Joint report of:
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The Special Commission of Inquiry into Healthcare Funding

NSW GOVERNMENT Health

1. This report is provided jointly by Dr Kerry Chant AO PSM, Chief Health Officer and Deputy Secretary, Population and Public Health, Ms Deb Willcox AM, Deputy Secretary, Health System Strategy and Patient Experience and Dr Nigel Lyons, Special Advisor, NSW Health. The views expressed are jointly held.
2. This report is prepared in response to a request from the Special Commission of Inquiry (Inquiry) dated 27 October 2023. It is provided for the purpose of the initial public hearing of the Inquiry and is introductory in nature. NSW Health understands that there will be further opportunity to present more detailed evidence during the course of the Inquiry.
3. The report covers matters from the perspective of the Ministry of Health as system manager rather than purporting to address specific local issues.

Question 1

Describe the funding structure for the provision of health services in NSW (including Commonwealth funding)

4. The funding structure for health care services in NSW is complex.
5. NSW public healthcare is funded primarily by the Australian and NSW Governments with additional funding received from direct source revenue such as private health insurance payments and individual payments.
6. Private providers, non-government organisations, Aboriginal Community Controlled Health Organisations (ACCHOs), not for profits and others provide health services in NSW.
7. The roles and responsibilities of the Australian Government and the states and territories in the delivery of health services are outlined in two key national agreements. The National Health Reform Agreement 2011 (NHRA) is a companion piece to the National Healthcare Agreement and provides the architecture, governance and guidance required to calculate the Commonwealth's financial contribution to the cost of delivering public hospital services. All jurisdictions agreed to an Addendum to the NHRA which is operating from 1 July 2020 to 30 June 2025.
8. The funding methodology set out in the NHRA is a 'growth funding' model where only growth is funded at a 45% contribution from the Commonwealth while the base is funded at the prior year's Commonwealth Contribution Rate. The Commonwealth contribution to NSW public hospital costs currently sits at around 40%.
9. The NHRA Addendum restricts growth funding in any one year to a national 6.5% growth cap. Where the cap is breached, the Commonwealth effectively shifts funding risk to the States irrespective of whether cost growth is within States' control, with the impact being the Commonwealth's contribution rate is effectively reduced.
10. Current state public health services are provided free at point of service delivery for Australian Medicare Card holders and overseas patients incountries with reciprocal rights agreements. As individuals do not incur any cost for either receiving treatment or medicines, this unintentionally drives activity to the public health system.
11. The National Health Funding Body (NHFB) assists the Administrator in determining and advising of the Commonwealth contributions to be paid to each jurisdiction on an annual basis in line with requirements under the NHRA. Jurisdictions are required to report on actual activity to the NHFB, with activity and

funding being reconciled at the conclusion of each financial year.

12. Activity Based Funding (ABF) is a way of funding NSW for in scope public hospitals activity for the number and variety of patients they treat. ABF uses a unit price for care provided to patients within agreed activity targets.

13. The National Weighted Activity Unit (NWAU) is the common unit of measurement across patient care types. A range of adjustments are applied to account for the relative cost of treating patient. Examples of adjustors include place of residence or treatment and Aboriginality. NWAU of one is applied for a clinical service provided to a patient who has an average level of resource intensity.

14. In NSW, 100 hospitals are eligible for ABF. To be eligible for ABF, a rural hospital needs to have more than 3,500 total NWAU per annum and in metropolitan areas, a hospital needs to have more than 1,800 admitted patient NWAU per annum.

15. There are 110 small rural hospitals where activity (volumes) is too low for ABF. These hospitals are block funded.

16. Block funding is a fixed amount allocated to the facility regardless of the activity performed. Block funding is informed by health service costing data plus escalation.

17. In addition to small rural hospitals, 17 facilities are also block funded, which include specialist standalone mental health hospitals and standalone major city hospitals providing specialist services.

18. The Australian Government also provides funding for health services through a range of time limited national partnership agreements, including for some public adult dental services, palliative care including in aged care facilities, mental health, comprehensive cancer treatment and vaccines.

19. At the state level, NSW Treasury prepares the NSW Budget annually that outlines the government's revenue and expenses for the coming year, including the health portfolio.

20. The Expenditure Review Committee (ERC) considers budget proposals as part of the annual budget process.

21. The Budget also provides an overview of the state economy and details the priorities the government will deliver and budget allocations for each cluster. For NSW Health, the budget allocation provides the overarching funding envelop for the delivery of health services.

22. Prior to COVID-19, Treasury funding to NSW Health had generally been predicated on:

    a. a funding model with historical 4-5% growth; and

    b. ERC decisions during budget cycles to implement key new policy decisions.

23. The growth funding model sets the recurrent expense budget for NSW Health. It is the approved rate for year-on-year expense growth, determined by ERC as part of the budget process. The growth funding model was put in place to provide greater funding certainty and improve sustainability of growth.

24. Historically, NSW has experienced steady growth rates. Since the formation of Local Health Districts (LHDs) until the beginning of COVID-19, the average growth rate has been approximately 5.9%. COVID-19 saw a spike, due to additional resourcing to respond to the pandemic. From this financial year the growth rate is anticipated to be significantly lower.

25. The major driver of expenditure for NSW Health is workforce. With rising inflation and the removal of the wages cap, expenses will increase impacting the NSW Health budget.

26. In developing the NSW Health Budget, the following components are included: the annualised budget plus any specific initiatives, activity growth and escalations, less savings and any ceasing initiatives.

27. As part of the NSW Health Budget, revenue budget is allocated that incorporates grants, patient fees, high cost drugs and other items. The quantum of the revenue budget is directly attributable to the expense budget.

28. The NSW Health Budget includes an allocation for capital works based on identified projects that include statewide, rural and regional and metropolitan projects.

29. Market trends indicate a growing requirement to move asset acquisitions to long term service delivery arrangements. This is a significant change with capital budgets being transitioned to operating budgets.

30. Through annual service level agreements, the Ministry of Health allocates budget to LHDs and Specialty Health Networks (SHNs) as outlined below:

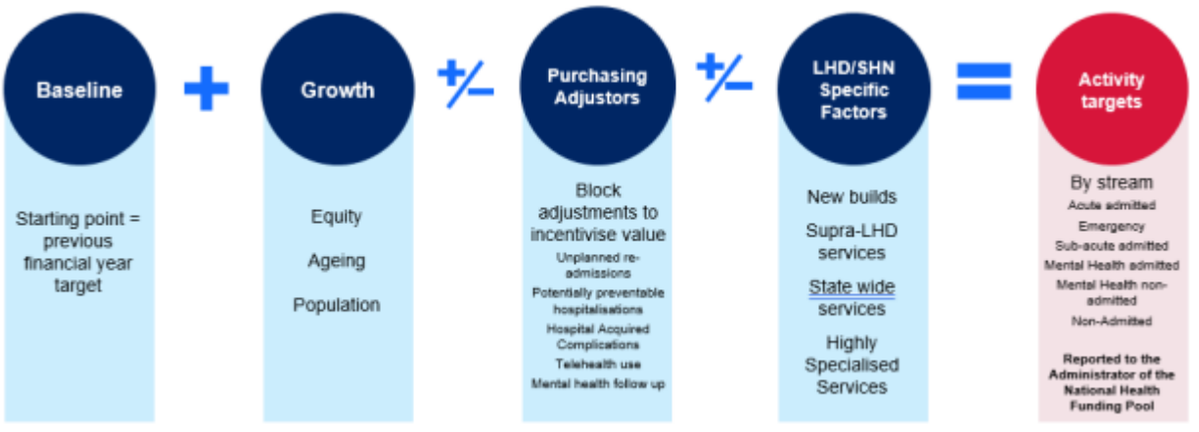


Figure 1: Budget development and allocation to LHD/SHNs
Source: NSW Health 2023

31. Service agreements are made between the LHD/SHN and the Secretary NSW Health setting budget, purchased activity and performance expectations. They are developed annually and published online in line with requirements under the NHRA.

32. As part of the NSW Health Performance Framework, the Ministry of Health as system manager monitors LHDs/SHNs achievement of agreed Key Performance Indicators (KPIs) and deliverables. Where under performance is identified, the Ministry and LHDs/SHNs work collaboratively to remediate the issue.

Question 2

Describe the governance and structure of NSW Health

33. The role and function of NSW Health organisations is principally set out in two Acts, the *Health Administration Act 1982* and the *Health Services Act 1997*, reflecting requirements articulated in the NHRA.

34. The structure of NSW Health is designed to manage the complexity of delivery of healthcare services across the State in a manner that balances efficiencies which may be gained from centralised delivery and governance against the need for local management responsive to the varying needs of different communities.

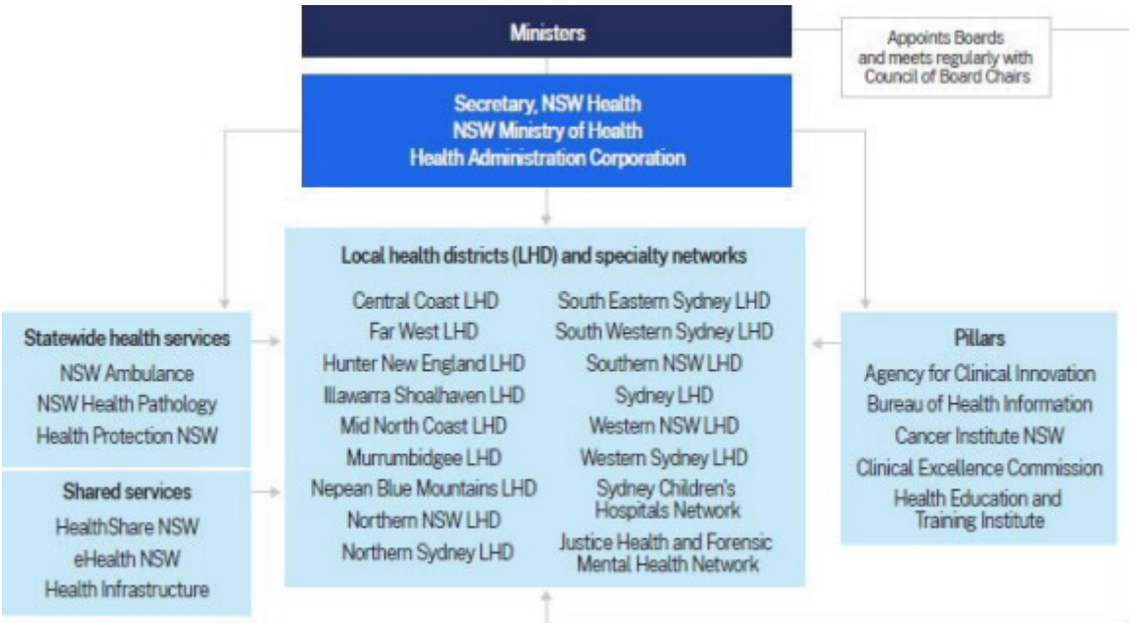


Figure 2: NSW Health Structure

Source: NSW Health website

35. The NSW Ministry of Health supports the executive and statutory roles of the Minister for Health and Minister for Regional Health, Minister for Mental Health and Minister for Medical Research.

36. The Ministry of Health has the role of 'system manager' in relation to the NSW health system, which operates over 220 public hospitals, as well as providing community health and other public health services.

37. The Ministry of Health guides the development of services and investments in the NSW public health system to ensure that the health priorities of the NSW Government are achieved for the community of NSW.

38. At a local level, fifteen LHDs are responsible for providing public health services in a wide range of settings for their local communities. Six LHDs cover the greater Sydney metropolitan regions, and nine cover rural and regional NSW. Relevant LHDs also manage the performance of Affiliated Health Organisations (AHOs), specified non-profit, religious, charitable or other non-government organisations and institutions who provide healthcare services in NSW.

39. Each LHD has a Board and is headed by a Chief Executive, who is appointed by the Board, with the concurrence of the Secretary and employed in the NSW Health

System. The LHDs and their Boards are charged with responsibility for determining how they deliver healthcare services within the framework of their Service Agreement with the Secretary and their Annual and longer-term Strategic Plan.

40. In addition to the fifteen LHDs, healthcare services are also delivered by two SHNs - the Sydney Children's Hospital Network and the Justice Health and Forensic Mental Health Network. Similarly, to LHDs, SHNs and their boards are responsible for determining how they deliver healthcare services within the framework of their Service Agreement with the Secretary and their Annual and longer-term Strategic Plan.

41. To ensure ongoing engagement and to provide clinical guidance to inform decisions, a Health System Advisory Council (HSAC) has been recently established. The HSAC consists of a multidisciplinary group of 24 doctors, nurses, midwives, oral health and allied health professionals together with the Ministry of Health Executive Management group.

42. Membership includes representation from the Aboriginal clinical community and primary healthcare. The HSAC provides independent and impartial strategic clinical advice, which reflects the views of clinicians in the health system, on key statewide and system priorities, for example HSAC is currently considering the role of Artificial Intelligence (AI) in healthcare delivery. This includes involving the clinical workforce in informing specific components of work. Clinical advice provided by the HSAC informs the operational arms of NSW Health and will guide the planning, preparation and execution of measures related to the delivery of healthcare.

43. At a local level, under the *Health Services Act 1997* the Secretary may make model by-laws for LHDs and SHNs. The NSW Health Model By-Laws for LHDs and SHNs require LHDs and SHNs to have in place a number of structures to facilitate clinician input and consultation, being:

    a. Medical Staff Executive Councils (LHDs only);
    b. Medical Staff Councils;
    c. Mental Health Medical Staff Councils (or an approved alternative engagement mechanism);
    d. LHD/SHN Clinical Councils; and
    e. Hospital Clinical Councils.

44. Engaging patients, their carers and families in the design, improvement and governance of health services and health programs is essential for creating patient-centred, effective, and equitable healthcare systems. It not only improves the consumer experience but also leads to better health outcomes, increased accountability, and greater innovation in healthcare delivery.

45. Elevating the Human Experience is NSW Health's first state-wide strategy to deliver an exceptional patient experience and make that experience empowering for everyone involved in receiving and providing care. Over 200 consumers, staff, and representatives from peak agencies such as Health Consumers NSW were involved in the co-design and co-development of All of Us – A guide to engaging consumers, carers, and communities across NSW Health.

46. A new consumer voice is being established within the Ministry of Health, to complement the HSAC. The group has two key functions, firstly to provide advice on specific statewide strategies and secondly to provide advice on methods and extent of engagement required on strategic priorities. This group will ensure the consumer voice is heard at the most senior levels at the Ministry of Health.

47. As system manager, the Ministry of Health monitors LHDs/SHNs achievement of

agreed KPIs and deliverables under the NSW Health Performance Framework. There is clear delineation regarding roles and responsibilities for all parties.

48. The LHDs and SHNs are supported by "Pillar" organisations:
    a. The Agency for Clinical Innovation (ACI),
    b. The Bureau of Health Information (BHI),
    c. Cancer Institute NSW
    d. The Clinical Excellence Commission (CEC) and
    e. The Health, Education and Training Institute (HETI)
49. BHI and CEC are board-governed statutory health corporations and ACI and HETI are Chief Executive governed statutory health corporations. The Cancer Institute NSW is also board-governed however it is established under the *Cancer Institute (NSW) Act 2003*.
50. The ACI is responsible for reviewing clinical variation and supporting clinical networks in clinical guideline/pathway development with encouragement toward standardised clinical approaches based on best evidence. The ACI works with clinicians, consumers and managers to design and promote better healthcare for NSW.
51. BHI provides independent reports to government, the community and healthcare professionals about the performance of the NSW public healthcare system, including safety and quality, effectiveness, efficiency, cost and responsiveness of the system to the health needs of the people of NSW.
52. The Cancer Institute NSW provides expertise on cancer control for the government, health service providers, medical researchers and the general community. It was also established to increase the survival rate for cancer patients, reduce the incidence of care in the community, and improve the quality of life of cancer patients and their carers.
53. The CEC is responsible for leading safety and quality improvement in the NSW public health system. It was established to reduce adverse events in public hospitals, support improvements and promote improved clinical care, safety and quality in health services across NSW.
54. HETI coordinates education and training for NSW Health staff, working closely with LHDs, SHNs, other public health organisations and health education and training providers to support the full range of roles across the public health system.
55. The Secretary is constituted as a corporation sole named the Health Administration Corporation (HAC) which is the legal vehicle through which the Secretary provides services including Statewide Health Services and Shared Services which support the LHDs and SHNs. HAC is subject to the direction and control of the Minister. HAC supports the LHDs and SHNs and is also the owner of most NSW Health real property assets.
56. The Statewide Health Services provided by HAC are:
    a. NSW Ambulance provides pre-hospital care, rescue, retrieval and transport services across NSW, by both road and air
    b. NSW Health Pathology provides pathology, forensic and analytical services across NSW.
    c. Health Protection NSW is responsible for surveillance and public health response in NSW including monitoring the incidence of notifiable infectious

disease, taking appropriate action to control the spread and reduce the burden of diseases and providing public health advice including in response to environmental issues.

57. The Shared Services are delivered by HAC through:

    a. HealthShare NSW provides centralised and standardised services across the State including through payroll and procurement functions and food and linen services.

    b. eHealth NSW provides leadership on the shape, delivery and management of Information Communication Technology (ICT) led healthcare.

    c. Health Infrastructure is responsible for the delivery of the NSW Government's major works hospital building program and provides assistance on projects of less than $10 million to LHDs who chose to purchase this service.

58. The NSW Health governance framework has remained relatively stable since 2011. With the experience of the pandemic, there is an opportunity to assess the balance between centralised decision making and devolution, noting that broad scale changes are disruptive, and the relative stability of arrangements has been a strength of the system over the past 10 years.

Question 3

Describe the health services provided in NSW by NSW Health

59. The NSW public health system is the largest public health system in Australia, providing world-class healthcare to the citizens of NSW. NSW Health consists of fifteen LHDs and two SHNs delivering health services to communities.

60. The community served by NSW Health has 28% of people aged 65 and over, 3.4% of people identifying as Aboriginal or Torres Strait Islander and 30% of people being born overseas[1].

61. In 2021/22, NSW Health activity included 290,167 surgeries performed, 1.8 million inpatient episodes, 3 million emergency department attendances and 1 million emergency and non-emergency incidents responded to by NSW Ambulance. In addition, 72,507 babies were born in a public hospital and 24 million meals were served to patients[2].

62. NSW Health undertakes comprehensive evidence based clinical services planning to ensure current and future services meet the needs of the NSW population. This includes consideration of where services should be delivered, including the need for any statewide services.

63. Services are delivered in a network framework that incorporates the statewide speciality services, cascading to the LHD services and then local services at facilities.

64. In each LHD, these arrangements are designed to provide a whole of person integrated care model enabling continuity of care and information transfer across the NSW Health system.

65. AHOs also form part of the public health system. These are non-profit, religious, charitable or other non-government organisations and institutions providing health care services whose performance is managed through relevant LHDs. The list of AHOs in NSW is provided under Schedule 3 of the *Health Services Act 1997.*

66. NSW Health also provides some highly specialised low volume services for all Australians as part of a national approach to ensure safe care for these complex procedures.

67. NSW also enters into agreements and arrangements with other jurisdictions to ensure those living in cross border regions can access the care they need.

Acute and secondary care

68. A core element of NSW Health's role is the delivery of public hospital services through a network of over 220 public hospitals providing a mix of services including emergency, inpatient, medical, surgical, paediatrics, maternity and sub-acute care

69. The hospitals operate at different levels, ranging from tertiary facilities which provide complex care through to Multipurpose Services (MPS).

70. The role and function of the hospital is outlined in a role delineation guide. This guide describes the minimum support services, workforce and other requirements for clinical services to be delivered safely. It delineates the level of clinical services.

71. These hospitals operate in a networked manner, enabling the delivery of safe, high quality care across the broad geography of NSW. The role delineation guide is one

[1] NSW Health Annual Report 2021-22, NSW Health 2022
[2] NSW Health Annual Report 2021-22, NSW Health 2022

of the tools used by LHDs and SHNs in service planning and development and can assist in considering appropriate clinical governance arrangements and in determining the services provided by a particular health facility.

72. This includes ensuring protocols in place to ensure recognition of specific conditions and transfer of appropriate patients to a higher level service for assessment. Some elements of care may be provided with networked support, including through virtual care arrangements.

73. Secondary care services provided at public hospitals include outpatient, ambulatory and rehabilitation care. Some services may be provided across settings, such as rehabilitation care which is provided in hospital and in the community setting.

Community health

74. Community health is defined as a range of community prevention, early intervention, assessment, treatment, health maintenance and continuing care services delivered by a variety of providers.

75. Community health services aim to ensure adequate short or long term clinical care and direct efforts towards addressing the social and environmental determinants of health.

76. Services are focused on specific population groups and/or a combination of health issues. Services operate in a range of care settings and in conjunction with acute and secondary care services to meet the needs of the community.

77. There is a shift to person centred integrated models of care that are co-ordinated across different care settings. This reflects the need to provide seamless, effective, and efficient care that reflects the whole of a person's health needs.

78. The NSW Health employs strategies that both foster communication and connectivity between primary, hospital and community health care providers and provide better access to community-based services closer to home

79. NSW Health provides a range community health services including but not limited to:

    a. Mental health services
    b. Drug and alcohol services
    c. Dental services
    d. Child and family health services
    e. Community nursing services
    f. Youth health services
    g. Violence, abuse and neglect prevention and response services
    h. Refugee health services
    i. Women's health services
    j. Palliative care services
    k. Hospital in the home services
    l. Urgent care services
    m. Aboriginal health services
    n. Sexual health services

Preventive health

80. Preventive health is a joint responsibility across governments and across communities.

81. The National Preventive Health Strategy 2021-2030 provides an overarching long-term approach to health prevention

82. Both the Australian Government and NSW Government have invested in measures to address the rising preventable chronic disease burden and improve poor health outcomes. This includes joint actions to improve the early detection and management of health conditions, achieve higher and equitable immunisation coverage, and targeted health promotion measures for vulnerable communities and priority cohorts including Aboriginal and Torres Strait Islander people.

83. There is a need to support healthy living in those with chronic diseases – this includes initiatives such as health coaching, support for people with substance use disorders and providing services to prevent further ill-health in persons with complex health needs – especially where there is an overlap in people living with a mental health condition, physical illness and social disadvantage. Our clinical community also works to prevent disease and worsening of disease through evidence-based interventions such as changes to diet, medication management, and recommendations for exercise, immunisation and tobacco cessation.

84. NSW Health also undertakes a range of initiatives to support the healthy ageing of the population. This includes falls prevention programs, physical activity, mental health support and ongoing age-specific health coaching which can all contribute to better health outcomes. Health programs can also be an important place for social connection for the ageing population.

85. In addition, NSW is focused on prevention actions to keep all people healthy and well through healthy eating and active living, improving oral, mental and sexual health, and reducing tobacco and e-cigarette, drug and alcohol related harms.

86. Many factors outside of the health system impact people's health and their ability to connect with the health system in an equitable way. These social determinates of health include a person's employment, education, housing and social supports.

87. The shared responsibility across governments and between agencies together with the multifactorial nature of preventive health all contribute to a complicated funding environment

88. NSW Health is working to coordinate efforts with our partners such as other NSW Government agencies including Communities and Justice, Education and Planning, together with primary care and non-government organisations to act collectively on the social determinants of health and promote wellness.

Question 4

Describe the health services provided in NSW outside of NSW Health (e.g., primary care) and other services such as aged care and disability care

89. Significant health care services are provided by organisations outside of NSW Health, including but not limited to, primary health care, aged care, private hospital services, dental services, mental health services, allied health services, drug health services, pharmaceutical services, youth health services, refugee health services and disability care.

90. Provision of these services is a shared responsibility, across all levels of government and with the private sector, non-government organisations and others. Partnerships facilitate management and delivery of this care.

91. Hospitals will continue to be a cornerstone in healthcare for patients who cannot be supported in the community or the home and virtual settings. Future health needs, technological advances and healthcare sustainability will necessitate new models of care.

92. NSW Health is already working towards more people accessing care outside hospital settings and providing more options for care in the community and the home, facilitated through strong partnerships with general practitioners, private and non-government organisations. This complements the range of services delivered by other providers.

93. The Australian Government has a key role in the social care system, with health care responsibilities articulated in the NHRA.

94. In addition to funding health services through the NHRA, Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS), the Australian Government is also responsible for the regulation of private health insurance.

95. The Australian Government has the lead role in managing, funding and delivering General Practitioner (GP) and primary health care. Primary care is often the first point of contact for people in need of health care and is designed to provide accessible, continuous, comprehensive and coordinated person focused care. Primary health care is delivered by a range of health professionals including GPs, dentists and pharmacists.

96. Further, the Australian Government is responsible for the planning, funding, policy, management and delivery of the national aged care system. This includes residential and community based care or supports for eligible people 65 years or over (50 years or over if you identify as an Aboriginal or Torres Strait Islander person).

97. The Australian and NSW Governments have a shared responsibility in supporting the National Disability Insurance Scheme (NDIS). Non-government organisations and private providers have a significant role in the delivery of disability support services. Access to mainstream services, community based activities and other government programs is a shared responsibility across many services.

98. A number of different healthcare providers operate private hospital services in NSW. Services delivered through private hospitals are largely procedural, with some recent expansion into other areas including drug health and mental health.

99. The Ministry of Health is the regulatory authority for privately owned and operated private health facilities across the state. Legislation sets the requirements for licensing including the minimum standards for the provision of safe, appropriate and quality health care for patients in private health facilities in NSW.

100. Private providers deliver a range of health services outside of hospitals including through:
    a. Pharmacies;
    b. aged care facilities,
    c. disability support providers;
    d. allied health;
    e. dental health; and
    f. mental health.

101. Non-government organisations deliver a broad suite of health services. Some of these are delivered in partnership with NSW Health and other government agencies. For services delivered in partnership with NSW Health, arrangements exist to ensure effective monitoring and oversight of service delivery. Services provided by non-government organisation include:
    a. mental health services;
    b. drug health services;
    c. community transport services;
    d. women's health;
    e. LGBTIQA+ health;
    f. youth health;
    g. refugee health
    h. services delivered through Aboriginal Medical Services (AMSs) and ACCHOs.

Question 5

Describe how the burden of disease and nature of healthcare needs in the NSW population has shifted:

a. over the last 40 years (since the introduction of Medicare); and

b. since the introduction of the National Healthcare Agreement and the National Health Reform Agreement (and Addendums)

102. The burden of disease has changed significantly over the last forty years, with an increased prevalence of conditions associated with ageing and mental health issues and escalating numbers of those with chronic disease.

103. The NSW population has also changed significantly between 1984 and today. In general, the population is older, more ethnically diverse, more educated and is living longer. However there has been growth in income disparity, especially for the lowest 10% of the population.

104. Nearly all Australians use health services in their last year of life, with 8% of health service costs were spent on people in their last year of life. By age, average costs for people in their last year of life ranged from $16,600 per person aged 20–29 to $37,100 per person aged 60–69. Average costs per person fell after the age of 70, down to $17,000 per person aged 80 and over.[3]

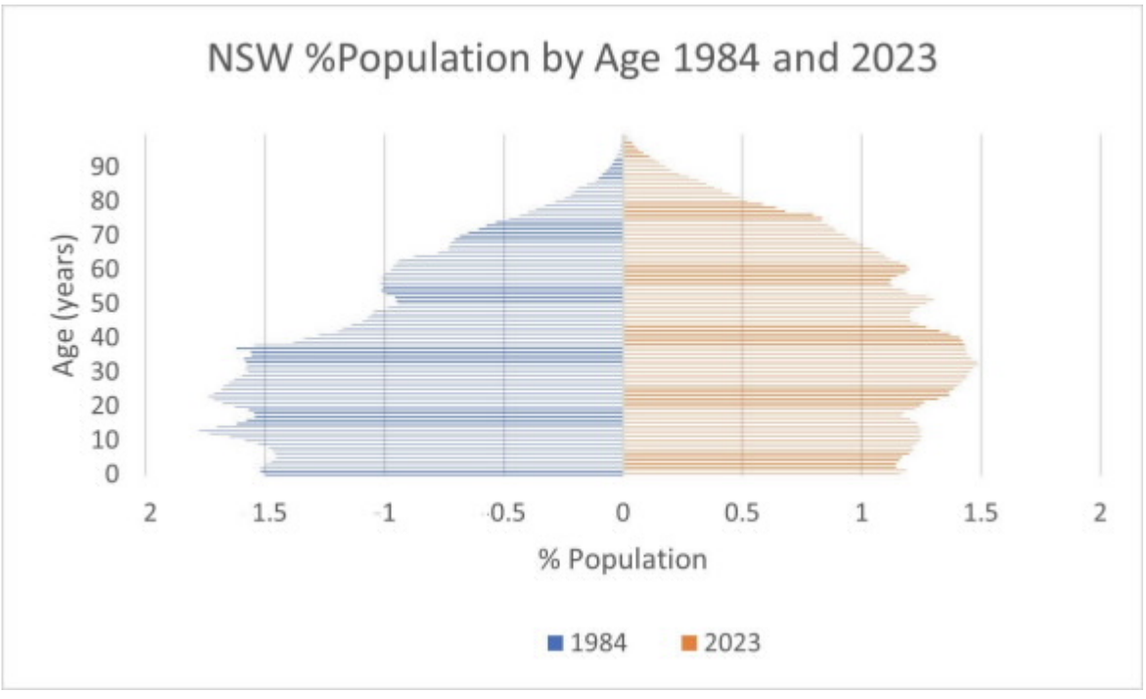


Figure 3: Change in age structure 1984 -2023

Source: ABS 2023

105. Australia has population growth above that of the OECD or European Union. This is largely due to net migration. The proportion of residents born overseas has been increasing since 1984. There has also been a significant shift in the country of birth for Australia's resident population, with differing waves over time. For example, the

[3] The last year of life: patterns in health service use and expenditure, Australian Institute of Health and Welfare 2022 at The last year of life: patterns in health service use and expenditure, Key findings - Australian Institute of Health and Welfare (aihw.gov.au) accessed 15/11/2023

proportion and number of residents born overseas from China, India and Nepal have grown significantly between 2012 and 2022.[4]

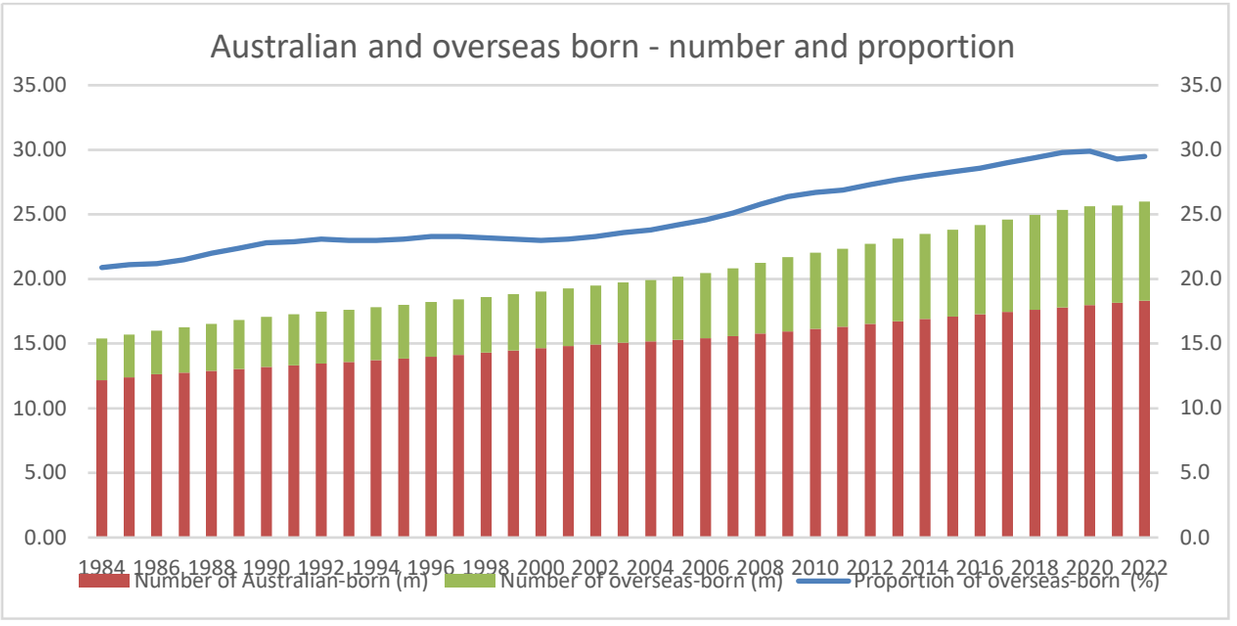


Figure 4: Changes in NSW population from 1984 -2022

Source: ABS 2023

106. Life expectancy has increased dramatically for most Australians. A girl born between 2011 and 2013 can expect to live to 84.3 years, and a boy to live 80.1 years, compared to 79.2 and 72.7 years for those born in 1984[5]. However, the growth in life expectancy has not been even across socio-economic status.

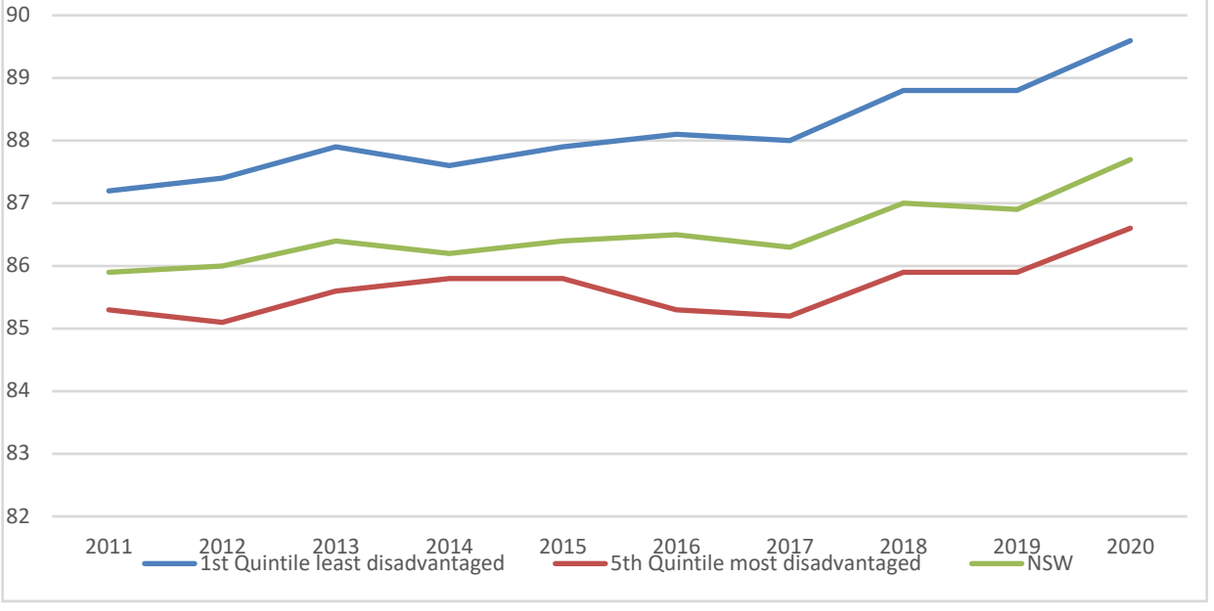


Figure 5: Growth in life expectancy across socio-economic quintiles

Source: ABS 2022

[4] Australia's Population by Country of Birth, Australian Bureau of Statistics, 2023 at https://www.abs.gov.au/statistics/people/population/australias-population-country-birth/latest-release accessed 15/11/2023

[5] Australian Health Services: too complex to navigate, Policy Issues Paper No 1, Victoria University, 2019 ISBN 0-6482621-3-8

107. Aboriginal and Torres Strait Islanders have also not had similar improvements in health status, with higher premature mortality than others in NSW.

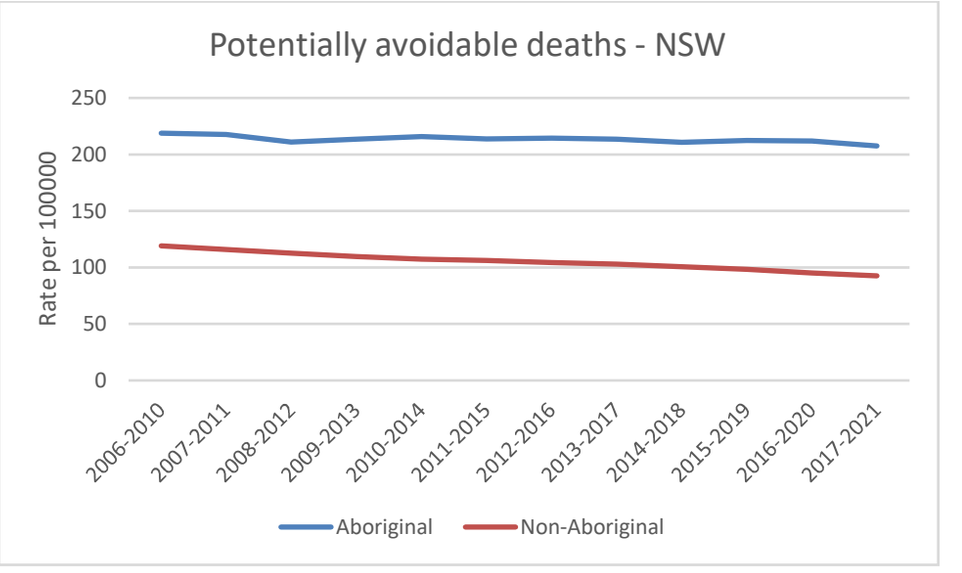


Figure 6: Potentially avoidable deaths in NSW from 2006/11 – 2017/21

Source: HealthStats NSW 2023

108. Since 1984, there has been a significant decline in deaths from cardiovascular disease. Over the 35 years from 1980 to 2015, the age-standardised death rate for heart attack fell by 86%, from 204 to 28 deaths per 100,000 population[6].

109. Cardiovascular disease is largely preventable, and many of its risk factors can be modified, including tobacco smoking, high blood pressure and cholesterol, physical inactivity, poor nutrition, and obesity.

110. The decline in deaths has been attributed to the success of prevention activities, including cessation of smoking, screening and treatment for hypercholesterolaemia, improved diet combined with improved treatment such as better and less invasive management of ischaemic heart disease.

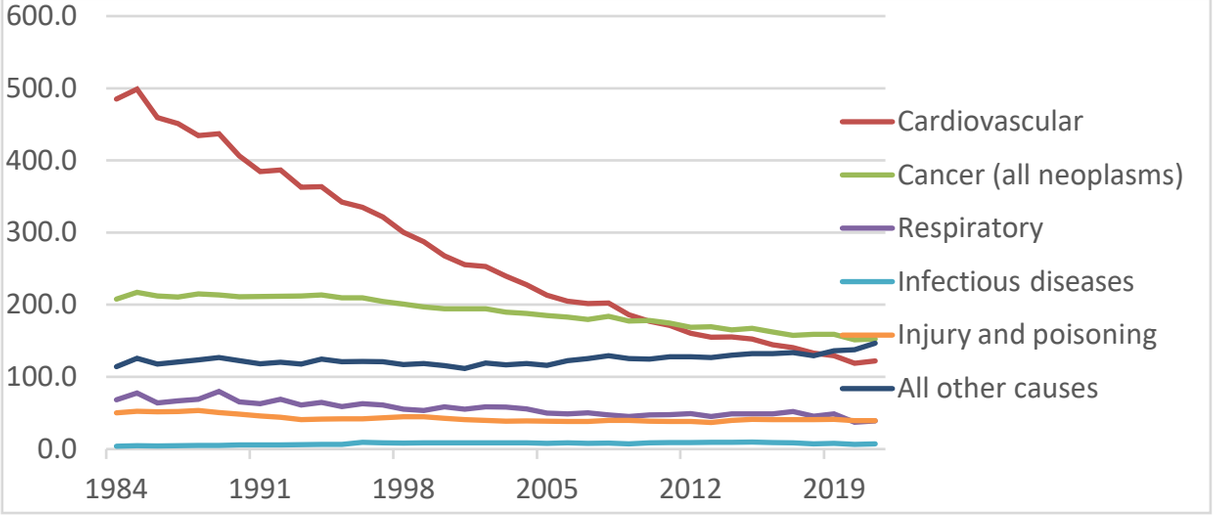


Figure 7: Change in causes of death (Age Standardised Rate per 100,000) (Australia)

Source: AIHW 2022

[6] Trends in cardiovascular deaths, Australian Institute of Health and Welfare, Bulletin 141, September 2017

111. Reductions in cancer death rates are associated with early cancer detection through improved diagnostics and screening programs coupled with improved treatments. Early cancer detection and improved diagnostics may also increase the rate of new cases of certain types of cancer, such as prostate, breast and colorectal cancer, however long-term reductions in the prevalence of cancer-causing agents such as tobacco smoking and poor diets in the population reduce the rates of other cancers.

112. The causes of cancer are complex and include both genetic and environmental factors, however many cancers are preventable through public health interventions. These include vaccination (for example, Human Papilloma Virus (HPV) vaccination to prevent cervical cancer and Hepatitis B vaccination to prevent liver cancer), changes to workplace exposures (such as exposure to radiation and asbestos) and government policy interventions to reduce tobacco smoke exposure or promote healthy eating and active living.

113. Tobacco is the leading preventable cause of morbidity and mortality in Australia. The proportion of total burden due to tobacco use fell from 10.4% in 2003, to 9.0% in 2015, to 8.6% in 2018.[7]

114. A range of regulatory actions have been taken with the objective of decreasing tobacco use over the last 40 years, including increasing bans on smoking in workplaces and public places, advertising bans, increasing tobacco excise duty and changes to tobacco packaging and banning point of safe tobacco advertising.

115. Not all social groups are at the same level of tobacco consumption, with some groups born overseas having higher rates which are more reflective of their country of origin than Australia.

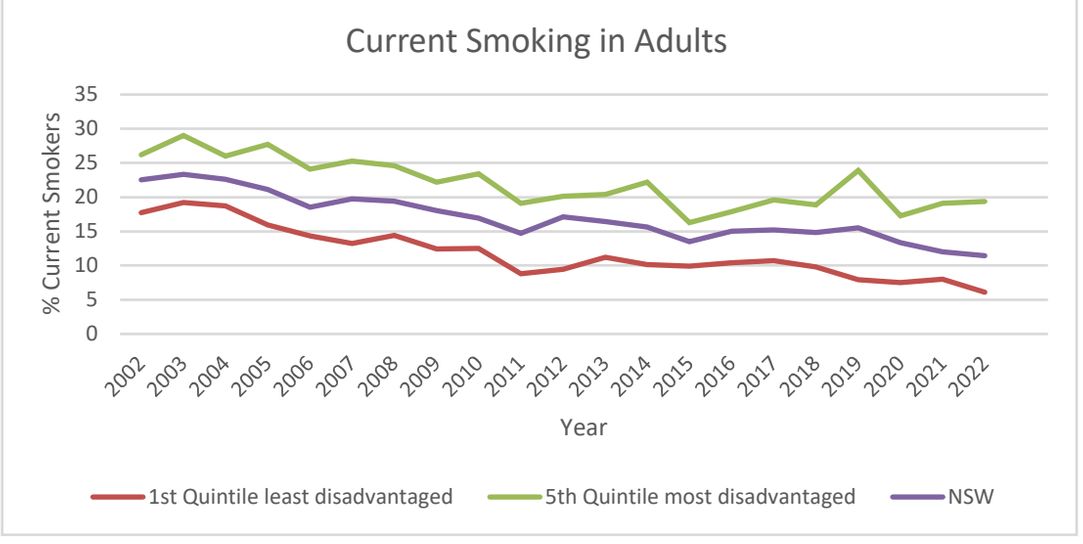


Figure 8: Change in tobacco use 2002 – 2018/19

Source: HealthStats NSW 2023

116. The burden of chronic disease has been increasing. By 2011, chronic diseases had become the leading cause of illness, disability and death in Australia, accounting for 90% of all deaths. Half of all Australians live with at least one chronic disease,

[7] Alcohol, tobacco and other drugs in Australia, Australian Institute of Health and Welfare, 2023 https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/drug-types/tobacco accessed 14/11/2023

and almost one in four (23%) live with two or more[8].

117. The AIHW has estimated that 4.5 million years were lost to premature death or living with chronic illness during 2011. Rates of chronic disease have risen further between 2011 and 2018.

118. Disability-adjusted life years (DALY) is a measure of healthy life lost, either through premature death or living with disability due to illness or injury

119. The burden of disease is changing, with the past twenty years showing declines in incidence of heart disease, stroke and lung and bowel cancer, but increases in type 2 diabetes, dementia, osteoarthritis and suicides and self-inflicted injuries. This reflects the ageing population, lifestyle changes and an increase in disease associated with mental health conditions.

120. Dementia was the second overall leading cause of burden of disease and injury in Australia, behind coronary heart disease. Age is the biggest risk factor for dementia. Dementia has physical, psychological, social and economic impacts. The cost of caring for individuals with dementia can be high, and as the population ages, the prevalence of the condition will increase. The number of Australians with dementia is predicted to more than double by 2058 to 849,300 (AIHW).

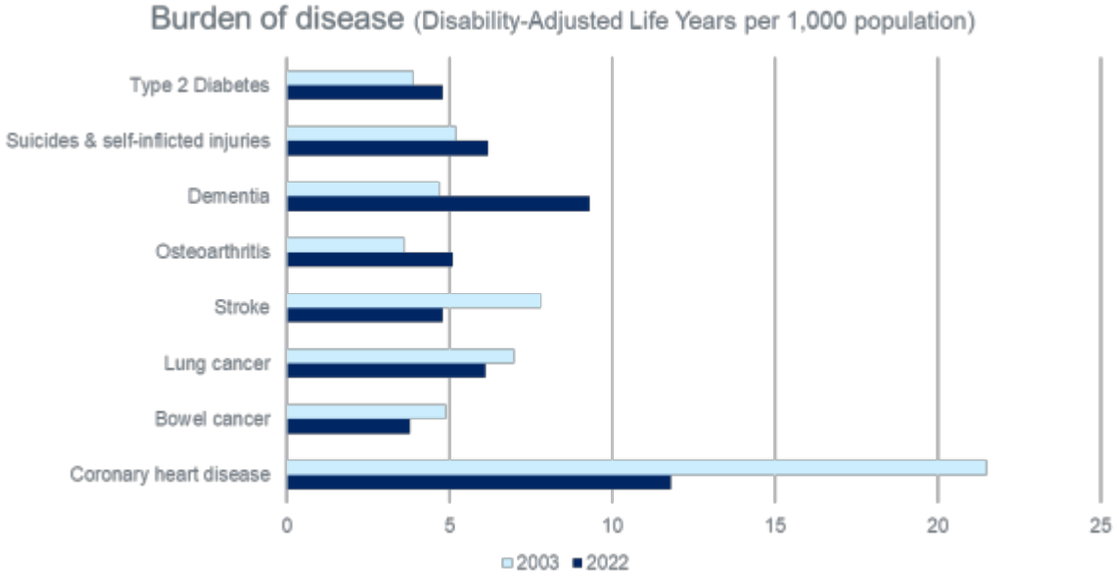


Figure 9: Changing burden of disease 2003-2022

Source: AIHW Burden of Disease Study 2022

121. Socio-economic factors are a key determinant of health outcomes. Adults in lower socio-economic groups tended to have higher health risk factors, including for obesity, smoking and high blood pressure. The rates of chronic conditions in these groups are also higher. Those in the lowest socio-economic groups have a much higher DALY than those who are in the highest quintile. This is particularly visible in the fifth to ninth decades of life

[8] Chronic disease: Australia's biggest challenge, Australia's Health 2014, Australian Institute of Health and Welfare 2014

	Age group (years)				
Socioeconomic group	Under 15	15–44	45–64	65–84	85+
1 (Lowest)	65.5	139.6	299.6	571.0	1,125.7
2	56.8	128.3	257.7	513.3	1,082.9
3	55.4	118.0	216.6	465.3	1,047.4
4	49.6	102.9	204.8	446.6	1,010.6
5 (Highest)	41.3	87.1	161.9	393.2	957.0
Note: DALY rate is expressed as DALY per 1,000 population.					

Figure 10: Age specific total burden (DALY) by life stage and socioeconomic group 2018

Source: AIHW Burden of Disease Study 2018

122. The social determinants of health, such as housing, education, social relationships, employment and income also significantly impact health outcomes. Inequities arise when there are systemic differences in health status, health risks or access to health care between groups that are avoidable and unfair. Efforts to reach and engage disadvantaged communities in health care, including outreach services and tailored and flexible services such as drop-in clinics can be more costly to deliver.

123. There is also a clear link between mental health and physical health. Physical activity and healthy eating have been shown to reduce symptoms of depression. Those with better social connectedness are less likely to experience cardiovascular diseases. Structured lifestyle interventions can reduce tobacco smoking and increase healthy behaviours. Four out of every five people living with mental health issues have a co-existing physical illness, and those with mental ill health have higher rates of chronic conditions[9].

[9] NSW Health Guideline: Physical Health Care for People Living with Mental Health Issues, issued 30 April 2021 accessed 25 October at https://www.health.nsw.gov.au/pds/ActivePDSDocuments/GL2021_006.pdf

Question 6: What are the major health problems and needs of different groups (including metropolitan and regional and rural groups) within the NSW population now. How are those needs expected to change in the coming decades?

124. Population growth, demographic changes and changes in the disease burden have resulted in an increasing volume of health care demand, especially in mental health, diabetes and other chronic diseases.

125. Nearly 90% of citizens come into contact with the broader health system of NSW each year, and of those, about 30% are accessing NSW Health services[10].

126. One third of the NSW population currently lives in regional areas. It is anticipated population growth will be slower in these areas, but ageing of that population will be faster than in metropolitan locations.

127. Specific groups in the community experience poorer health outcomes and access to care (for example, people over age 75 and from lower socio-economic backgrounds), which is exacerbated by poor linkages in current health care models.

128. It is estimated two-thirds of the disease burden in NSW is due to conditions that could largely be managed outside the hospital setting (for example, patients with chronic disease, who currently access high rates of care in all settings). Hospitalisation can exacerbate a condition that could have been better managed through provision of prevention activities in community-based health care.

129. For Aboriginal people, the difference in life expectancy between Aboriginal people in NSW and the general population is estimated to be approximately 7-9 years. The greatest contributors to higher mortality rates and excess deaths experienced by Aboriginal people are chronic disease, in particular cardiovascular disease, mental health, diabetes, cancers, and injury.

130. For culturally and linguistically diverse communities, culture influences how these consumers define health and illness and how they perceive and respond to health information. It affects how healthcare is sought, how symptoms are described, how treatment options are considered, and whether treatment will be chosen and adhered to. Risk factors contributing to poor health outcomes for these communities can also reflect patterns of health in their country of origin.

131. Not used.

132. The health of culturally and linguistically diverse consumers can be affected by poor access to health services and a lack of appropriate information to make informed decisions.

133. By 2032, 1.5 million more people will need to access care from the NSW health system compared with today[11]. In addition, the complexity of demand is increasing due to an increase in the number of co-morbidities.

134. By 2032, at least 750,000 more people will have multiple chronic diseases, increasing the complexity of care they need. If the health system continues to rely on the current models of care to address this increase and more complex demand, indicative estimates suggest future demand would drive 1.7 times more activity in the health system by 2032[12].

[10] Future Health: Guiding the next decade of care in NSW 2022-2032, NSW Health 2022
[11] Future Health: Guiding the next decade of care in NSW 2022-2032, NSW Health 2022
[12] Future Health: Guiding the next decade of care in NSW 2022-2032, NSW Health 2022

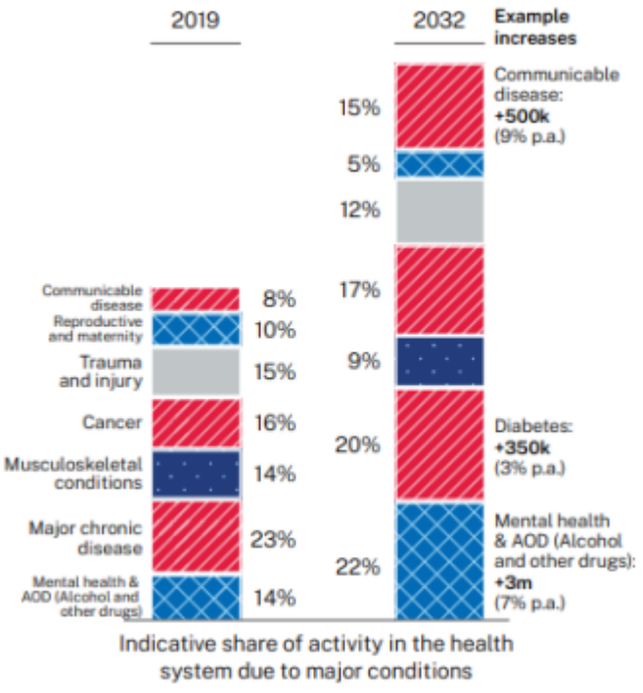


Figure 11: Projected scale of activity increase in NSW current to 2032

Source: Future Health Report, NSW Health 2022

135. The number of people over the age of 65 in NSW is rising. Life expectancies are increasing. By 2061, it is projected that there will be 11.5 million people living in New South Wales, 3.3 million more than in 2020. Life expectancy at birth is projected to reach 91.7 years of age for women and 89.4 for men by 2061, compared to 85.9 for women and 82.2 for men in 2020[13].

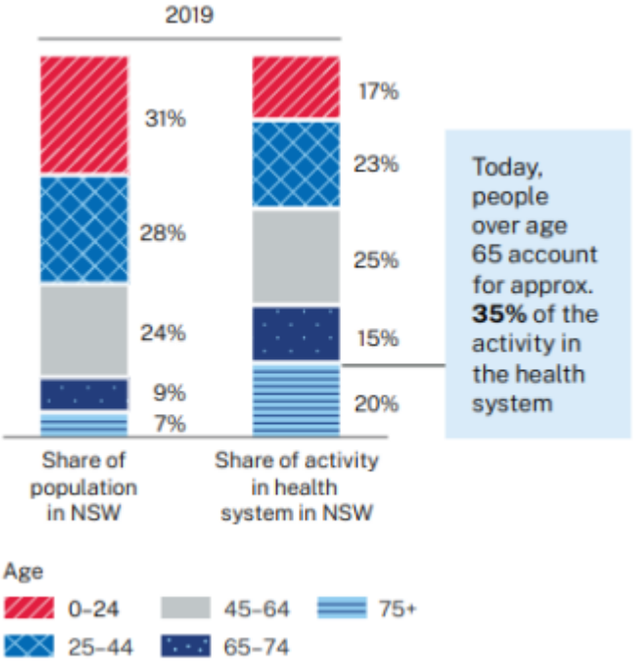


Figure 12: Effects of demographic shifts on the NSW health system

Source: Future Health Report, NSW Health 2022

[13] Future Health: Guiding the next decade of care in NSW 2022-2032, NSW Health 2022

136. As people live longer, the propensity for co-morbidities and chronic health conditions increases, which drives the need for a co-ordinated approach to care across the health, aged care, primary care and disability sectors.

137. Provision of clinical care for older people requires an effective interface among the health system, residential aged care facilities (RACFs), primary care services and the disability sector, with clearly defined roles and responsibilities for all parties

138. In addition to providing general medical care for RACF residents, GPs are also needed to support and co-ordinate the care of older people with mental health conditions and to support palliative care and end of life care. GPs often express a desire for additional training to undertake these roles.

139. Access to quality clinical care in RACFs is critical in preventing unnecessary admissions to hospital. This includes effective medication management, nutrition and hydration, pressure care, oral care and access to GPs and allied health professionals to provide specific advice regarding clinical needs of individual clients.

140. Hospitals and emergency departments have also been used as a last resort for older people and those living with a disability when there are no other services available to support them either at home or in the community. In more remote rural communities, LHDs have become the default provider of aged care services.

141. Improved access to primary care services reduces the demand for low-acuity hospital presentations, which is critical not only for the elderly, but also for people with chronic disease, those who are socioeconomically disadvantaged or other vulnerable populations.

142. Consistent and accessible primary care has a significant impact on good health outcomes.

143. Failures in primary care place an increased reliance on the local public hospital system and emergency department utilisation. It also places pressure on the ability of the hospital system to cope with both primary care and associated ongoing follow up and support.

144. Regional and rural groups presently face unique challenges in terms of access to care, particularly specialist care. This can result in the need to travel long distances for care and incur greater costs. Patients who live in communities that border the state can experience additional challenges to accessing health care.

Question 7

How well adapted is:

a. the existing governance and structures of NSW Health; and

b. the existing funding model,

to meet the shifting burden of disease and health care needs of the NSW population?

145. Fundamental to how NSW Health is positioned to manage the complex environment and respond effectively to the changing burden of disease is the funding models and governance of the public health system.

146. The broad governance settings for the NSW Health system, including the role of the State as the system manager and the governance of the LHDs including their Boards are set out under the NHRA.

147. Ensuring the right governance settings to support local decision making while enabling effective oversight and management of the public health system is crucial.

148. The current governance structure has provided NSW Health with the capacity to adapt and scale across the system to meet the changing needs of communities. This has been supported by an effective clinical governance framework to ensure the provision of safe high quality care in NSW.

149. Whilst devolution has supported a very strong capacity to adapt care to local circumstances, it can also bring challenges with regards to equity and efficiency for initiatives that require standardisation rather than localisation, such as procurement and recruitment practices or the introduction of new technologies that need to be implemented and used in a standardised way across the state for scale and consistency.

150. Current jurisdictional governance arrangements across primary and community health make the provision of integrated, multidisciplinary care challenging.

151. Given the challenges facing the NSW public health system and the need to respond to the changing burden of disease, a review of the long-term NSW and national funding model is required. This includes review of the long-term funding envelope and growth rates for the NSW Health budget.

152. There needs to be a far greater focus on prioritisation and disinvestment from low value care and further work to reduce futile care. What is meant by value based care is as follows:

a. health outcomes that matter to patients;

b. experiences of receiving care;

c. experiences of providing care; and

d. effectiveness and efficiency of care.

153. This approach is supported by a focused effort on ensuring the health system is pursing allocative strategies for value. It requires a more purposeful discussion with the community by all levels of the health system.

154. The ABF model promotes technical efficiency and transparency in funding allocation, particularly at the state and LHD or SHN levels. It is not designed to allocate funding at the hospital or facility level, which is determined by the relevant LHD or SHN.

155. The introduction of ABF has brought considerable national transparency to the funding of public hospital services, but at the expense of supporting innovation and care outside the hospital.

156. ABF, as it is currently implemented nationally, focuses on throughput (activity) and not on outcomes. This focus on technical efficiency is at the expense of allocative efficiency.

157. An increased focus on outcome-based funding and preventive health could improve access and equity particularly for vulnerable cohorts and those in regional and rural communities.

158. ABF does not always reflect the needs of NSW communities and does not support provision of a broader range of services in some settings to promote improved health equity if the patients accessing the service have barriers to accessing care in other settings.

159. In addition, there are a range of adjustors that are applied to ABF to account for various factors such as remoteness, which add additional complexity to the model.

160. The Independent Health and Aged Care Pricing Authority (IHACPA) has a role in determining public hospital and healthcare pricing including the National Efficient Price (NEP) for public hospital services that are funded on an activity basis. IHACPA is also responsible for adjusting the NEP to reflect legitimate and unavoidable variations in cost of delivering healthcare services and determining which services are in scope to receive funding under the NHRA.

161. Each year, the IHACPA publishes the General List of In-Scope Public Hospital Services (the General List) as part of the NEP Determination. The General List defines the public hospital services eligible for Commonwealth funding.

162. Jurisdictions can apply to have services included on, or excluded from, the General List. Jurisdictions have tried to include models of care that provide care in the community on the General List as these models are more effective in responding to the changing burden of disease.

163. IHACPA conducts an analysis of each application to determine if services are transferred from the community to public hospitals for the primary purpose of making services eligible for Commonwealth funding. New models can blur the boundaries between primary care and hospital services, making inclusion of new models of care difficult.

Question 8

What steps, programs and models of care have NSW Health implemented (or intend to implement) to address the shifting burden of disease and health care needs of the NSW population. Are there barriers to this because of the existing funding models?

164. Recognising the challenges presented by the changing burden of disease, NSW Health developed the *Future Health Strategic Framework 2022-2032* to position the NSW public health system to meet the needs of patients, community and workforce over the next decade.

165. The strategy is designed to see improved health outcomes through an integrated health system where patients can access the care they need in the most appropriate setting and low value care is avoided.

166. This includes prioritising safety and quality and emphasises the importance of delivering care that is personalised to individual needs and preferences.

167. Investment in preventative health, care in the community, in the home, and through virtual health services driven by a person-centred approach to healthcare, will enable people to have more control over their own health. NSW Health's investment in these areas reflects the future of healthcare delivery.

168. It also focuses on equitable access to timely and coordinated care across all settings in a way that reflects contemporary community expectations.

169. This approach must be reflected in national arrangements, given the intersections between the roles and responsibilities in care provision of the Australian and NSW Governments. This includes agreed shared goals and objectives, clear roles and responsibilities, and strong associated accountability mechanisms.

170. To improve an individual's access and navigation of health system, NSW Health is implementing the Single Front Door, a transformational strategy harnessing patient portals and apps aimed at enhanced engagement and empowering patients/consumers to make informed choices about accessing healthcare services.

171. Issues and decisions external to health also impact an individual's health and wellbeing, such as the impact of appropriate housing on wellbeing, and the impact of planning decisions on the ability to exercise and access green space.

172. NSW Health has implemented an extensive range of strategies and programs to meet the changing health needs of communities, some of which are outlined below.

Preventive health

173. In responding to the changing burden of disease, coordinated investment in preventative health and early intervention is part of a whole of health and social system response, including the need to address the wider determinants of health.

174. Preventive services and early interventions should be strong pillars of Australia's healthcare system to support people to be healthy and well. People living in Australia are experiencing increasingly complex health care needs.

175. Low proportional investment in preventive health, the wider determinants of health and increasing burden of chronic disease has led to increased spending on treatments to manage conditions that could be prevented, detected earlier or managed more effectively in a comprehensive primary care setting reducing the need for hospitalisation.

176. NSW Health prevention activities have a particular focus on priority populations such as Aboriginal and Torres Strait Islander people, those experiencing homelessness, LGBTIQA+ communities, those experience mental health or drug health issues and culturally and linguistically diverse communities. A snapshot of NSW Health prevention activities include:
    a. Quitline for smoking cessation programs;
    b. Immunisation programs and apps to support timely vaccinations;
    c. HIV prevention programs including targeted cohorts;
    d. Screening programs including newborn bloodspot screening, bowel, breast etc;
    e. Health Coaching services, including the Get Healthy program with tailored program for Aboriginal people;
    f. Mental health programs;
    g. HIV, Hepatitis B and Hepatitis C prevention and management programs;
    h. Cancer survivorship support;
    i. Supporting councils providing safe drinking water;
    j. Supporting councils in regulatory activities e.g., tattoo parlours, legionella control;
    k. Public awareness campaigns to encourage healthy behaviours and to warn of particular threats to health (e.g., heat waves or poor air quality); and
    l. Better integration of preventive health programs and clinical care programs.

Community and Primary

177. NSW Health's activities in providing care in the community in response to the changing burden of disease are extensive and are underpinned by a vision to provide more person centred, connected and integrated care.
178. These initiatives range from those delivered at the statewide level to those delivered more locally to meet the needs of communities.
179. The statewide diabetes initiative is a formal partnership between NSW Health, Primary Health Networks (PHNs), LHDs and ACCHOs, Diabetes NSW & ACT and other partners to improve the coordination of diabetes care across NSW and keep people well and out of hospital.
180. Cross agency initiatives also play a key role in delivering care.
181. Transformational cross-agency work supports all NSW families to access high-quality health, education and community services in the first 2000 days (pregnancy through to the first five years) of a child's life.
182. The early years are critical and are a predictor of school performance, adolescent pregnancy and involvement with the criminal justice system in the adolescent years as well as being related to obesity, elevated blood pressure and depression in adulthood and a predictor of coronary heart disease and diabetes in later life.
183. Cross agency collaboration and engagement also supports delivery of mental health services and care. This includes:
    a. maintaining and strengthening student mental health and wellbeing;
    b. improving service collaboration and outcomes for shared client groups at the interface of mental health, homelessness, and social housing services;

c. improving Aboriginal social and emotional wellbeing; and

d. better meeting the health needs of people with a mental health issue in forensic mental health services and custody.

184. Providing alternate pathways for people experiencing mental ill health enables rapid access to specialist mental health services together with alternatives to emergency departments. This includes the establishment of 19 Safe Havens across NSW as an alternate to the emergency department for people experiencing suicidal distress.

185. The mental health co-responder model known as Police, Ambulance and Clinical Early Response (PACER) places mental health clinicians in police stations to support first responder responses to mental health emergencies by providing an immediate, compassionate response and connection to appropriate services for ongoing care, without always needing to go to the emergency department.

186. Although not the responsibility of the NSW Government, NSW Health has developed 'workarounds' to care for those accessing aged care services to prevent unnecessary admissions to hospital. These include virtual care and aged care outreach services. These outreach services provide timely access to multi-disciplinary care when a person experiences an acute deterioration in their health.

187. NSW Health has also implemented secondary triage processes to provide an alternate pathway for low acuity RACF residents calls to NSW Ambulance via MyEmergencyDoctor Service and the Integrated Care Residential Aged Care initiative to support facility staff to care for unwell residents by providing training, and virtual care support and triage.

188. In regional and remote locations, there are 63 MPS across NSW that provide integrated health and aged care services for older people. The funding for MPS comes from the Australian and NSW Governments.

189. To support the provision of high quality safe care in regional and rural communities, initiatives such as virtual care have been established to provide timely access to specialist care and support.

Supporting delivery of care

190. To address the changing burden of disease, NSW Health has implemented a range of strategies, programs and initiatives to support new models of care and provision of care closer to home.

191. This includes, for example, a comprehensive health infrastructure strategy to support investment in a range of care options from the home to local centres and hospital precincts as well as virtual care settings.

192. NSW Health has embraced technology to provide virtual care where clinically appropriate, together with hospital avoidance and hospital length of stay minimisation models and are increasingly networking and integrating services to improve equity of access to patients.

193. As part of this whole of system digitisation, the introduction of the Single Digital Patient Record (SDPR) will provide a secure, holistic and integrated view of the care a patient receives across the NSW Health system. Clinicians will have fast, secure and easy statewide access to an integrated record of an individual's medical history in real-time. It is anticipated the SDPR will be implemented in all NSW Health public hospitals over the next 6 years.

194. The SDPR will replace the current nine electronic Medical Record systems, 10 Patient Administration Systems and five Pathology Laboratory Information

Management Systems in use across NSW Health into one platform. This will reduce duplication of costs and efforts required to support and maintain these systems.

195. It will also enable patients to have greater access to their own health information which will in turn help GPs have a better level of information about their patients who interact with the public health system.

196. All of this work is underpinned by the need for effective data and analytics. The NSW Health Lumos Program is an example of this, linking records to map patient journey through the health system in collaboration with 10 PHNs and over 600 participating General Practices.

197. In creating a sustainable health system, other statewide initiatives are essential to ensure efficient use of resources across the system and support new models of care.

198. Statewide initiatives such as the electronic medication management system have delivered significant results that contribute to improved clinical safety and quality of care together, while also delivering savings for the health system.

199. NSW Health is also undertaking a system wide Procurement Reform Program to deliver an integrated end-to-end procurement and supply chain system which will result in greater efficiency and savings across the system.

Figure 13: Four workstreams of the NSW Health Procurement Reform Program

Source: NSW Health

Funding model reform

200. Funding models must enable the system to respond to the changing burden of disease. The current funding models do not effectively support the delivery of innovative and new models of care. The current models too often leave NSW Health as a provider of last resort, with failures in primary care, aged and disability care. Risk and responsibility must be shared.

201. The definition of public hospital services and hospital avoidance measures should be broadened to enable provision of a Commonwealth funding contribution under the NHRA to better reflect how care is now delivered. ABF should also reflect the need to provide a broader range of services in some settings if the patients accessing the service have barriers to accessing care in other settings. This approach is important to address health inequalities. Examples of such settings may include drug and alcohol, mental health and sexual health services.

202. The NHRA Addendum restricts growth funding under this agreement in any one year to a national 6.5% growth cap. This cap should be removed to ensure more equitable sharing of risk and to enable a timelier movement of the Commonwealth share of public hospital funding to 45%.

203. The NHRA funding model, as applied by IHACPA, relies on historical data, with a three-year lag in cost data underpinning the NEP and National Efficient Cost (NEC). The model was designed to operate in a stable environment. However, flow on effects of COVID-19 have seen unprecedented inflationary pressure and wage growth which are not reflected in the historical trends. The NEP should accurately reflect the increased cost of delivering care in hospitals.

204. Existing funding and pricing models also do not acknowledge the important role of health services in primary and secondary prevention – for example, immunisation and tobacco cessation.

205. Integrated funding models to support care in the community need to be fast-tracked, with a more blended funding model moving away from a reliance on ABF in dominating decisions on budget allocations at the state level. This would assist in enabling the delivery of different models of care and provide more scope for innovation. However, implementation of any new funding model would need to consider underlying equity and the responsibility to maintain the safe operation of the public health system.

Question 9

To what extent (if any) do:

a. the existing governance and structure of NSW Health, and/or

b. existing funding models,

present barriers to the development and implementation of innovative or optimal models of care?

206. The environment shaping the delivery of healthcare has changed significantly, requiring the adaptation of systems, processes and people to ensure the ongoing sustainability of the public health system. The changing burden of disease has placed increasing pressure on health and social care systems which are not sufficiently connected or coordinated in the provision of care.

207. An emerging issue that further impedes the system's capacity to respond to changing conditions and increased demand relates to the lack of social licence to implement alternate models of service delivery.

208. Community expectations are largely tied to traditional models of care delivery, with a focus on doctor led, hospital based surgical interventions. Engaging with communities on emerging evidence supporting alternate models is required to support a positive discussion with communities about the need to provide care in different ways. This includes support for new models of care that maximise clinicians' scope of practice and care provision in lower acuity settings.

209. The provision of safe, effective and high quality acute services is fundamental to the NSW public health system. The changing burden of disease and increase in chronic conditions sees a need for greater emphasis on generalist practitioners to provide whole of person care.

210. Given the ageing population, increasing comorbidities and workforce challenges, it will be increasingly important to work as one system, engaging effectively with partners, both across governments and with non-government organisations, the private sector and communities. Ensuring equitable access to health care and supporting a healthy and well community requires considerable action outside of Health.

211. Governance and funding barriers to the development and implementation of innovative or optimal models of care include:

a. Lack of flexible and agile funding models, both national and state, to support evidence based innovative models of care, including the delivery of care out of hospitals, greater investment in prevention and drive improved health equity;

b. Limited integrated regional health planning and delivery impacting effective delivery of person centred and coordinated primary and community care;

c. Variable implementation of outcome-based funding models and insufficient focus on preventive health to improve access and equity particularly for vulnerable cohorts and those in regional and rural communities;

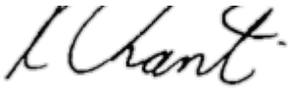
d. Insufficient investment in multidisciplinary care, and lack of focus on generalists, allied health and nurse practitioners and enhancing scope of practice;

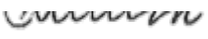
e. Inability to regulate where or how medical health specialists consultative care is provided, resulting in activity being driven to the public health system.

f. Ability to meaningfully engage with the community to adopt new ways of health care delivery;

g. Need for further strengthened linked data with data sources outside of health to better inform funding models and support evaluation of models of care including improving reach to members of the community who are not seeking the care they are likely to need.

212. To better respond to the changing burden of disease, options could include development of health hubs to integrate care provision to respond more effectively to local health care needs and better harness digital solutions. Any proposed model would need to evaluate both service delivery and patient experience.





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17 November 2023