has been a greater focus on achieving technical efficiency. The NHRA led to fundamental changes in the way public hospitals are funded both throughout Australia (and specifically in NSW) by determining the contribution that the Commonwealth Government pays states and territories on the basis of their hospitals' activity and the National Efficient Price (NEP).
13. The NHRA seeks to:
 - Encourage activity that considers not just technical efficiency, but also aims to improve access, for example, by reducing waiting lists
 - Reduce funding risk on states (compared to the previous 5-year bilateral agreements between the Commonwealth and states) by connecting Commonwealth funding to: (i) activity and (ii) the cost of delivering services
 - Facilitate allocative efficiency within the hospital system by paying for activity that accounts for the complexity and the types of services that patients need.
14. The NHRA introduced ABF, which was then adopted as the hospital funding model for health authorities across all states and territories. The Commonwealth Government's contribution is directly tied to each jurisdiction's activity, as well as the cost per episode. For the latter, the Commonwealth's contribution is connected to the nationally determined efficient price per unit of hospital activity.
15. The NEP is based on the average cost of delivering hospital activities, as collected on an annual basis through the National Hospital Costs Data Collection (NHCDC). The NEP is determined each year as new NHCDC data becomes available and is therefore responsive to cost changes. While there is a three-year lag between the NHCDC and the NEP determination, costs are indexed to account for historical cost changes.
16. Beyond the Commonwealth's contribution, which accounts for approximately 45% of public hospital funding, states and territories make up the difference from their own revenue and untied Commonwealth grants. The state and territory governments, as system managers, have substantial discretion in how they allocate their contribution to Local Health Networks. States, including NSW, adopt Service Agreements that include the State Efficient Price (SEP) to fund hospitals.

Concepts for consideration in health resource management

Funding models

17. The role of funding models is to align the financial incentives with the objectives of the health system. That is, the funding model should facilitate the uptake of effective and valuable care, in line with the needs of patients, and delivered efficiently and equitably. At the same time, the funding system should also encourage sustainability such that the resources consumed by health deliver high value benefits.
18. Different funding models create different incentives for the main actors within the system: payer, providers and patients.
19. A comprehensive description of funding models can be found in the Deeble Institute's *A roadmap towards scalable value-based payments in Australian healthcare* (2022).⁵ In brief, **ABF** drives activity and can create efficiency within specific units of acuity. **Bundled payments** probably drive better integration of care. **Capitation** potentially allows more flexibility in response. Commonly these are combined. Capitation is an approach to dividing the total pie for the purposes of population-based allocation, ABF provides a method to equalise payment for the same activity.
20. Different funding models can be used to incentivise or disincentivise decision-making. The funding models incur different degrees of financial and other risk for the payer and service provider. The main risks for different models are overservicing, underservicing, lack of decision space for clinical judgement, and lack of oversight/incentives to spend on non-clinical care.

Efficiency and equity

21. Objectives of a high-performing universal health system include **efficiency, equity**, high quality, sustainability and accountability. The key objectives of efficiency and equity must be met to ensure a health system achieves the maximum amount of health possible, with minimal waste and with the available resources. Definitions for efficiency and equity are provided in the Glossary.
22. Resource management and allocation play an important role in achieving efficiency and equity, but funding is not the only factor influencing these outcomes.
23. Equity (see Box below) is implicit in universal health systems, but it goes beyond equal access to health care. It also takes into account the equal quality of care and consideration of the diverse needs of different populations.
24. Sometimes, it is necessary to forego some efficiency in order to achieve greater equity, as equity may impose higher costs on the health system. Under some circumstances, achieving greater access to a service in underserved rural remote setting may cost more than in metropolitan areas. If the same dollar invested in health care produces fewer outputs in rural areas than it would in metropolitan areas, then that investment is improving equity of access by trading off technical efficiency.

25. However, this is not always the case. Investing in equity may also improve efficiency, such as when investing in health services for a high priority population improves health outcomes by more than alternative investments in lower priority populations could achieve.

Equity

Health equity is when everyone has a fair and just opportunity to attain their optimal health. Health disparities are the metric used to measure progress towards achieving health equity.

There are substantial health disparities in Australia, especially for lower socioeconomic groups, culturally and linguistic diverse communities, and First Nations people.

Health inequities arise substantially from socioeconomic, cultural and political determinants of health. Inequitable access to health care in Australia is a small but important contributor to health inequity, but health care can have an important role in addressing the effects in health inequity.

Compared to the health systems of other similar-economy countries, the Australian system ranks well in terms of overall access. However, there are significant equity of access issues.

These inequities in access to health care relate to high out-of-pocket costs for some services, the under-provision of health care for those most in need, the maldistribution of healthcare services relative to population, and access issues related to geography, cultural appropriateness and health literacy.

The healthcare funding arrangements in Australia contribute to inequity in access due to:

- their complexity
- the over-reliance on private sector providers with substantial co-payments for some types of services such as specialists, outpatients and allied health
- differential access to procedural health care in public and private sectors
- disproportionate requirements of funding hospital care which perpetuates geographic inequities in funding distributions
- lower levels of providers and health services in rural and remote settings, which results in lower per capita health expenditure in those settings.

These factors further disadvantage First Nations people, where there is a higher need, more socioeconomic disadvantage and less capacity to pay for health care, disproportionate representation in areas with lower service capability, and access issues related to colonisation and disempowerment, culture appropriateness and lower health literacy.

System-level design

26. To achieve a health system's objectives, it is necessary for policy makers to create an ecosystem in which system managers are incentivised to make decisions according to the best available evidence to support efficiency and equity.

Levels of decision-making

1. Cabinet – how much is allocated to health versus other government priorities
2. Design and implementation of funding models that drive the quantum and distribution of the health budget that is allocated to preventive health, primary care and acute care
3. Individual decisions by health care managers, providers and patients.

27. In designing a system, it is impossible to separate funding reform from governance reform. The location, decision space, capacity, authority and responsibility for funding decisions determine efficiency and the flow-on effects for equity. The flexibility or responsiveness of funding is impacted by how funding is tied to specific activities or purposes. The more that funding is tied, the less flexibility local governance has to respond to local needs.
28. There are expectations that future decision-making should be based on advanced planning systems that collate information on all of these different factors. There are also limitations to understanding local contexts by using high level public service usage data alone.
29. Therefore, the most important consideration is to design the right mix of funding models to fit the governance structures that are developed.

Challenges and complexities with current funding and funding governance arrangements in NSW

30. Funding challenges and complexities regularly cited both anecdotally and in evidence submitted to the Inquiry are listed below.
31. **Lack of transparency** between the NSW Ministry of Health and LHDs on how resources are allocated. LHDs necessarily undertake their own resource planning to make best use of the available income through contractual agreements and formula-based income. This may not directly align with the funding purposes as laid out in agreements.
32. **Conflicting incentives** to keep up certain types of activity – even if inefficient – to maintain funding flow. The need to shift to different funding channels presents hurdles to adopting new models of care, particularly when this entails a shift to less reliable or unfamiliar funding rules, or a reliance on the participation of independent service providers. An example would be a risk-stratification model that would identify and manage patients at risk of hospitalisation in the community. There is likely to be a period of uncertainty and possibly increased funding required for both acute and early detection and management before savings in acute care are realised. This is not because of the national ABF model, but it could be related to the way NSW funds services outside of ABF.
33. It is in the best financial interest of states under the national model to **prevent hospitalisations**. This is because public hospital costs are a shared responsibility between Commonwealth and state. For every hospital activity prevented, the state stands to gain more through savings than it loses in Commonwealth NHRA funding. There have been multiple attempts to shift service provision from hospitals to community-based care, including preventive care and chronic disease management, for example under the NSW Health Integrated Care banner and including nursing outreach, models of shared care with GPs, and commissioning specialists to run diagnostic services within primary care settings.
34. While preventing hospitalisations is a goal, **every prevented hospitalisation does not necessarily reduce the National Weighted Activity Unit (NWAU)/ABF payment**. If hospitals are running at capacity, and a prevention program is highly effective at reducing hospitalisation, then a hospital will be able to replace that ‘prevented hospitalisation’ with another hospitalisation. This is because there are waiting lists, and demand is greater than supply. This situation would deliver both health and financial benefits - a hospitalisation prevented, and someone taken off the waiting list.
35. It should be noted that the Commonwealth contribution to public/preventive health funding is also allocated through the NHRA on a block funded basis. This gives states total flexibility on how they want to spend on preventive strategies.
36. **Short term funding cycles** for initiatives targeting priority cohorts. Equity-oriented programs tend to follow centrally established goals with local implementation. LHDs nominate for participation and to receive fixed-term funding, with extension of the initiative dependent on demonstrated outcomes. LHDs effectively seek to participate and obtain funding through a competitive process, recruit and train staff, establish new monitoring and reporting frameworks, and demonstrate program effectiveness to receive ongoing funding. Generally, the cycle of initiatives is around 3.5 to 4 years, with an expectation that results will be demonstrated within that timeframe. This is a problematic model for several reasons (i) it is difficult to recruit and retain staff with short term contracts (ii) it requires local regions to be responsive to central opportunities, rather than central funding to be responsive to local needs, and (iii) the effectiveness of the initiative may not be fully determined within the timeframe.

37. **Lack of comprehensive planning** across health services that are state and Commonwealth-funded, such as primary care, aged care and acute care.
38. **Inefficiencies in rural areas** including the inability of the public sector to negotiate participation of specialists in care.
39. State-funded services are the **de facto safety net** to fill gaps in services that are not provided in the network of Commonwealth-subsidised providers in the community. For example, small rural areas with high rates of chronic diseases, with not enough GPs or specialists, will present to multipurpose services with severe symptoms.
40. **Underserviced areas** for general practice, private specialist, aged care and disability services result in higher costs to NSW because NSW Health may often be the provider of last resort and pays the full cost of the alternative service (i.e. NSW Health does not charge co-payments, whereas most Commonwealth services include co-payments or other patient contributions).
41. **Mental health** as a service area is poorly served by the current model. The Independent Health and Aged Care Pricing Authority (IHACPA) is continuing to evolve its classification in mental health and a new classification system for admitted mental health was introduced in 2022–23, funded through ABF. IHACPA is seeking to introduce ABF for Community Mental Health Services on 1 July 2025. This will make the Commonwealth contribution towards mental health more responsive to activity and costs. The challenges for appropriately funding mental health care include the extent of heterogeneity in the costs of provision of mental health – that is, cost determinants like length of stay are not as easily predictable – the need to incentivise high quality and continuity of care in non-hospital settings, the mix of service models, and the diagnostic spectrum.
42. **Future of virtual care** and determination of certainty of funding. Currently virtual care is either specific purpose block funded (usually where there is an infrastructure to supply it like rpavirtual) or costs are absorbed as an alternative to existing services, for example, the VRGS (Virtual Rural Generalist Scheme).
43. Despite substantial efforts from NSW Health, more work needs to be done to address “**low value care**”.

Achieving health equity

44. The largest determinant of funding to LHDs is hospital activity. However, hospital capacity to LHD population is not equal across LHDs, meaning some LHDs receive more funding proportional to population share. The activity in some larger hospitals (historically referred to as teaching hospitals) is more expensive than others because of unmeasured case mix differences (i.e. more complex patient load) and other activities like teaching and research. Similarly, the population served by tertiary and quaternary services is appropriately greater than the population of the LHDs in which they are based.
45. The cost of care in some smaller hospitals is disproportionately higher because of their size relative to activity. In the case of smaller rural hospitals, the costs of providing the services are higher due to higher medical, nursing and support costs. The smaller rural hospitals are block funded to allow for the activity-to-cost difference.

46. NSW Health implemented a 20-year program in 1996 to reduce some of the historical discrepancies in funding between Area Health Services, as they were then known. The funding formula for AHSs progressively increased the share of growth funding that went to relatively under-funded services, and also included a loading for socioeconomic disadvantage and First Nations representation in the AHS population. This did, in part, reduce some of the historical discrepancies. This approach was replaced as part of the NHRA agreement on Commonwealth cost-sharing which is based on ABF.
47. Under the NHRA, the Commonwealth Government's contribution to public hospital funding follows activity and costs. These funding flows therefore reflect the current capacity of each local health system to deliver activity. If it were deemed desirable to alter the current funding flows to improve, say, greater equity of access in some local areas, NSW could increase a local health system's capacity (e.g. build a new hospital). Under the NHRA, there are then measures in place such that Commonwealth funding would follow that decision.
48. NSW Health has implemented a range of programs intended to address areas of health inequity, particularly in chronic disease prevention and management, and maternal and child health. The impact of these programs has not been sufficiently evaluated but is likely to be small given their duration and funding commitment.

Aims for NSW Health funding models

49. Below are aims for funding models in NSW.

Achieve both technical and allocative efficiency

50. The current model (both in NSW and other states) has a focus on technical efficiency and has probably been successful in contributing to the improved efficiency of the public hospital system. However, this focus has resulted in less attention being paid in NSW to fairness and allocative efficiency across the health system spanning preventive, primary and acute care. Arguably, this may cause increasing disparities of access to state health dollars by various population groups across LHDs.
51. This is well enough enunciated in the recent NHRA Review which states that the current Commonwealth/State 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.⁶

52. There are two elements to this. (i) the current funding model is not transparent in recognising higher cost of delivering services in some settings, such as rural/remote, but

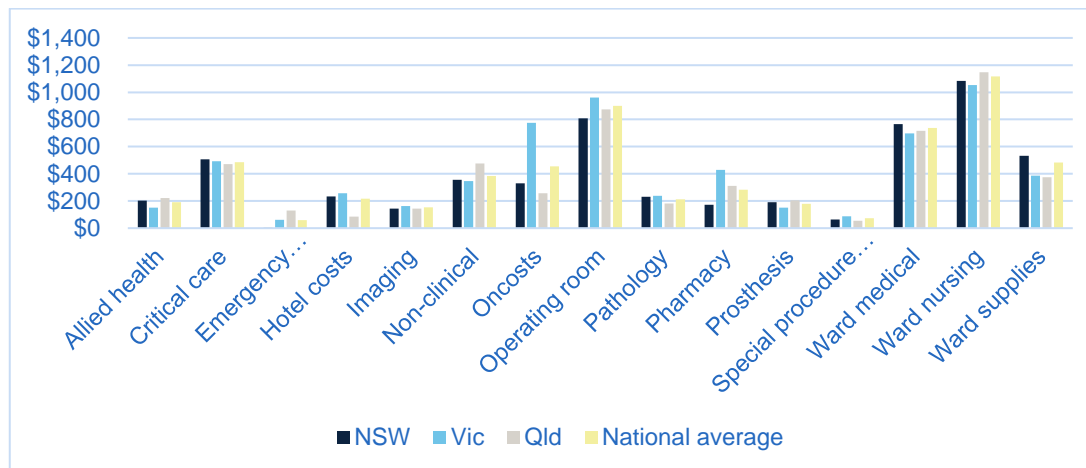
more generally anywhere there is a shortage of medical and other workforce, and (ii) there are historically defined capacities (i.e. where big hospitals are) and, as a consequence, where activity capacity is.

Incentivise an appropriate balance between secondary/tertiary care and community health services/health prevention

53. The current model predominantly funds hospital care – either through ABF or block funding grants. There are limited additions of designated Commonwealth and/or State grants, but these are a tiny fraction of the total LHD funding.
54. Where funding is provided for other than inpatient care, it is predominantly directed at alternative service delivery models where a person would otherwise require inpatient/outpatient care such as Hospital in the Home, virtual care, rapid access clinics, caring for people in the community and urgent care services.
55. These are important services. However, it is argued that the health gains from high quality and timely hospital care could be significantly enhanced by designated monies being provided to the LHDs for services such as community health, improving health literacy and health prevention programs.
56. These services are disincentivised in the current focus on ABF as the funding tool.
57. The existing funding arrangements between the Commonwealth and state do not recognise continuity of care within the health sector. Importantly, they also fail to recognise continuity across the health-aged care-disability sectors, noting that, frequently, the same individuals are receiving elements of care from two or three sectors. This is translated at a local level in system inefficiencies such the duplication of services or the shifting of service responsibility.

Incentivise efficiency in acute/subacute care

58. There has been considerable success in recent years in NSW in achieving improved efficiency whereby NSW has the second lowest average cost of providing care for an admitted patient of all states and territories. The National Hospital Cost Data Collection of 2020–21 reveals that NSW has lower than national average costs in operating rooms, oncology, ward nursing costs and pharmacy (Figure 1). Note that there may be differences across jurisdictions in the allocation of costs across these different funding buckets. These lower costs in NSW are slightly offset through higher costs in areas like pathology and ward supplies.

Figure 1: Cost per National Weighted Activity Unit 2020–21 by selected cost buckets

Source: IHACPA National Benchmarking Portal

Ensure equity of access to ambulatory care specialist services

59. Access to specialist outpatient/ambulatory care services, particularly for people with complex conditions or needs, is variable. Public hospitals provide limited outpatient specialist services, which means that people are forced to see specialists privately. Private specialists generally require a co-payment.
60. NSW LHDs have revenue targets that are largely addressed through encouraging patients to use their private health insurance and subsequent billing, and through cost shifting. A consequence of this is that many specialist outpatients have moved to a public Medicare Benefits Schedule billing model – the clinics in effect run as private clinics but with no co-payment, and the remuneration from MBS billings returns wholly or partially to the LHD. This has exacerbated variation in access to free public outpatient specialist clinics.

Be transparent to clinicians/community

61. The annual funding to LHDs lacks transparency in how it is calculated. It is similarly unclear in the Service Agreement which funding ceases and the duration of the new funding. It is also unclear how new enhancements are funded during the year.
62. Many of the enhancements often relate to time-limited grants in areas such as mental health and drug and alcohol. The effectiveness of these supplemental allocations is inhibited by lack of certainty of ongoing funding. It is argued that cessation of funding often causes difficulty in LHD administration, failure to improve health outcomes, and clinical angst.⁷
63. The Commonwealth contribution through the NHRA includes several adjustments that recognise the additional cost of delivering services in rural and remote areas, as well as for Aboriginal and Torres Strait Islander patients. The adjustments are converted into NWAU and are empirically derived through the analysis of the cost data.

Fairly reflect the differentials in annual population growth for each LHD

64. The annual population growth factor adjustments have historically not kept pace with actual population growth. More importantly, they have disadvantaged those LHDs with larger population growths. Anecdotally, lead clinical groups argue that service enhancements rarely keep up with fundamental population shifts.
65. There are rarely areas where demand is falling, so meeting demand requires growth in overall resourcing as well as differential distribution.

Transparently adjust and fund differential weightings to the SEP, which reflect unavoidable cost factors (for ABF)

66. ABF calculations inadequately cater for the additional costs associated with providing health services to specific population groups. These differentials are mix of cost factors of service and equity. For example:
- People access higher-cost emergency departments (EDs), rather than bulk billing primary care or specialist doctors due to a shortage these doctors.
 - There are higher costs for service delivery for people requiring higher health literacy support or interpreters, particularly in Central Coast/Western Sydney/South-Western Sydney/Nepean Blue Mountains/Illawarra LHDs. For those LHDs, patients are more likely to attend ED rather than primary care services, so they enter the health system sicker and later in their diagnosis⁸. Some of these additional costs are encapsulated in the ABF construct, but many have argued that these adjustments are inadequate.
 - There are additional costs for management of people with chronic conditions and/or with obesity.⁹
 - Hospitals in rural communities face unavoidable attraction and retention costs for labour¹⁰ and support services (e.g. accommodation¹¹).
 - Rural communities lack Commonwealth-funded primary care/aged care services, and substitution by state health services is unfunded.

Only apply ABF for smaller hospitals when it enables valid cost comparisons between service delivery costs

67. Many of the very small hospitals in NSW are currently block funded. However, there is a view that ABF is still not an appropriate funding model for other smaller hospitals that have shifted to ABF funding.¹² It is argued there are unavoidable fixed costs which, in small hospitals, constitute a much larger proportion of total costs. Hence the capacity for achieving a SEP is limited.
68. The threshold for a hospital to become ABF is 3,500 NWAU. In the move to ABF, there needs to be evidence that the hospital consistently exceeds this activity threshold. While the decision about the funding level to move to ABF is with the Pricing Authority (i.e. IHACPA's Board), states are consulted before doing so.

Provide a transparent linkage between the forward capital works program and movement over time to allocative efficiency

69. NSW has a 20-year capital replacement program. Much of this capital placement program is directed at refurbishment and old stock replacement. However, the link between capital enhancements and contribution to improved efficiency and equity is not transparent. Any forward capital works program should be based on a clinical service plan that identifies the best mechanism for delivering those services, which may or may not include new

infrastructure. It is also argued that the connection between the capital construct completion and the realisation of agreed clinical service mix (as per the clinical services plan accompanying the capital planning), is not strongly monitored.

Carefully assess the benefits of further centralisation to support clinical health services against their unintended consequences

70. There are reported financial benefits in centralisation of clinical support services (e.g. patient transport services, linen and food). Some believe further service centralisation may not achieve anticipated savings and may be detrimental to good LHD governance, although there is not agreement on this.

Opportunities to improve NSW funding and funding governance arrangements

71. There are several opportunities the Inquiry might consider to improve NSW funding arrangements. These sit outside of NHRA and Commonwealth contributions. They are not necessarily mutually exclusive.

Opportunity 1: Publish an annual measure showing how each LHD is achieving needs-adjusted population share of the state Health budget

72. The historical and structural-based service capacity and ABF combine to perpetuate LHD funding differences which may not reflect inequities in health care need across the LHDs.
73. As a monitoring guide, rather than a funding tool - introduce an annually published measure of state health dollars to/from a fair population resource distribution between LHDs that is based on population needs.
74. As with the previous NSW Health RDF, this calculation would compare average state health dollars per weighted population (i.e. ageing, socioeconomic factors, adjusted for private hospital usage) per LHD. The need for accurate and timely data to undertake this analysis is critical.
75. Costs associated with cross-border flow adjustments should also be transparent. It is noted that many cross-border flows are appropriate to improve safety and efficiency. The formula could also incorporate Commonwealth-funded aged care/primary care. There may be additional value in providing similar reporting of the Commonwealth expenditure on primary and aged care. As such, there would be differentiation of equity for state dollars and a further calculation for state and direct Commonwealth-funded dollars.

Opportunity 2: Make explicit how local populations and service capacity are built into the funding model used to fund LHDs

76. Resource allocation needs to consider the variability in the characteristics of local populations and the capacity of local health systems to adequately service local demand. This includes consideration of issues of equity, socioeconomic status, culturally and linguistically diverse communities and First Nations communities, as well as the burden of disease. An understanding of the cost of service, variability in this, and the reason for the variability is important.
77. The state analysis of local population needs should take account of local population planning done by the LHD in collaboration with the relevant Primary Health Network/s (PHN).
78. Particularly important is an assessment of the capacity of the health system to respond to conditions known to have high inequity. Conditions like cardiovascular disease, which continues to show persistent inequity in mortality, are highly treatable yet the groups most at risk frequently show lower uptake or access to effective clinical interventions both within and across LHDs.

Opportunity 3: Create a clear and significant community health, health prevention and health literacy component of the LHD funding envelope

79. Resource allocation for prevention actions should be recognised and separately accounted for within the LHD Service Level Agreements. This funding should have the clear aim of mitigating the growth of demand for hospital care. There would be additional funding retained centrally for statewide health promotion activities.
80. The investment in prevention, and the extent to which it is directed to addressing inequity, should be measured. Much health inequity results from upstream determinants of health and requires cross-sectoral responses. However, there are significant opportunities to address prevention measures within the control of the health system, such as addressing and managing risk factors for chronic disease.
81. Identifying the funding and resource (e.g. staffing mix, infrastructure) requirements to address inequity in cardiovascular (and other) disease will support decisions on the appropriate funding models.

Opportunity 4: Introduce a two-tiered funding model with population need driving allocation to LHDs and LHD activity driving functions to service providers

82. This would be an alternative to Opportunity 1, and would entail shifting allocations to LHDs, based on weighted population with subsequent use of ABF/block funding at LHD level. For example, the proposed revised Queensland funding model is based on:
- the use of equity parameters (i.e. population-based funding) to establish budgets for combined clusters of “like” bordering Hospital and Health Services (HHSs) (akin to NSW LHDs), and then,
 - the application of price/volume allocations to the hospitals *within* each HHS.
83. While the proposed Queensland funding model may have some applicability for NSW, a simpler model for NSW could be direct population-based funding to *each* LHD (rather than by clusters). This would use ABF for the hospital component of the budget (as per point 4 below). This is similar to the model that was previously in place in NSW some years ago.
84. Achieving this opportunity requires 1) a set of principles on which allocation is based, and 2) sufficient tools to collate and analyse that data for nuanced decision-making. Furthermore, if next layer allocation lies with LHDs, this would impact dynamics of local health systems. It would impact interactions with private service providers, including non-for-profit commissioned wrap-around providers (health, social, disability and aged care) as well as Medicare-funded fee for service providers (specialists, GPs), not to mention the PHNs. Without expectations of joint information governance at the local level, silos, gaps and overlaps are likely to persist.

Opportunity 5: Refine the ABF model for hospital funding

85. Some form of ABF should be retained for hospital funding. Two approaches to improving current arrangements could be assessed.
86. One option is to refine the current ABF model and move it from funding based on an average price to a funding model that recognises that some hospital costs are fixed - irrespective of the type or level of activity. Some hospital costs are variable based on the

volume and mix of patients. The fixed costs are funded on a Base Care Tariff (BCT) and the activity is funded by ABF.

87. ABF is used only to fund the activity, not the fixed costs of a hospital component for peer groups of hospitals – akin to the current methodology of Commonwealth funding in aged care. For example, in the aged care sector, the BCT is 45% of total costs in metro but 85% of total costs in small rural remote facilities. Work is under way to refine the existing peer groups of hospitals.
88. The base care component would vary between peer groups while the activity component based on the SEP would be common across all hospitals. The identification of peer groups would group hospitals to reflect those with unavoidable price/NWAU differentiation.
89. There is a second option if it was decided to maintain the broad approach of the existing ABF methodology to determine the *totality* of the hospital budget (i.e. no fixed/variable components). The second option is to introduce transparent adjustments to the price for unavoidable price/NWAU differentials between LHDs (e.g. costs associated with size of hospitals, poor health literacy, higher levels of people from non-English speaking and lower socioeconomic backgrounds, obesity and chronic disease prevalence).
90. Under this possible reform, there would be slightly different SEPs for each LHD which reflect the differential cost factors of providing the service to the local population.

Opportunity 6: Ensure transparency of capital works program

91. The forward capital works program should be transparent as to how it assists the progressive movement to equity. The capital works summary should include a postdelivery evaluation on the clinical care improvements identified in the business case. That is, the summary should demonstrate how the program of works has delivered on the business case commitments for innovation, service increase and improvement, FTE enhancement and quality of care. All of these elements should be clearly articulated prior to the case being approved).

Glossary

Activity-based funding	<p>Activity-based funding is an umbrella term that can refer to both fee for service or diagnosis-related-group (DRG) based funding.</p> <p>A basic fee-for service model typically involves payment for a discrete input into health such as a particular episode of care (e.g. GP visit). More activity equals more income.</p> <p>DRG-based funding provides a payment for a diagnosis-related episode of care. There is an incentive to efficiently service that diagnosis. More patients (and their diagnosis) brings income, but providing excessive services to treat the patient does not.</p> <p>In ABF funding models, the payer carries the greatest amount of risk as the provider is paid for every episode of care. Payment is received to treat unexpected complexities or complications.</p>
Bundled payments	<p>Bundled payments also involve funding per volume of services, but over an extended time period (for example, a hip replacement might require a net hospital episode plus 12 months of follow-up rehabilitation). Funding is provided for the entire bundle of services that a patient will need.</p> <p>In bundled funding models, the provider assumes some of the risk as they are required to cover the total cost of the bundle of services, even if these exceed the price paid. However, if the services cost less than expected, the provider shares in any savings.</p>
Capitation	<p>Capitation-based funding pays a service provider a set amount for each individual they serve. Funding is provided regardless of the specific healthcare needs of each patient in question.</p> <p>In capitation funding models, the provider carries most of the risk as they are responsible for every funding decision relating to the care of each individual. In this model, there is also potential for greater reward for providers who reduce healthcare costs, for example, through preventive health.</p>
Block funding	<p>Block funding is a lump sum paid to cover either all, or a subset of, anticipated expenses (e.g. operational expenses).</p> <p>In Australia, block funding supports teaching, training and research in public hospitals, some public health programs, and funding for some smaller rural and regional hospitals where the NEP is not appropriate to determine efficient expenditure due to economy of scale.</p>
Efficiency	<p>To meet the objective of efficiency, the health system must meet the following three efficiency principles – allocative efficiency, technical efficiency and dynamic efficiency.</p>
Technical efficiency	<p>Technical efficiency is ensuring that the health system produces healthcare goods and services at the least cost. It refers to the relationship between resource inputs and outputs at a point in time.</p>
Dynamic efficiency	<p>Dynamic efficiency refers to resource allocation over time. Dynamic efficiency is concerned with achieving the optimal rate of innovation and investment to improve production processes over time.</p> <p>Considering dynamic efficiency ensures funding decisions reflect both the current and the future value of achieving a certain level of effectiveness in a specific area.</p>

Equity	<p>Equity refers to the absence of systematic disparities between different social groups. Health equity implies that everyone should have a fair opportunity to attain their full health potential.</p> <p>Equity is achieved in the health system when health services are equally available to all people with the same health conditions and health needs, regardless of their age, sex, gender, race, ethnicity or indigeneity, geographical location, religion, socioeconomic status, migrant status, disability, language, sexual orientation, political affiliation or other factors.</p> <p>Equity is implicit in universal health systems, but it goes beyond equal access to health care. It also takes into account the equal quality of care and consideration of the diverse needs of different populations.</p>
Low value care	<p>Low value care refers to health service actions that produce little or no additional health benefit while potentially increasing the risk of harm to the individual. It is an example of allocative inefficiency.</p>

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- ⁷ South Eastern Sydney Local Health District, Submission No 4 (October 2023)
- ⁸ Western Sydney Local Health District, Submission No 7 (October 2023)
- ⁹ SCOI submission 30 from the Charles Perkins Centre, University of Sydney Submission No 30 (October 2023)
- ¹⁰ Far West Local Health District, Submission No 8 (October 2023)
- ¹¹ Southern NSW Local Health District, Submission No 10 (October 2023)
- ¹² Illawarra Shoalhaven Local Health District, Submission No 25 (November 2023)