# Reform Critical

## A Fragmented Health System at Breaking Point

**Impact Economics and Policy**

FEBRUARY 2023

*Prepared with the support of the*
***Health Services Union***
*NSW ACT QLD Branch*

# About Impact Economics and Policy

Impact Economics and Policy brings together a group of expert economists and policy specialists with experience working for government, non-for-profits and big four consulting.

Established at the start of 2022, our mission is to partner with clients for impact through providing robust evidence, fresh analysis and strategic communication to tackle Australia's biggest public policy challenges.

# About HSU

The Health Services Union NSW/ACT/Qld represents some 47,000 workers in both public and private health as well as ambulance paramedics and disability and aged care workers

In the public health system, HSU members are cleaners, catering staff, administration officers, hospital security, paramedics and allied health professionals.

## ACKNOWLEDGEMENT OF COUNTRY

We acknowledge Aboriginal and Torres Strait Islander peoples as the Traditional Owners of Country throughout Australia and their continuing connection to both their lands and seas. We also pay our respects to Elders – past and present – and generations of Aboriginal and Torres Strait Islander peoples now and into the future.

We accept the invitation of the Uluru Statement of the Heart and support the campaign for a First Nations Voice to Parliament to be protected by the Australian Constitution.

# Contents

# 1. EXECUTIVE SUMMARY

Despite the collective sacrifices of the people of NSW through the pandemic to protect the health system, it is cracking under the pressure of a post pandemic increase in demand for services. While COVID-19 is a large driver of the current crisis, even before the pandemic hit there were concerns that the health system would not be able to deal with the sustained increases in demand for services and rising costs.

As the Commonwealth Government considers the recommendations of the latest review of Medicare there is a risk that the broader system wide drivers of the current crisis will not be addressed. The health system is complex, and responses need to reflect a patient centered approach rather than artificial silos between primary and acute care, private and public provision, and commonwealth and state funding.

And while state premiers and doctors groups call for more resources to meet the additional demand, it is important that any responses reflect that the current crisis is not just about a lack of funding, but is driven by how that funding is being spent.

Emergency department wait times have blown out not because there is an underinvestment in emergency departments, but because the funding of primary health care does not prioritise keeping people healthy in the community and people are staying in hospital longer than necessary due to failures in the delivery of aged care and disability services.

People in Western Sydney don't struggle to see a GP because there are not enough GPs trained in Australia, but because they are disproportionally located in high income areas where there are lower health needs, but greater financial rewards. Neither NSW or Australia needs to spend more on health care, but we do need to spend smarter to maximise population health.

Australia's fragmented health system, where responsibilities and funding are split across state-federal and public-private lines means it does not deliver the best outcomes for the money spent. The current system does not incentivise outcomes, rather it incentivises the provision of more health services. This is undermining the delivery of quality, evidence based and cost effective health care, and means simplistic solutions such as increasing rebates, more GPs and more nurses is not the solution.

## A HEALTH SYSTEM IN CRISIS

To understand the extent of the current crisis and its origins, it is necessary to first explore how our health system is not meeting the basic aims of every health care system:

- Patient care
- Healthy populations
- Efficient health care
- Sustainable workforce
- Equity in access

## *PATIENT CARE*

Analysis by Impact Economics and Policy finds that patient care and access to high quality and timely health care in NSW is under significant threat:

- In April-June 2022, 10 per cent of people that urgently needed an Ambulance in NSW waited over two hours.
- Patient complaints about health care services have increased by 40 per cent since the start of the pandemic, and 144 per cent since 2011-12.

## *HEALTHY POPULATIONS*

The health system is failing to keep our population healthy, with an underinvestment in prevention and primary health care, and funding mechanisms that are no longer fit for purpose:

- Between 2012-13 and 2017-18 there was a 25 per cent increase in preventable admissions to hospitals, which Impact Economics and Policy estimates are costing the NSW hospital system over $1.1 billion per year.
- Despite one third of Australia's disease burden being preventable, Australia spends 85 per cent less on preventative and community health than Canada.
- NSW spends $100 less per person than the Australian average on community health care, a funding shortfall of $872 million per year on services that could prevent illness and hospitalisations.

## *EFFICIENT HEALTHCARE*

With the cost of the health system projected to increase from 10 to 15 per cent of GDP by 2065, it is important that waste and mismanagement is minimised. Analysis for this report shows:

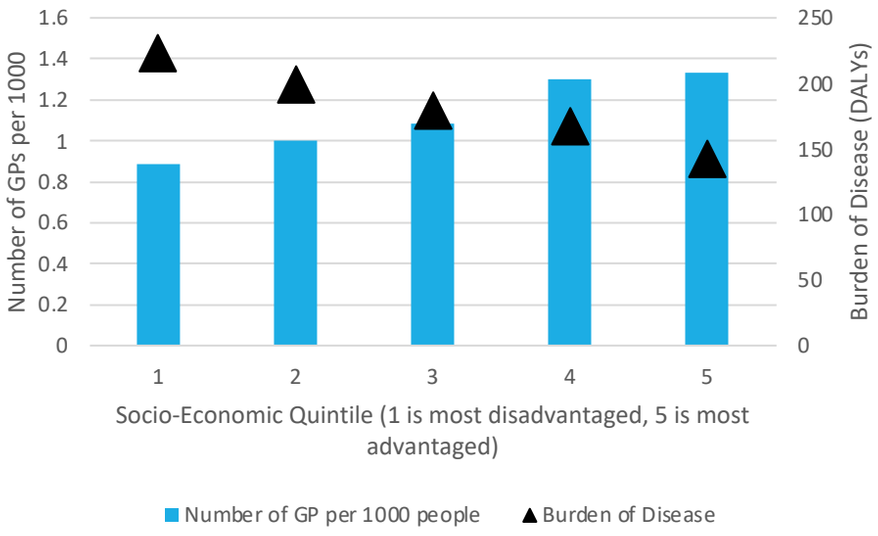
- Over $2.5 billion in 2021-22 was lost due to fraud in Australia's Medicare Benefits and Pharmaceutical Benefits Schemes.
- Rates of caesarean section have reached 50 per cent in the private hospital system, over three times the levels recommended by the World Health Organisation, costing our health system $350 million a year.
- In 2020-21 NSW spent $997 million on visiting medical officer costs, which was four times more than Victoria and ten times more than Queensland.
- Approximately 10 per cent of Private Health Insurance premium income is spent on administration and a further 3.8 per cent on profits, representing up to $1.5 billion in NSW that is being diverted from core health care spending.

## *SUSTAINABLE WORKFORCE*

Impact Economics and Policy undertook a survey of almost 4,500 members of the Health Services Union NSW QLD and ACT, which found that almost half were either unsure or definitely intended to leave their occupation within five years. This will only add to existing and projected workforce issues facing the sector:

- Over 3 million people in NSW live in areas with less than 1 General Practitioner for every 1,000 people.
- High socio-economic areas such as Woollahra have 2 times the number of GPs per 1,000 people than low socio-economic areas such as Liverpool, despite higher health care needs in low income areas.

**FIGURE 1: GPs LOCATED IN AREAS WITH LOWER NEEDS, HIGHER INCOMES**




Source: Impact Economics and Policy analysis using Australian Health Workforce Data and AIHW (2022) Health Across Socio-Economic Groups

- Between May 2010 and March 2020 the number of vacancies in the health sector doubled in NSW from around 3,000 to 6,000, and by July 2022 they nearly doubled again to almost 12,000 vacancies.
- Impact Economics and Policy estimates that by the end of the decade the NSW hospital sector will need an additional 25,000 FTE medical, allied health and other health care staff to meet projected increases in demand.

## *EQUITY IN ACCESS*

The pandemic has tragically demonstrated that Australians do not enjoy equity in health outcomes, with people from low socio economic areas over three times more likely to have died from COVID-19. Likewise, the current pressures faced by our health system will impact individuals and families from lower socio-economic groups more than other groups:

- Those without access to private health insurance in NSW face long waits for 'elective' surgery, with a large spike in the number of surgeries where wait times are above the clinically recommended time, up from 2 per cent in 2018-19 to 10 per cent in 2020-21.
- In 2021-22 almost 450,000 Australians delayed or did not seek care from both GPs and Specialists and over 300,000 Australians delayed or did not seek care from a mental health professional due to the cost.

## A HISTORY OF REVIEWS

The current crisis follows the warnings of over twenty reviews and inquiries into the health system over the past four decades – which have continually failed to deliver fundamental reform. One of the reasons for this failure is that none of these reviews looked at the health system as a whole, despite many reviews calling for such an overarching review.

As the Commonwealth Government considers the findings of its latest review: Strengthening Medicare it is worth reflecting that its focus on the primary health care system does not encompass 67 per cent of the health system. This ongoing gap in a major review of the entire system and the barriers to reform could reasonably be filled through a Royal Commission into the health system, with the powers to examine the entire system.

Similar to the Aged Care and Disability Royal Commissions, a Royal Commission into the health system would facilitate an examination of all the drivers and structural issues that are undermining the performance of the health system.

Many of the reviews have highlighted structural and financial barriers that prevent the system responding to changing health care needs, as well as problems created by the overlap and gaps in the roles and responsibilities of levels of government and healthcare providers.

These barriers include:

- Workforce shortages caused by poor planning and limits on scope of practice
- Underinvestment in community health care, and lack of incentives for coordination of care across disciplines
- Blame and cost shifting between levels of government, and fragmented governance
- Poor incentives driven by fragmented funding arrangements between public and private health care

These system fault lines are a result of fundamental design features of the Australian health care system, that lead to fragmentation, over servicing and inefficient health care delivery. These issues are raised repeatedly, in review after review, and yet responses have tended to address the symptoms rather than the systematic failures of our health system.

**Recommendation One:**

Given the critical issues facing the health system in NSW, a Royal Commission is urgently needed to examine all the drivers and structural issues undermining the performance of the health system.

## WORKFORCE SHORTAGES

The health system relies on a diverse and large workforce to deliver the health care services the people of NSW rely on. This workforce is more than just doctors and nurses working in hospitals, with hundreds of occupations needed across the sector, including paramedics, pharmacists, allied health professionals, cleaners, administrators, security, diagnostic and other health care staff.

Poor pay and conditions, a lack of training of new workers and the failure to fully utilise the current workforce through limitations on scope of practice are all contributing to workforce shortages.

The projected shortage of health care workers, highlights the need to attract and retain key health workforce staff. Improving the pay and conditions of non-medical staff in the health system would help attract and retain the necessary workforce for the future.

**Recommendation Two:**

Undertake a national review of pay and conditions in the health care workforce to underpin future supply of workers.

**Recommendation Three:**

Re-establish the National Health Workforce Agency, a national body to co-ordinate health workforce planning across states and territories.

Since the Australian Health Workforce Agency was abolished in 2014 there has been a lack of national leadership to address the issues facing the health workforce. These issues are only going to become more acute, as an additional 25,000 workers are needed in the hospital sector alone in NSW by the end of the decade and reestablishment of a national body would help address current and future issues across state boundaries.

Decisions around scope of practice are currently heavily politicised and contested, which is potentially undermining the best practice application of evidence relating to scope of practice and models of care. Opposition to the expansion of pharmacist and midwifery scope of practice, against the evidence from international implementation, highlights these issues.

In the United Kingdom the National Institute for Clinical Excellence provides advice on best practice across health and social care at arm's length from government, including on scope of practice. But it also covers approval of drugs for reimbursement and implementation of models of care. Such a body in Australia could consolidate a number of separate processes, and provide strong national leadership on best evidence health care across health care settings.

**Recommendation Four:**

Establish a new independent body to provide guidance on best practice models of care, scope of practice, and funding of new drugs and medical procedures.

## UNDERINVESTMENT IN COMMUNITY HEALTH CARE, AND LACK OF INCENTIVES FOR COORDINATION OF CARE ACROSS DISCIPLINES

The rising prevalence of chronic conditions represents one of the most fundamental demand shifts in health care over the past 40 years, and will continue to drive expenditure and demand in the health system unless addressed.

It is widely accepted that Australia's health system must be reoriented to shift its focus from treating patients who are already unwell to preventing chronic diseases and risk factors before they occur. However Australia's heavy reliance on fee for service in primary health care, and a lack of investment in preventative health is undermining attempts for this realignment.

Highlighting the importance of this issue, Impact Economics and Policy modelling showing that the number of hospital admissions associated with just three chronic conditions will increase by 1.2 million in NSW over the next forty years, and account for close to fifty per cent of all presentations by 2060.

Australia underinvests in prevention compared to international comparators, spending just 2 per cent of the whole health budget on prevention. Additional funding for prevention, to match international efforts would help keep more Australians healthy and lower the direct health and broader economic costs of chronic disease.

**Recommendation Five:**

Governments should increase spending on prevention to 5 per cent of health budget.

**Recommendation Six:**

Government should develop new funding mechanisms for health care that shift away from fee for service towards outcome or capitation based payments.

As recommended in the Commonwealth Government's Strengthening Medicare Report there is also a need to shift away from fee-for-service funding models for primary care to supporting multi-disciplinary team-based care in the community, with a greater role for allied health professionals, pharmacists and nurses.

## FRAGMENTATION BETWEEN PUBLIC AND PRIVATE HEALTH SYSTEMS

Australia's health system relies on public and private funding and provision of health care services. While 65 per cent of health care services are directly funded by government, the majority of health care services are delivered by the private sector through both private hospitals and privately operating medical practitioners.

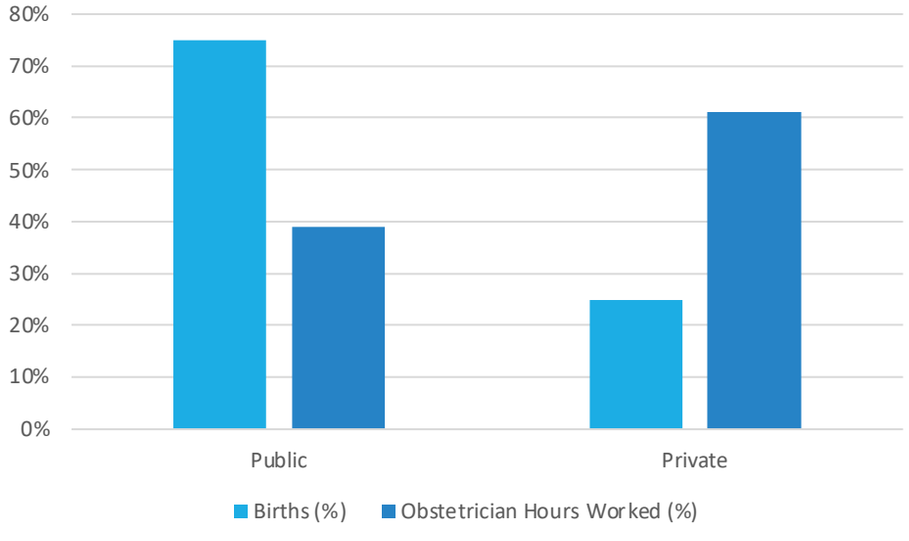
The dual systems of public and private funding and provision leads to fragmentation of care, significant waste of resources, undermines the equity objectives of Australia's universal system and incentivises overservicing.

The government subsidises private health insurance by around $7 billion every year. However, since incentives to take out private health insurance in Australia were introduced on the basis of reducing pressure on the public system, wait times for elective surgery in the public system have actually increased.

***Elective surgery wait times have a cost in terms of pain and suffering, poorer health outcomes and lost productivity. Impact Economics and Policy modelling for this report estimates that wait times in NSW led to productivity losses of almost $400 million in 2021-22.***

This is because resources, including medical practitioner time, have been diverted from the public to the private system where salaries are often much higher. For example, while 75 per cent of women give birth in the public system, only 39 per cent of obstetrician time is spent working in the public system.

**FIGURE 2: BIRTHS AND OBSTETRICIAN HOURS WORKED BY HOSPITAL SECTOR (%)**




Source: Impact Economics and Policy Calculations using AIHW (2022) and National Health Workforce Dataset – Hours Clinical Public by Hours Clinical Private (2022)

Private providers also have an incentive to cream skim or to select the lower cost patients, and divert higher cost patients to the public system. Evidence from Victoria has found patients with higher disease severity are more likely to be transferred to public hospitals, and lead to longer hospital stays than patients transferred to other private hospitals. This means private providers earn greater profits, while the public system is left to deal with higher cost and more resource intensive patients.

Long term there are real questions about the sustainability of private health insurance as the population ages. Already there is a large demographic shift where young, healthier Australians are dropping private health insurance. There are also significant administration costs associated with the private health insurance system to fund care in private hospitals, that costs the NSW health system up to $1.5 billion a year.

In addition to moving away from fee for service payment methods, consideration of replacing the private health insurance rebate with direct subsidies of private hospital care, through a new hospital benefit, could drive efficiency and greater equity across the system.

**Recommendation Seven:**

Government should consider removing subsidies for private health insurance, and instead directly support use of private health care through a new hospital benefit payment.

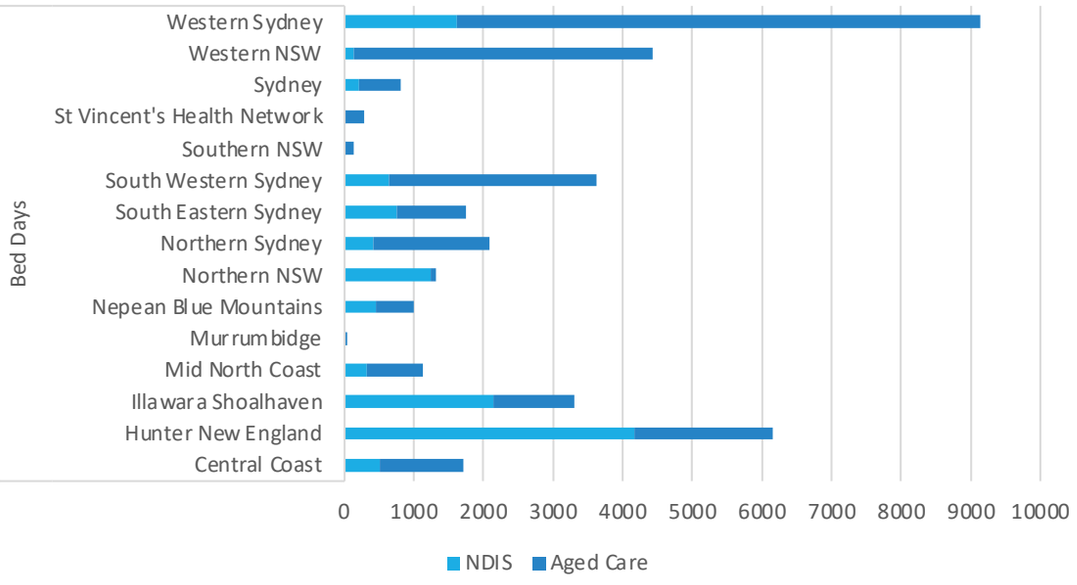
## FRAGMENTATION BETWEEN THE COMMONWEALTH AND STATES AND TERRITORIES

There is no single public funder of health care services in Australia with all levels of government responsible for providing health care. The involvement of three levels of government, without adequate governance alignment, leads to cost shifting between levels of government and does not support the development of fully integrated models of care.

One way that cost shifting manifests is through delays in discharge from state run public hospitals. Figures from the NSW Government show that each day in NSW there are almost 1,000 hospital beds occupied by people that would otherwise be in aged care facilities or receiving NDIS assistance. This is equivalent to one Royal Prince Alfred Hospital filled with these patients, and ***over fifty per cent of NDIS patients have delayed discharges with an average length of stay of 100 days***.

These long stayers that could be in aged care or receiving supports under the NDIS are costing the NSW health system over $500 million per year.

**FIGURE 3: EXCESS DAYS OF NDIS AND AGED CARE PATIENTS IN NSW PUBLIC HOSPITALS**




Integrated care requires that systems are people focused, rather than organisation focused. Having split responsibilities without adequate governance structures means patients can get lost across the care continuum and not receive integrated care.

Health care delivery could be further strengthened through greater devolution to local health bodies, jointly funded and overseen by all levels of government, allowing better service integration and helping overcome the current fragmentation of funding and service delivery.

**Recommendation Eight:**

Strengthen national governance frameworks, and look to further strengthen the role of local health networks in health care delivery to overcome the current fragmentation between levels of government.

# Conclusion

Australia has on many metrics one of the best health systems in the world, but it is failing to deal with the additional demands of the pandemic and it is not ready to face the ageing of Australia's population.

Reforms are needed that take a whole of system approach and should be informed by a Royal Commission. Notwithstanding the need for a wholesale review, a number of reforms drawing on the long history of reviews into various aspects of the health system could be undertaken immediately.

The time for delaying, blocking and not progressing much needed reforms to our health system are over. The costs are rising, and not just in terms of financial costs but in terms of poorer health outcomes for Australians that rely on the health system to keep them and their loved ones safe and healthy.

# 2. A HEALTH SYSTEM IN CRISIS

Borders were closed, schools were moved online, suburbs were in lockdown, elective surgery was suspended, visits to aged care facilities were stopped, travel and movement of people was restricted - all to reduce the impact of the COVID-19 pandemic on our health system and ensure its continued functioning. The people of NSW and Australia made real and lasting sacrifices to protect their health system from the worst of COVID-19.

Yet despite our sacrifices the health system is in crisis. Struggling under the weight of additional demand and years of failure to undertake the structural, governance and funding reforms needed to build a strong health system that is fit for purpose. [1]

While COVID-19 is a large driver of the current crisis, even before the pandemic the health system was operating under significant pressure and there were concerns that it would not be able to deal with the continued increases in demand for health services. Demand that is only forecast to grow.

Drivers of Health System Demand Growth:

- Population growth and ageing
- Increase in chronic disease
- Greater demand for health services as incomes grow
- Cost of new technology

An answer could simply be to spend more money on health care to meet this additional demand. However, the current crisis is not just about a lack of funding but how that funding is being spent. Australia's fragmented health system, where responsibilities and funding are split across state-federal and public-private lines means it does not deliver the best outcomes for the money spent.[2]

To understand the extent of the current crisis and its origins, in this first chapter we explore the extent to which our health system is not meeting the basic aims of every health care system.

1 New South Wales Parliament (2022). Legislative Council. Portfolio Committee No. 2 - Health. Report no. 60. Impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales, Parliament of New South Wales; Breadon, P., Romanes, D., Fox, L., Bolton, J., and Richardson, L. (2022). *A new Medicare: Strengthening general practice*. Grattan Institute.

2 Productivity Commission 2017, *Shifting the Dial: 5 Year Productivity Review*, Report No. 84, Canberra. Available from https://www.pc.gov.au/inquiries/completed/productivity-review/report.

## BUILDING BLOCKS OF A STRONG HEALTH SYSTEM CRUMBLING

Building a strong and resilient health system requires focusing on the 'five aims of health care'[3]:

- Patient care
- Healthy populations
- Efficient health care
- Sustainable workforce
- Equity in access

The latest performance data shows that across each of these five aims the health system in NSW is failing. However, the data also highlights that many of the issues were present prior to the pandemic. Blaming the pandemic alone for the current issues would miss the structural issues with Australia's health system that have rendered it fragmented, inefficient, inflexible, and organisation- rather than person-focused.[4]

## 2.1 PATIENT CARE

Health care should focus on providing safe, effective, patient centred and timely care to everyone. Patients should not be harmed by the care they receive, with measures such as complaints from patients and adverse events, including falls, providing important measures of health system performance.

As users of the health system, we want to receive care when and where we need it, but we also want that care to be high quality and centred on our needs. This is critical to ensuring that patient outcomes are not compromised by long delays and poor-quality care.

Australia has, by international standards, a high-quality health system and is ranked 3 by the Commonwealth Fund for overall health system performance out of 11 high income countries.[5] However, in terms of access to care Australia only ranks 8 out of 11 countries due to delays in treatment and the high out of pocket costs faced by patients.[6]

**3** Nundy S, Cooper LA, Mate KS. The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity. *JAMA.* 2022;327(6):521–522. doi:10.1001/jama.2021.25181

**4** Jackson, C.L. and O'Halloran, D. (2021), Reforming our health care system: time to rip off the band-aid?. Med J Aust, 215: 301-303.e1. https://doi.org/10.5694/mja2.51261

**5** The Commonwealth Fund (2021), Mirror Mirror: Reflecting Poorly, Health Care in the U.S. Compared to Other High-Income Countries, https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly

**6** Ibid.

## CASE STUDY MICK GRAYSON

**Role** - Paramedic for more than 33 years in regional New South Wales

Not much ruffles veteran paramedic Mick Grayson, who has clocked more than three decades on the job in regional New South Wales. He has pretty much seen it all. Lately, however, his concern about the fragile state of the health system has been growing, leaving him worried about the quality-of-care patients receive and the access they have to treatment.

***"It's not uncommon to be greeted with 'oh, we have no beds, we're going to ramp you' and you're like, would you like to know what's wrong with the patient first?"***

***"It's like, hang on, you've forgotten something here. There's a person on the end of this bed that needs triage. If you can't physically put them somewhere, that's fine but you may actually need to do something for that patient whilst they are sitting on our stretcher waiting for a bed to become available."***

Mick says that as issues with the health system increase, paramedics have been left at a crossroad, with the community, especially in regional areas, relying on them more and more for clinical care that traditionally would happen in other primary settings.

***"There's not as many doctors committed to the area, so we have a lot of doctors that come in for one or two years and they just leave. These sorts of things have a flow on effect to the wider health system because when you don't have a GP or someone like that, it's basically ring an ambulance."***

According to Mick that flow-on effect has highlighted the lack of support provided by the health system to paramedics.

***"Work defaults to the paramedics but there's no real integration into the health system so I think we are let down a lot because it's coming back to paramedics trying to make the best decisions they can without the backing of a health system to support them."***

Some health system issues presented particular challenges for paramedics supporting rural and regional communities.

***"In hospital transfers, where they send you out of town and there's a long drive there and back it basically means the town is not covered for five or six hours while you are gone."***

***"Those transfers are booked often without much thought behind the time of day that they want to send them and it's like 'well, we just want them out of our hospital' but who's going to jump in a car and race out to the kid that's not breathing at four in the morning or something like that because we can't be."***

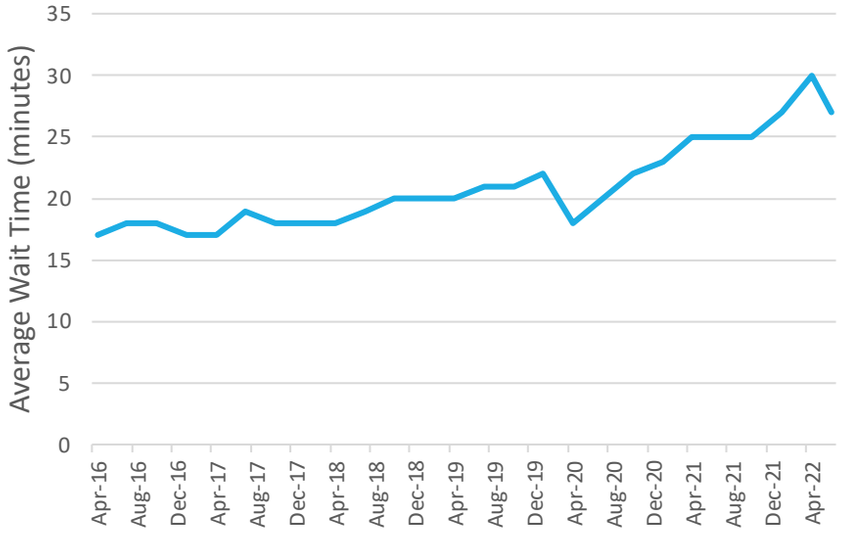
***"We hear those sorts of things. We will be driving, and we are far away, and we hear them send a car to our town from forty minutes away, and you just hope it's no one you know."***

### 2.1.1 Timely Care

There has been a large increase since the pandemic in wait times for ambulances in NSW, with average time taken for a priority 2 call increasing by 44 per cent.[7] But even before the pandemic there had been a long-time trend increase in wait times. Between 2017 and 2019 there was a 17.6 per cent increase in average wait times for priority 2 ambulance calls.[8]

While average wait times are important, they can often hide more worrying trends. One in ten people that call an ambulance in NSW with a priority 2 emergency waited over 2 hours for an ambulance to arrive between April and June 2022.[9]

**FIGURE 4: AVERAGE WAIT TIMES FOR AMBULANCES IN NSW - PRIORITY 2 – ALL CALLS**

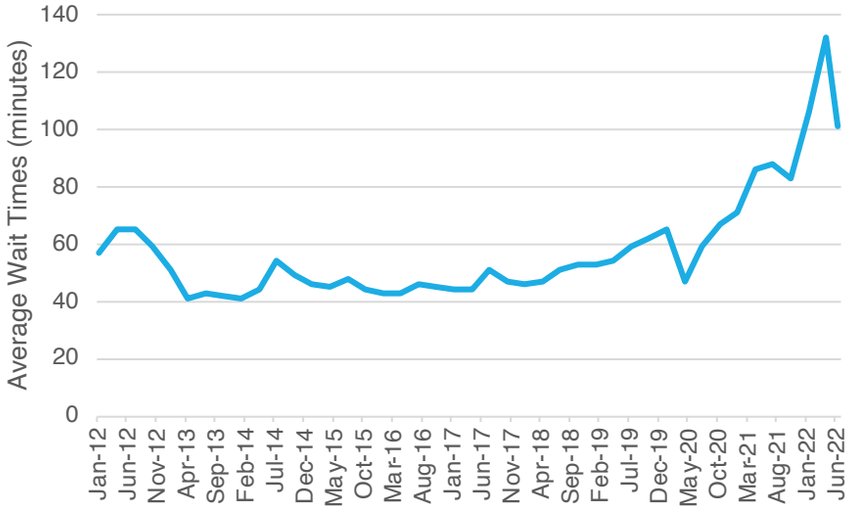



7 Impact Economics and Policy calculations using Bureau of Health Information NSW (2022) data.

8 Ibid.

9 Bureau of Health Information NSW (2022): https://www.bhi.nsw.gov.au/data-portal

**FIGURE 5: AVERAGE WAIT TIMES FOR AMBULANCES IN NSW – PRIORITY 2 – LONGEST TEN PERCENT OF CALLS**




Source: Bureau of Health Information NSW (2022)

The increase in wait times are systematic of a number of issues, including the need to invest more in paramedic services. However, these wait times are also indicative of a primary health care system that is not keeping people healthy and the need for reforms to better managed chronic conditions in the community.

### 2.1.2 Quality Care

Assessing overall health care quality with reliable indicators is problematic, however adverse events and complaints are one way to assess whether quality standards are improving or worsening over time.

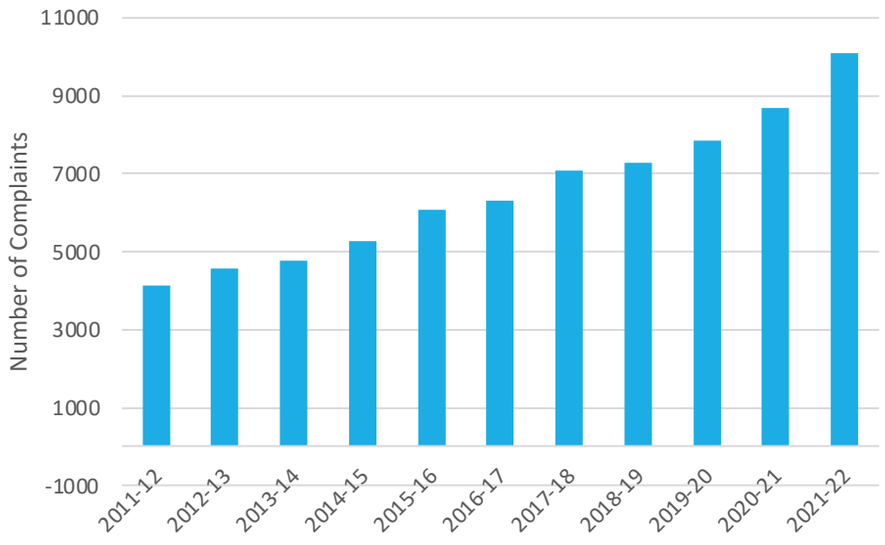
People in NSW are able to lodge complaints about health care they have received from organisations and individuals with the Health Care Complaint Commissioner.

Since the start of the pandemic complaints have risen by almost 40 per cent, or 2,800 each year. In the ten years since 2011-12 the total number of complaints in NSW more than doubled, increasing by 144 per cent. While this may reflect changes in expectations, it is also an indication of falling quality as the health system is placed under stress.

> ***Health has been completely decimated and underfunded and has turned into a race to the bottom not about patient care safety or quality of service provision. I can no longer practice ethically.***
>
> **Survey Respondent, Male, 45-54, Hospital Worker**

Australia's current funding methods for health care do not include any incentives for the provision of high-quality health care, such as outcome-based payments. Instead, the system relies on fee for service and case mix payments which both incentivise the provision of more services, rather than the provision of quality services that improve patient health.

**FIGURE 6: HEALTH CARE COMPLAINTS NSW**




Source: Health Care Complaints Commissioner (Various), Annual Reports

## 2.2 HEALTHY POPULATIONS

In addition to treating people when they are unwell, our health system needs to keep people healthy. Millions of years of healthy life are lost due to illness, injury or premature death , and Australians live an average of almost eleven years in poor health, equating to around 13 per cent of their lives.[10]

Preventing chronic illness and managing those with chronic conditions in the community can take significant pressure off the health system, however the current funding mechanisms do not incentivise or support providers to keep patients healthy. Instead our fee for service funding model encourages the greater provision of services.

Almost half of the NSW population have one or more chronic health conditions, including cancer, cardiovascular disease, arthritis, asthma, diabetes, chronic kidney disease, and mental health conditions.[11] Many of these are preventable, with risk factors such as smoking, obesity and lack of exercise a major contributor to the burden of chronic disease.

New South Wales has a strong public health network, that operated effectively during the COVID-19 pandemic. But relative to other states it underinvests in prevention and community health, contributing to significant additional costs in our health system due to preventable hospital admission.

### 2.2.1 Community Health Care

Australia spends little in comparison to other advanced nations on public health and prevention. Even accounting for the increase during the pandemic, Australia spent just 0.15 per cent of its GDP on public health during 2020, compared to the almost 1 per cent of GDP that

**10** Wang, Haidong et al.(2020) Global age-sex-specific fertility, mortality, healthy life expectancy (HALE), and population estimates in 204 countries and territories, 1950–2019: a comprehensive demographic analysis for the Global Burden of Disease Study 2019, The Lancet, Volume 396, Issue 10258, 1160 - 1203

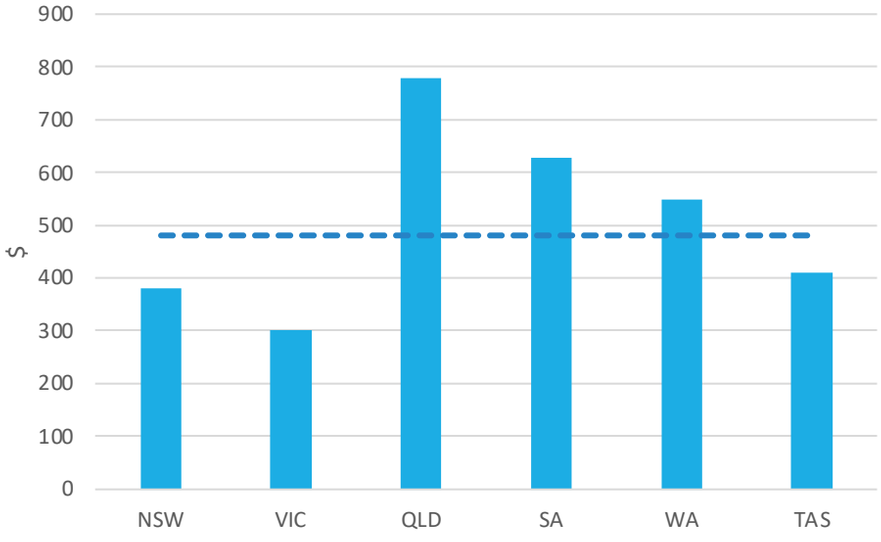
**11** AIHW (2022), Chronic Conditions and Multimorbity: https://www.aihw.gov.au/reports/australias-health/chronic-conditions-and-multimorbidity

Canada spent.[12] Overall Australia spends less that 2 per cent of its entire health budget on public health and prevention.[13]

Given one third of the disease burden in Australia is preventable, including from obesity and smoking, this lack of investment in prevention is undermining the health of Australians and contributing to a high number of preventable admissions.[14]

While NSW spends more per head of population on community and public health than Victoria or Tasmania, it spends well below Queensland, South Australia or Western Australia.

**FIGURE 7: PER CAPITA SPENDING ON COMMUNITY AND PUBLIC HEALTH BY STATE AND TERRITORY**




Source: AIHW (2022), Health Expenditure Australia 2019-20: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/data

NSW would need to increase its spending on community and public health by $872 million per annum to match the average across other states in Australia, or $100 per person. This expenditure would help improve the health of people in NSW, and reduce pressure on the ambulance and hospital systems.

## 2.3 EFFICIENT HEALTHCARE

The health care system needs to be sustainable, and cost effective otherwise it places undue pressure on individuals and government finances. The State Government of NSW currently spends 29 per cent of its budget on health care, with this forecast to increase to 38 per cent by 2061.[15]

Modelling for this report by Impact Economics and Policy show that in order to meet the additional demand expenditure on health as a percentage of Gross State Product will increase

12 AIHW (2022), Health Expenditure Australia 2019-20 and Canadian Institute for Health Information (2022), Public and Private Sector Health Expenditures by Use of Funds: https://www.cihi.ca/en/public-and-private-sector-health-expenditures-by-use-of-funds

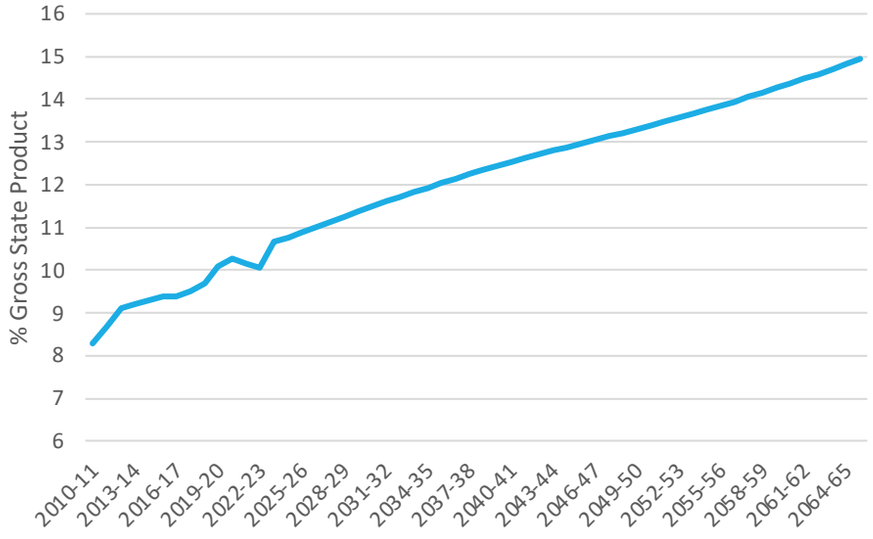
13 AIHW (2022), Health Expenditure Australia 2019-20

14 Crosland P, Ananthapavan J, Davison J, Lambert M, Carter R. The health burden of preventable disease in Australia: a systematic review. Aust N Z J Public Health. 2019 Apr;43(2):163-170. doi: 10.1111/1753-6405.12882. Epub 2019 Mar 4. PMID: 30830711.

15 NSW Government (2021), 2021-22 NSW Integenerational Report: Towards 2061 – Planning for the Future, https://www.treasury.nsw.gov.au/sites/default/files/2021-06/2021-22_nsw_intergenerational_report.pdf

from around 10 per cent of GDP in 2022 to 15 per cent of Gross State Product by 2065-66, with slightly higher growth in NSW due to demographic differences with the rest of Australia.

**FIGURE 8: SPENDING ON HEALTH CARE IN NSW (% OF GROSS STATE PRODUCT)**




Source: Impact Economics and Policy Modelling (see Appendix Two for Methodology)

## *By 2061 health care spending will take up 38 per cent of the NSW Budget*

This continues the trend in growth over the past decade, and highlights the need to address the systematic drivers of expenditure growth. While many of these cost increases are unavoidable, there are also significant inefficiencies and scope for reducing costs.

### 2.3.1 Evidence of Overservicing and Fraud

Recent reports have highlighted that there is significant scope for improvements in the delivery of health care in Australia that could save significant resources and deliver higher quality care. Australia's Medicare system operates on a fee for service basis, which effectively rewards practitioners for the number of services provided not the outcomes for patients. This creates incentives to overservice, and may be resulting in significant fraud in the Medicare system.

It has been estimated by a number of reports that over $2 billion a year is lost due to fraud and overservicing in the Medicare and Pharmaceutical Benefit system.[16]

**TABLE 1: ESTIMATES OF THE COST OF HEALTH PROVIDER NON-COMPLIANCE 2021-22**

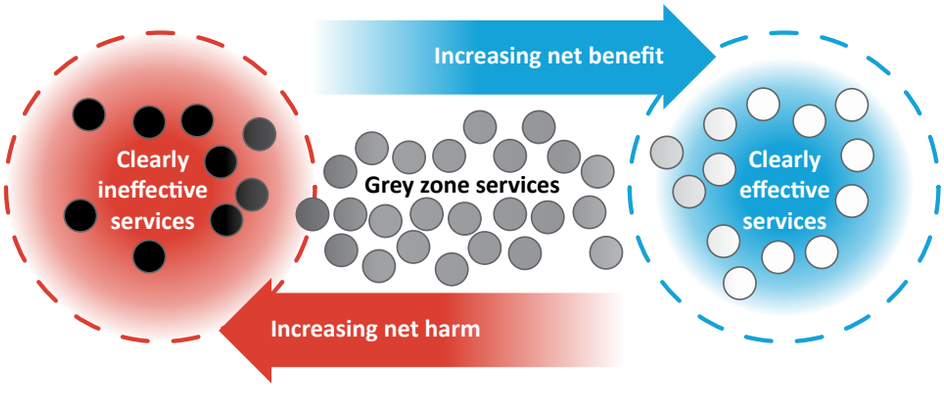
| Source | Detail | 2021-22 PBS/MBS non-compliance implication ($ million)* |
|---|---|---|
| Health Provider Compliance Division Strategy and Operating Model Summary (Boston Consulting Group, 2016) | Global examples suggest that a compliance division such as [PBID] should be able to recover 1–4 per cent of total healthcare spend. | **482 - 1982** |
| Analytics in Health Provider Compliance at Department of Health (McKinsey, 2016) | 6 per cent is considered a reasonable estimate of improper payment rate. | **2892** |
| PBID Audit Review (Boston Consulting Group, 2018) | Industry heuristics and research show total non-compliance likely to be between 3 and 5 per cent of total payments made. | **1446-2410** |
| Medicare compliance: what providers need to know (Health, 2019)b | It is estimated that two to five per cent of claiming may be non-compliant | **964-2410** |

Source: This table is reproduced from ANAO (2020), Managing Health Practitioner Compliance: https://www.anao.gov.au/sites/default/files/Auditor-General_Report_2020-21_17.pdf

*Cost estimates updated from original ANAO publication by Impact Economics and Policy using Department of Health (2022), Portfolio Budget Statement October 2022 figures.

While estimating rates of fraud are relatively straight forward, estimating rates of overservicing are more problematic. There are a few procedures, test or interventions that are always or never beneficial, and in the most part health care services are in the 'grey zone' where professional judgement is required. It is this grey zone, where incentives exist to provide a service regardless of appropriateness, where Australia's reliance on fee for service is likely to be leading to significant overservicing.

**FIGURE 9: GREY ZONE SERVICES**

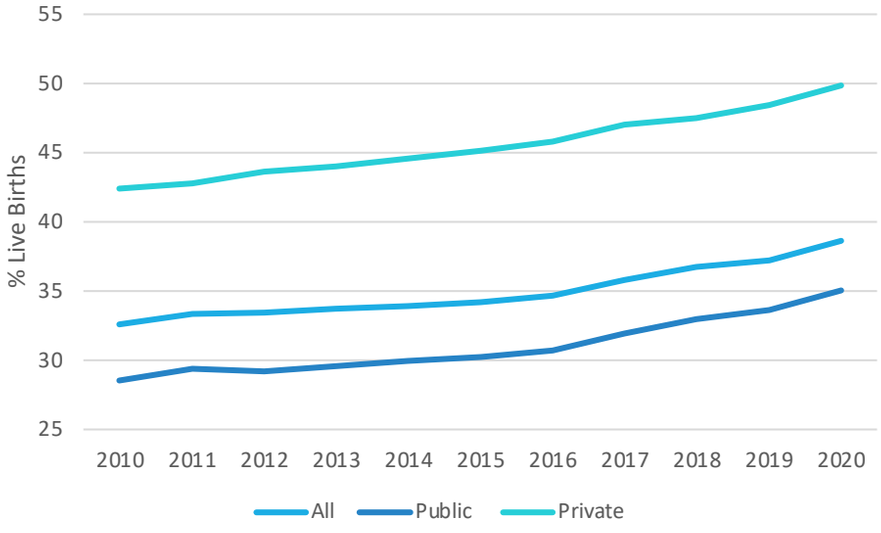



Source: Brownlee S, Chalkidou K, Doust J, Elshaug AG, Glasziou P, Heath I, Nagpal S, Saini V, Srivastava D, Chalmers K, Korenstein D. Evidence for overuse of medical services around the world. Lancet. 2017 Jul 8;390(10090):156-168. doi: 10.1016/S0140-6736(16)32585-5. Epub 2017 Jan 9. Erratum in: Lancet. 2022 Mar 5;399(10328):908. PMID: 28077234; PMCID: PMC5708862.

One example where population wide statistics point to significant overservicing is the rate of caesarean sections. Caesarean sections are on the one hand lifesaving interventions when needed, but on the other reduce maternal and child health outcomes when unnecessary. They fall within the grey zone of health care interventions.

Australia has one of the highest rates of caesarean sections in the OECD, with 38.6 per cent of live births being caesarean sections in 2020.[17] This has been steadily increasing over the past decade, and in 2020 almost 50 per cent of live births in private hospitals were caesarean section. This is well above the 10-15 per cent accepted by the World Health Organisation as being associated with reduced rates of maternal and neonatal mortality.[18]

**FIGURE 10: PROPORTION OF WOMEN WHO GAVE BIRTH VIA CAESAREAN SECTION BY HOSPITAL SECTOR**




Source: AIHW (2022), AIHW analysis of National Perinatal Data Collection

There have been concerns raised that Australia's high rates of caesarean section are, at least in part, due to the financial incentives for providers to preference caesarean sections over natural births. Australia's health system incentivises higher rates of caesarean section in two ways: [19]

- Higher payment rates for hospitals and clinicians; and
- Guarantee that obstetricians are present at the birth, which is associated with higher payment for their services.

A reduction in the rates of caesarean sections in Australia to 15 per cent could save the health system $378 million a year given the lower costs on average of vaginal births, but more importantly would lead to improved health outcomes for women and babies.[20]

**17** AIHW (2022), Australia's Mothers and Babies, https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/labour-and-birth/method-of-birth

**18** Betran, Ana Pilar, Maria Regina Torloni, Jun Zhang, Jiangfeng Ye, Rafael Mikolajczyk, Catherine Deneux-Tharaux, Olufemi Taiwo Oladapo, et al. 2015. "What Is the Optimal Rate of Caesarean Section at Population Level? A Systematic Review of Ecologic Studies." *Reproductive Health 12 (1).*

**19** Hoxha I, Syrogiannouli L, Luta X, Tal K, Goodman DC, da Costa BR, Jüni P. Caesarean sections and for-profit status of hospitals: systematic review and meta-analysis. BMJ Open. 2017 Feb 17;7(2):e013670. doi: 10.1136/bmjopen-2016-013670. PMID: 28213600; PMCID: PMC5318567.

**20** Costing based on national efficient price figures included in Scarf, V.L., Yu, S., Viney, R. *et al.* Modelling the cost of place of birth: a pathway analysis. *BMC Health Serv Res* **21**, 816 (2021). https://doi.org/10.1186/s12913-021-06810-9

### 2.3.2 Visiting Medical Officer Costs

Doctors salaries are one driver of health care costs, and can explain some of the variation in the overall costs of health care between countries.

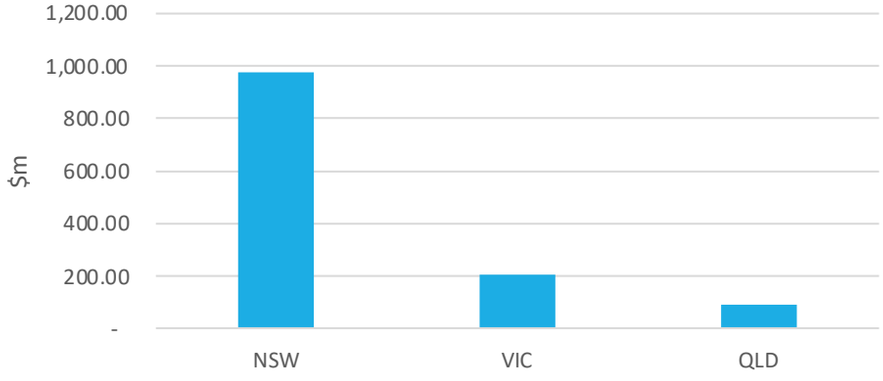
> ***The health system is imploding due to it being too top heavy and has lost touch with the workers that it relies on every day. They progress and the later stay stagnate or forced to increase their workloads to ensure that the safety/cleanliness/treatment/maintenance of all in all aspects in a hospital setting is maintained at the highest level. It's unfair to request so much from the workers and then deliver so little as a reward.***
>
> **Survey Respondent, Male, 45-54, Hospital Worker**

State governments employ doctors through full time, permanent roles and casual arrangements, including visiting medical officer and locum positions. These casual arrangements are often associated with higher locum fees, which can be up to $4,000 per day or $20,000 per week.[21]

Over the past decade in NSW there has been an increasing reliance on locums and visiting medical officers, with expenditure on visiting medical officers increasing 54 per cent since 2013.[22] In 2022 the cost of visiting medical officers to the NSW health system topped $1 billion.[23]

***In 2020-21 (the last year comparisons are available) NSW spent four times more than Victoria and ten times more than Queensland on visiting medical officers.***

**FIGURE 11: VISITING MEDICAL OFFICER COSTS - 2020-21**




Source: AIHW (2022), Recurrent expenditure ($'000) on public hospital services, states and territories, 2020–21

**21** ABC (2022), Locum doctor fee rises lead charity to withdraw financial support in five NSW towns: https://www.abc.net.au/news/2022-08-09/nsw-towns-at-risk-no-gp-services-locum-doctor-costs/101311848

**22** NSW Department of Health (2014, 2022), NSW Health Annual Reports 2013-14 and 2021-22, https://www.health.nsw.gov.au/annualreport/Pages/default.aspx

**23** NSW Department of Health (2022), NSW Health Annual Report 2021-22, https://www.health.nsw.gov.au/annualreport/Pages/default.aspx

While doctors benefit from higher incomes from working across the public and private health systems, the over reliance on part time and occasional medical workers is both costly and undermines continuity of health care, an important driver of health care quality for patients.[24]

## 2.4 SUSTAINABLE WORKFORCE

A diverse and large workforce is needed to deliver the health care services Australians rely on. The pandemic has placed this workforce under severe pressure, and burnout is threatening to undermine the sustainability of the workforce and health care delivery.

Embedding sustainability in our health workforce includes utilising the diverse skills to the maximum scope of practice and not limiting the ability of certain workers to undertake tasks for which they are qualified.

Skill shortages have emerged for workers including nurses, GPs and aged care workers.

Training enough workers for tomorrow while also supporting the workers of today to stay in the health care workforce is critical to addressing skill shortages, and stopping the key workers we have from leaving the industry.

> ***The stress and workload of the job doesn't reflect the pay. It's becoming apparent to me that I'm considering if it's all worth it. To think of doing this until retirement scares me. I don't think I'd physically, let alone mentally, last.***
>
> **Survey Respondent, Female, 25-34, Allied Health Worker**

**24** Dreiher, J., Comaneshter, D. S., Rosenbluth, Y., Battat, E., Bitterman, H., & Cohen, A. D. (2012). The association between continuity of care in the community and health outcomes: a population-based study. *Israel journal of health policy research*, *1*(1), 1-12.

## **CASE STUDY** - TESS OXLEY

**Role** - Qualified paramedic at Campbelltown ambulance station in Southwest Sydney

A lot may have changed since Tess Oxley began her career as a paramedic 13 years ago, but her commitment to providing care to the most vulnerable people in New South Wales has remained unwavering. Still, she admits, it has not been easy – especially working within a health system that seems constantly at breaking point.

Tess's key concern, shared with many of her colleagues, is that patient well-being is being compromised due to the current crises in the system that have resulted in an overextended workforce, and a lack of time to listen to people's stories.

***"If you can't sit there and listen to your patient and you miss one thing, and that one thing actually ends up being important, that patient goes from a potentially four-hour stay in a hospital to a three week stay in a hospital."***

Hospital delays have meant patients are often forced to endure long waiting times, despite presenting with symptoms of serious medical issues.

***"The hospital delays are massive. A month or two ago we were having hospital delays of eight, nine or ten hours for every patient. We've had patients with warning signs for heart attacks, still on our stretchers in the corridor waiting two, three or four hours to be seen by a doctor."***

Much of the support Tess provides is to residents of aged care facilities, who she says risk being robbed of their dignity due to staff and capacity issues at hospitals.

***"It's not just the medical care and assessment and treatment that suffer. It's the dignity that you lose when you are stuck on a stretcher or when you are stuck in a chair waiting for hours, you lose those basic things."***

Despite this pressure cooker environment, Tess maintains that being a paramedic, and the connection she forms with vulnerable people that she supports every day on the job is the ultimate privilege.

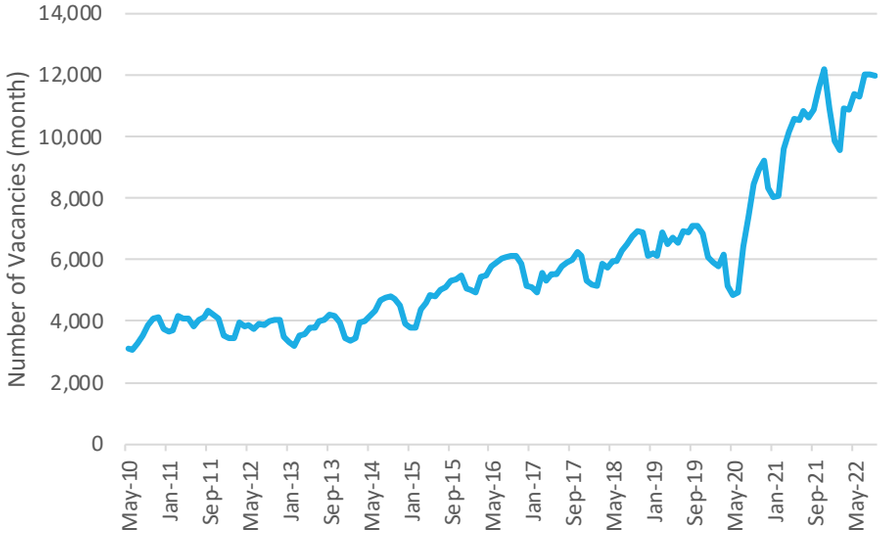
However, for Tess, the lack of advocacy for health workers, within the upper echelons of the health system has never been more apparent.

***"We need a commitment from our leaders - health needs to be a priority and health workers need to be a priority. You can put in as many fancy machines as you'd like, you can build hospitals that have great artworks on the entryway but if your health workers aren't valued, if they are not paid, if they don't feel listened to, they're not going to perform in the way that they need to, which is then going to increase a reliance on a health system."***

### 2.4.1 Skill Shortages

While vacancies across the health sector were rising before the pandemic, they have accelerated since March 2020. Between May 2010 and March 2020 the number of vacancies in the health sector doubled in NSW from around 3,000 to 6,000, but by October 2022 they have nearly doubled again to almost 12,000 vacancies.

**FIGURE 12: NUMBER OF VACANCIES IN HEALTH SECTOR NSW BY MONTH**




Source: National Skills Commission (2022)

A number of factors are driving this shortage, including poor conditions and pay which make working in the health sector an unattractive and unsustainable career option. NSW has seen a much larger increase in casual employment in the health sector since 2014 than either Victoria or Queensland. In addition, NSW has not been able to increase the number of health graduates by as much as either Victoria or Queensland over the same period.

## 2.5 EQUITY IN ACCESS

The COVID-19 pandemic highlighted large disparities in health outcomes across different socio-economic groups in Australia, but many of these disparities were evident before the pandemic. Aboriginal and Torres Strait Islander Australians experience significantly worse health outcomes that non-Indigenous Australians, with the gap in life expectancy for males still close to a decade.[25]

People from lower socio-economic backgrounds have significantly worse health outcomes than people from higher socio-economic backgrounds in Australia. Studies have consistently shown that there is no trade-off between equity and efficiency in health care with more equitable distribution of health care resources also delivering more efficient health care, in terms of increasing the health gains from every dollar spent on services.

In Australia equity in health outcomes is further undermined by high out of pocket costs and long wait times for elective surgery.

**25** Productivity Commission (2022), Closing the Gap Information Repository: https://www.pc.gov.au/closing-the-gap-data/dashboard/socioeconomic/outcome-area1

### 2.5.1 Unequal Disease Burden

Australia's and NSW's chronic disease burden is spread unequally, depending on factors such as where people live, their income, education, conditions of employment, housing and social support. These social determinants of health lead to differences in people's risk factors for chronic diseases.

Australians who are socioeconomically disadvantaged are more likely to have chronic disease risk factors, higher rates of illness, disability and death, and shorter lives, than people from higher socioeconomic groups.[26]

For example, based on the Australian Bureau of Statistics 2017–18 National Health Survey, it is estimated that people in the lowest socioeconomic areas of Australia were:

- 3.3 times as likely than people in higher socioeconomic areas to smoke daily
- 1.6 times as likely to be obese
- 1.3 times as likely to do insufficient physical activity
- 1.2 times as likely to have uncontrolled high blood pressure.[27]

**26** Fran Baum, A. O. (2018). People's health and the social determinants of health. *Health Promotion Journal of Australia*, *29*(1), 8-9.

**27** Australian Institute of Health and Welfare (AIHW) 2022, Health across socioeconomic groups web article, AIHW website. Available from https://www.aihw.gov.au/reports/australias-health/health-across-socioeconomic-groups

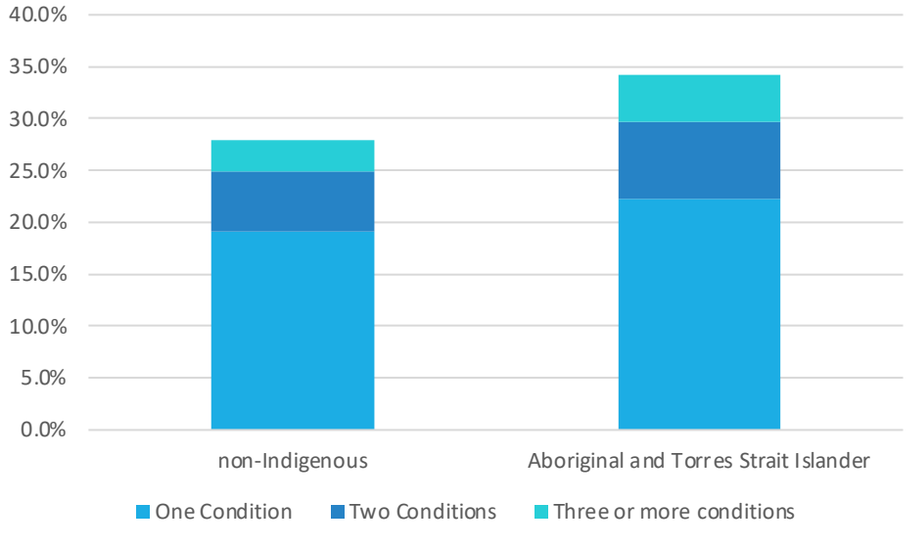
## ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

There has been significant progress towards closing the health gap between Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians. However, Indigenous Australians still have a substantially lower life expectancy. In 2015–2017, the life expectancy gap for Indigenous men was 8.8 years and for Indigenous women it was 7.8 years.

In NSW, the gap in life expectancy for Indigenous men was significantly worse than the national figures, with Indigenous men expected to live 9.6 years, almost a decade, less than non-Indigenous men. Social and economic factors are estimated to account for at least 34 per cent of the health gap between Indigenous and non-Indigenous Australians, while health risk factors, such as smoking, obesity, alcohol use and diet, are responsible for around 19 per cent of the gap.[28]

Latest figures from the 2021 Census illustrate the additional burden of disease, with rates of chronic disease 20 per cent higher amongst Aboriginal and Torres Strait Islander people in NSW compared to non-Indigenous people.[29]

**FIGURE 13: 2021 CENSUS - RATES OF CHRONIC HEALTH CONDITIONS IN NSW**




Source: ABS 2022, 2021 Census Table Builder

Aboriginal Community Controlled Health Services have been highly effective as primary health care providers in addressing social determinants of health, barriers to access, and health inequity, resulting in improved health outcomes for Aboriginal and Torres Strait Islander people. With a focus on early intervention and comprehensive care, they are staffed by primary and allied healthcare teams, which may include GPs, nurses and nurse practitioners, a range of allied health professionals, pharmacists, dentists, practice managers and administrative staff.[30]

**28** Australian Government 2020, *Closing the Gap Report 2020, Canberra: Australian Government. Available from* https://ctgreport.niaa.gov.au/sites/default/files/pdf/closing-the-gap-report-2020.pdf.

**29** ABS (2022), 2021 Census Table Builder

**30** Panaretto KS, Wenitong M, Button S, Ring IT (2014) Aboriginal Community Controlled Health Services leading the way in primary care, *Medical Journal of Australia*, 200 (11): 649-652. doi: 10.5694/mja13.00005; Pearson O, Schwartzkopff K, Dawson A, Karagi A, Davy C, Brown A, Braunack-Mayer A (2020) Aboriginal community controlled health organisations address health equity through action on the social determinants of health of Aboriginal and Torres Strait Islander peoples in Australia. *BMC Public Health* 20, 1859 . https://doi.org/10.1186/s12889-020-09943-4

Strengthening the Aboriginal Controlled Health Sector is a central component of the Closing the Gap agreement, and greater support for and funding of the sector is needed to address the significant health disparities faced by Aboriginal and Torres Strait Islander Australians.

There should be a model for funding and delivery of primary care services in Australia.

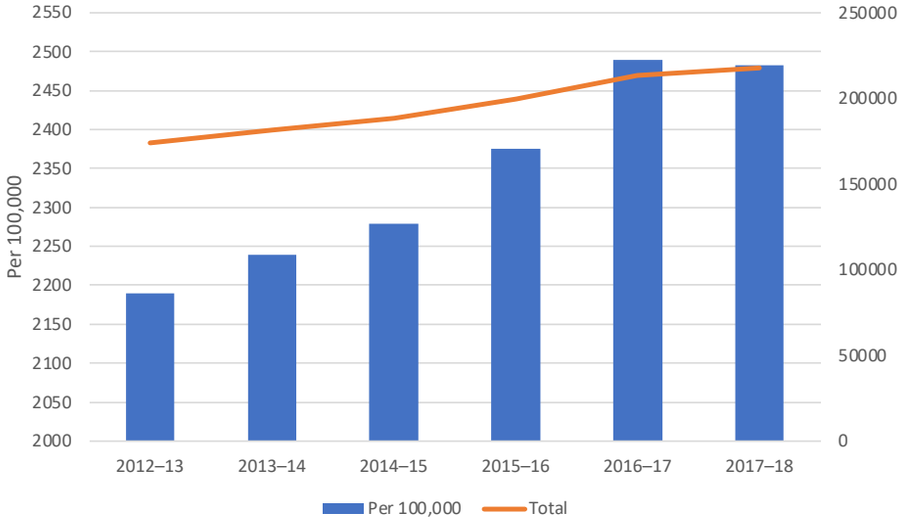
### Wait Times for Elective Surgery

Patients in the public hospital system often have to wait months or even years for necessary surgery in the public hospital system in Australia, whereas they can access treatment almost immediately in the private system.[31]

***The average wait time for elective surgery in NSW was already increasing prior to the pandemic, from 79 days in 2011-12 to 85 days in 2018-19, but has now increased to 108 days in 2020-21.***

This has led to a massive increase in the number of people that are waiting longer than recommended for surgery, up 3,153 people since 2011-12 to 17,893 people in 2022-23.

**FIGURE 14: NUMBER OF PATIENTS WAITING LONGER THAN RECOMMENDED TIME (NSW)**

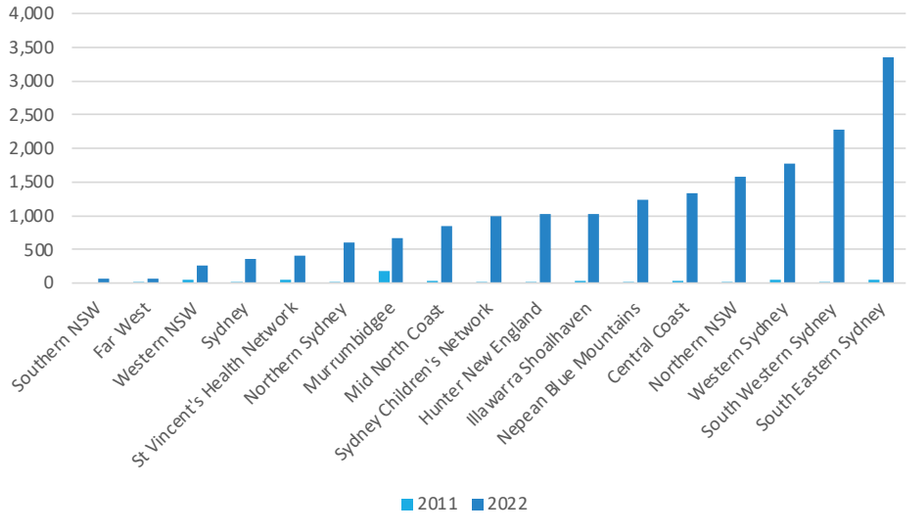



Source: BHI (2022), Patients on Waiting List Ready for Surgery at End of Quarter, https://www.bhi.nsw.gov.au/data-portal

Some areas in NSW have seen larger increases, with South Eastern Sydney (3356), South Western Sydney (2285), Western Sydney (1778) and Northern NSW (1580) having the most patients waiting longer than recommended.

**31** HBF (2017) Wait Times in Public and Private Hospitals: https://www.hbf.com.au/-/media/files/reports/hbf-wait-times-report-2018.pdf

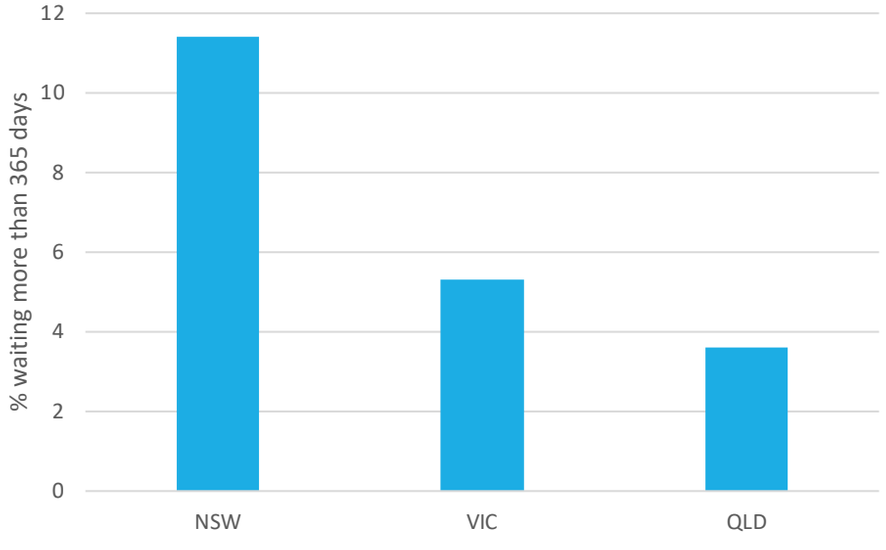
**FIGURE 15: INCREASE IN NUMBER OF PATIENTS WAITING LONGER THAN RECOMMENDED 2011-2022 (LOCAL HEALTH DISTRICT)**




Source: BHI(2022), Special Data Request.

Comparing the performance in NSW to that in Victoria and QLD the percentage of patients waiting more that 1 year for elective surgery is significantly higher. In NSW more than twice as many patients wait more than 1 year than in Victoria and more than three times as many patients wait more than 1 year than in Queensland.

**FIGURE 16: PERCENTAGE WAITED MORE THAN 365 DAYS**

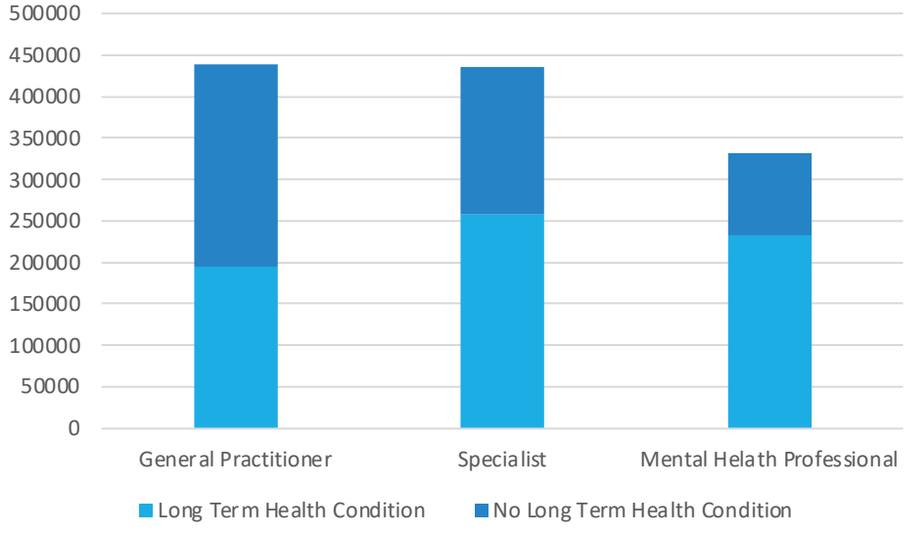



Source: AIHW (2022), Elective surgery waiting times 2020–21: https://www.aihw.gov.au/reports-data/my-hospitals/sectors/elective-surgery

### 2.5.2 High Out of Pocket Costs

While Australia's health system is often considered universal, it relies heavily on patient out of pocket costs to fund health care, with these costs representing 18 per cent of total health care spending. These costs can act as barriers to accessing health care, with hundreds of thousands of Australians delaying or not seeking care each year due to costs. This particularly impacts Australians with long term health conditions, who are more likely to delay or not receive care due to cost.

**FIGURE 17: AUSTRALIANS AGED OVER 15 DELAYING OR NOT RECEIVING CARE DUE TO COST – 2021-22**




Source: Impact Economics and Policy Analysis using Australian Bureau of Statistics (2022), Patient Experience Australia: https://www.abs.gov.au/statistics/health/health-services/patient-experiences/2021-22#data-downloads

## 2.6 A HEALTH SYSTEM IN NEED OF REFORM

Australia and by extension NSW's health system is by many metrics one of the best in the world, with costs that are comparable to other developed countries.[32] But with its last major overhaul in the 1980s when Medicare was introduced, the health system has not kept up with changing needs of patients, the increase in chronic disease, and inequalities in access to healthcare and health outcomes.

Australia's health workforce policies, funding models, and management of the system make it difficult for primary care services to deliver the care needed to prevent and manage chronic diseases.[33] The health workforce, including hospital staff and GPs, are stressed and overwhelmed by the complex needs and demands of today's patients.

The current crisis follows the warnings of countless reviews and inquiries into the health system over the past four decades (see Appendix One) – which have continually failed to deliver fundamental reform. Each of these reviews have in different ways sounded the alarm about the main drivers of increased demand, and the fault lines in our health system that limit our ability to meet that demand cost-effectively.

Over the past forty years there have been ongoing reform efforts to drive cost effectiveness and high quality in health care delivery, from the introduction of case mix funding for hospitals to various initiatives to encourage a greater focus on chronic disease management. But all these reform efforts have fallen short of structural reforms to fundamentally shift the incentives in the system that underpin fragmented care and often lead to overservicing and low quality care.

For too long report after report calling for reform and fundamental realignment of our health systems incentives have been ignored. One reason for this failure to act is that there has not been one review to cover all the issues across the health system as often recommended in the numerous reviews undertaken over the past forty years.[34] This ongoing gap in a major review of the entire system and the barriers to reform could only reasonably be filled through a Royal Commission into the health system, with the powers to look at the entire system.

Similar to the Aged Care and Disability Royal Commissions, a Royal Commission into the health system would facilitate an examination of all the drivers and structural issues that are undermining the performance of the health system to be explored and addressed.

**Recommendation One**:

Given the critical issues facing the health system in NSW, a Royal Commission is urgently needed to examine all the drivers and structural issues undermining the performance of the health system.

**32** The Commonwealth Fund (2021), Mirror Mirror: Reflecting Poorly, Health Care in the U.S. Compared to Other High-Income Countries, https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly

**33** Breadon, P., Romanes, D., Fox, L., Bolton, J., and Richardson, L. (2022). *A new Medicare: Strengthening general practice*. Grattan Institute: https://grattan.edu.au/wp-content/uploads/2022/12/A-new-Medicare-strengthening-general-practice-Grattan-Report.pdf

**34** Calder, R; Dunkin R; Rochford C; Nichols T, 2019. Australian health services: too complex to navigate. A review of the national reviews of Australia's health service arrangements. Australian Health Policy Collaboration, Policy Issues Paper No. 1 2019, AHPC. Available from https://www.vu.edu.au/sites/default/files/australian-health-services-too-complex-to-navigate.pdf

## CASE STUDY

### Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales

I had the misfortune of falling ill late one night. I presented to the local hospital. We have no doctor at the hospital, there was no local Doctor on call, so I was told I would have to go to Wagga Wagga, but there were no ambulances available either (the ambulance drivers had been on duty for 14 hours already). So, in considerable pain, my husband drove me the 100 kilometres to Wagga Wagga hospital.

When I got there, I presented to emergency, I waited in the waiting room for over 2 hours, then went into the other triage room where I was for the next 10 hours. I find this unacceptable in this day and age. ***Just because we are not in the city doesn't mean we should be treated like we live in a third world country***. Doctors in rural and remote hospitals could change this. It would free up ambulances and emergency departments and most importantly save lives.

### 2.6.1 A Consistent Set of Issues

Many of the reviews into the health system over the past forty years have highlighted structural and financial barriers that prevent the system responding to changing health care needs, as well as problems created by the overlap and gaps in the roles and responsibilities of levels of government and healthcare providers.[35]

These barriers and problems include the following:

- Workforce shortages caused by poor planning and limits on scope of practice
- Underinvestment in community health care, and lack of incentives for coordination of care across disciplines
- Blame and cost shifting between levels of government, and fragmented governance
- Poor incentives driven by fragmentated funding arrangements between public and private health care

These system fault lines are a result of fundamental design features of the Australian health care system, that lead to fragmentation, over servicing and inefficient health care delivery. These issues are raised repeatedly, in review after review, and yet there has been no action to date to address these issues.

In the next sections of this report we explore each of these fault lines, how they impact the ability to meet the five fundamental aims of health care and what reforms are needed.

**35** Calder, R; Dunkin R; Rochford C; Nichols T, 2019. Australian health services: too complex to navigate. A review of the national reviews of Australia's health service arrangements. Australian Health Policy Collaboration, Policy Issues Paper No. 1 2019, AHPC. Available from **https://www.vu.edu.au/sites/default/files/australian-health-services-too-complex-to-navigate.pdf**

## EXPLAINER

## WHAT IS SCOPE OF PRACTICE

Scope of Practice relates to activities that a health practitioner is authorised to undertake in keeping with their professional licence and/or employment. It covers the procedures, actions, and processes they can perform.

The current and projected shortage of health care workers presents serious challenges for the delivery of quality health care. A number of reports have highlighted systematic issues with the training system, and limits placed on scope of practice as areas of major concern.[36] These issues are undermining each of the five aims of the health care system – patient care; healthy populations; efficient health care; sustainable workforce and equity in access.

**Patient Care** – Limits on scope of practice lead to care not being provided in the best setting by the best team of health care workers, undermining quality

**Healthy Populations** - Inadequate workforce focused on prevention and keeping those with chronic disease healthy undermines health populations

**Efficient health care** – Limits to scope of practice can result in higher costs as models of care are not consistent with cost effectiveness, and delays in treatment can lead to high long term cost

**Sustainable Workforce** – Inadequate training can drive shortages due to lack of planning and limits of scope of practice can lead to underutilisation of certain health care professionals, placing greater pressure on remaining workforce

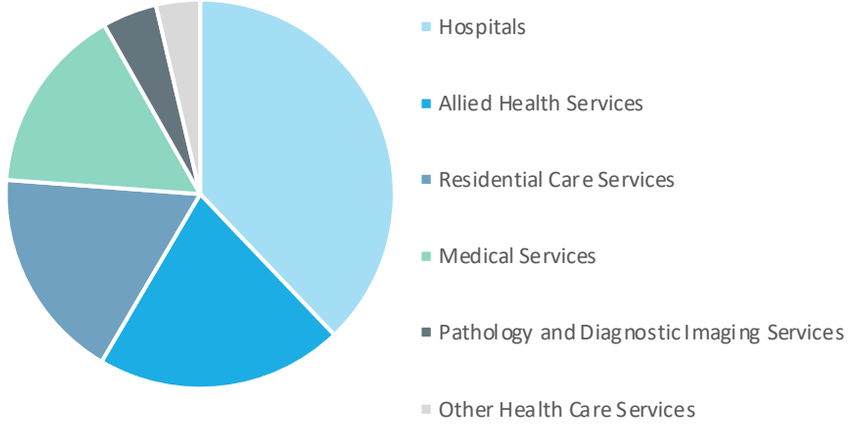
**Equity in Access** - Can limit access to health care services based on ability to pay or location

**36** Productivity Commission 2017, *Shifting the Dial: 5 Year Productivity Review*, Report No. 84, Canberra. Available from https://www.pc.gov.au/inquiries/completed/productivity-review/report.

# 3. WORKFORCE SHORTAGES

A diverse and large workforce is needed to deliver the health care services the people of NSW rely on. This workforce is more than just doctors and nurses working in hospitals, with hundreds of occupations needed across the sector, including paramedics, pharmacists, allied health professionals, cleaners, administrators and health care workers.

**FIGURE 18: AUSTRALIA'S HEALTHCARE WORKFORCE AND LOCATION OF EMPLOYMENT**




Source: ABS, Labour Force Survey, Detailed, November 2022, seasonally adjusted.

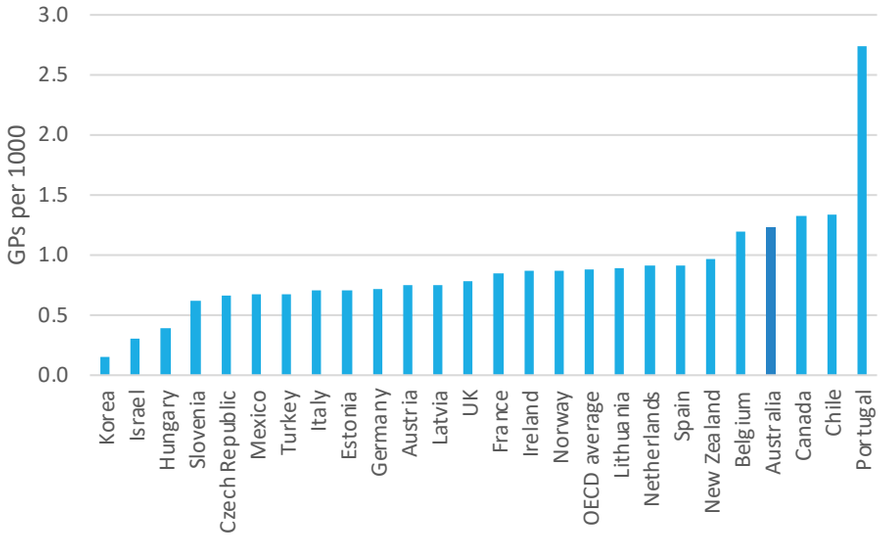
## 3.1 IMPACT OF WORKFORCE SHORTAGES - LACK OF ACCESS IN AREAS WHERE HEALTHCARE WORKERS NEEDED THE MOST

Each community requires the appropriate mix of medical specialties.[37] Currently the optimal distribution and service mix is not consistently achieved across Australia, resulting in service gaps and inefficiencies, which impact the quality of patient care.[38] While in some areas people are waiting weeks to see a GP, in other areas they get same day appointments. This is not due to an overall shortage of GPs, with Australia having amongst the highest level of GPs per 1,000 people in the OECD.

**37** Australian Government Department of Health (2021), National Medical Workforce Strategy 2021-31, https://www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf

**38** Ibid

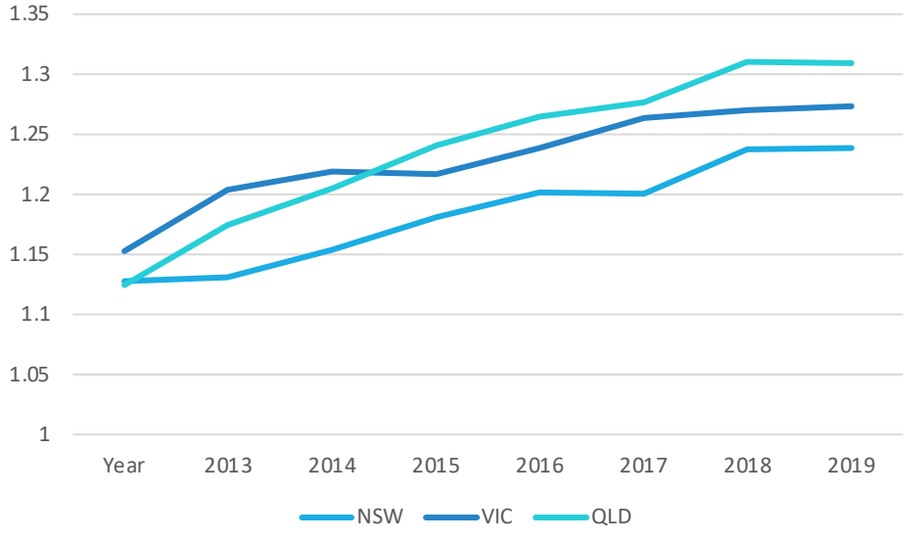
**FIGURE 19: GPs PER 1000 PEOPLE**




Source: Grattan Institute (2022) A New Medicare - Stregthening General Practice

The impacts of the poor distribution of health care workers is evident across the country, but data suggests that in NSW the issues are being felt more acutely. For example, on average people in NSW have less access to GPs than in Queensland or Victoria. Over 3 million people in NSW live in areas with less than 1 GP for every 1,000 people.[39]

**FIGURE 20: GPs PER 1,000 OF POPULATION IN NSW, VICTORIA AND QUEENSLAND**



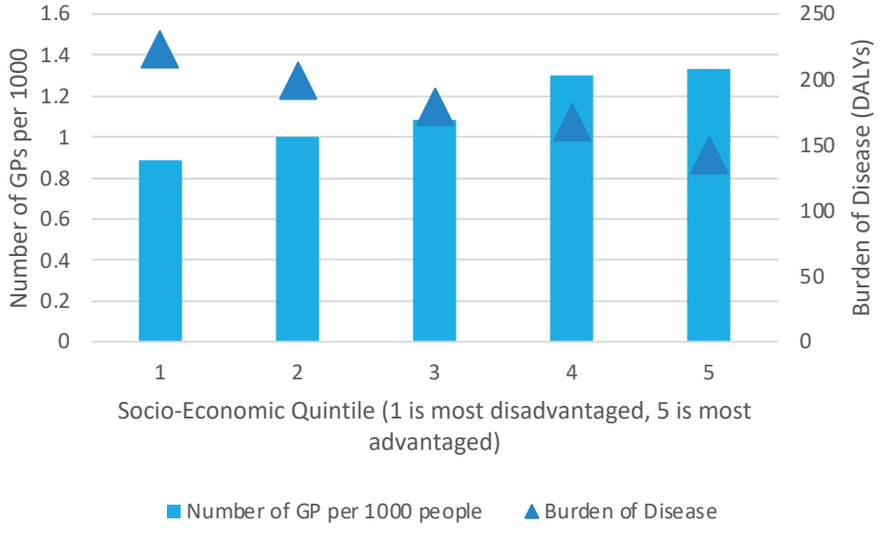

Source: National Health Workforce Dataset (2021)

**39** Impact Economics and Policy Calculations based on National Health Workforce Dataset adjusted for average FTE figures from PC (2022).

Doctors are free to work where they wish under Australia's Medicare system, and they choose to work predominately in higher socio-economic areas where they are more able to charge higher fees and therefore earn more income. This leaves lower socio-economic areas with higher health care needs in shortage of doctors, and represents a large misallocation of health care resources.

Within NSW there is large variation across areas, with people living in low socio-economic areas having less access to GPs than people living in higher socio-economic areas. For example, Woollahra has two times the number of GPs per 1,000 people than Liverpool.[40]

**FIGURE 21: GPs LOCATED IN AREAS WITH LOWER NEEDS, HIGHER INCOMES**




Source: Impact Economics and Policy analysis using Australian Health Workforce Data and AIHW (2022) Health Across Socio-Economic Groups

40 Impact Economics and Policy analysis using Health Workforce Australia data

## CASE STUDY

### Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales

The wait time to see a doctor in rural areas has gotten out of control. I travel 50 kms to see a doctor, but it takes up to 4-5 weeks to get in. I found a breast lump and had to wait 4 weeks to see a GP. I rang the hospital and they said I'd need to see my GP. The mental anguish over waiting so long was hell. I rang Breast Screen Dubbo 130klms away and had to wait 4 weeks to get in even after telling them about the lump.

I also rang Coonabarabran hospital at 11pm at night due to my grandson having a rash all over his body. I ask to make sure a doctor was there; I was told yes and to come straight in. When we got there the doctor didn't even see us, the nurse took the baby's observations and rang the doctor. He told her to give him some medication and come back in the morning. The nurse drew up the medication and asked me to check it was the correct dose of 1ml.

I didn't know the medication or what the doctor had said so I didn't know if what she was saying was correct. When giving a paediatric dose from over the phone 2 nurses are supposed to confirm the order and two nurses are supposed to check the dose before it is given. The nurse in question then gave me the medication to administer to the child as she had no idea how to deal with a baby.

This could have had serious repercussions, but this is an everyday occurrence out here and things need to change.

## 3.2 FUTURE DEMAND FOR HEALTH CARE WORKERS UNLIKELY TO BE MET

There are currently 12,000 vacancies across the health and social care sectors in NSW. This represents a four fold increase over the past decade.

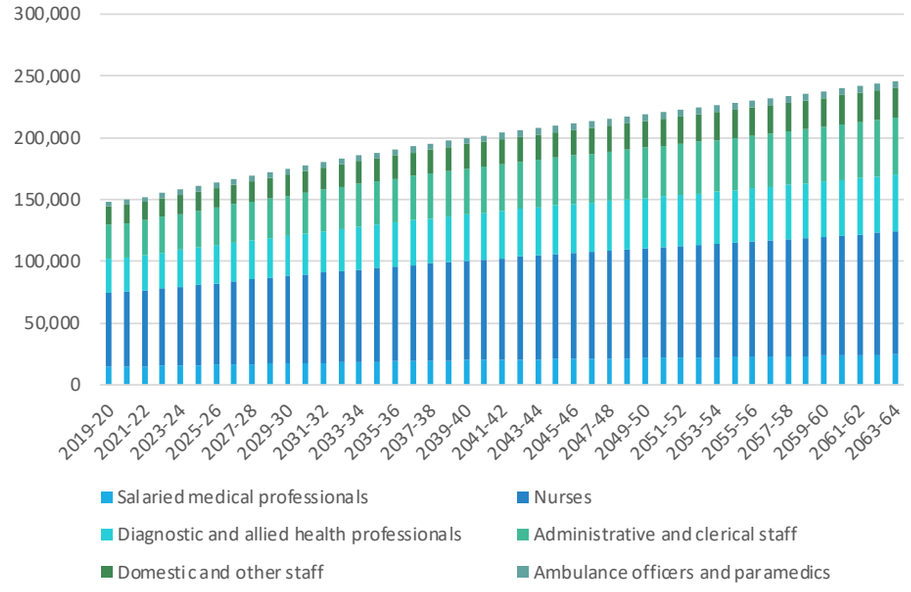
In the long term, an ageing population is only going to increase the demand for workers in the health sector, and policy reform is needed to both train more health workers and retain them in the sector to meet these demands. In addition, it will become increasingly critical that the workforce we have is used in the most efficient way possible and restrictions on the scope of practice are not undermining the delivery of cost-effective health care.

Impact Economics and Policy modelling indicates that to keep up with demand for hospital services, NSW will require tens of thousands of additional health care workers.

In 2030 an additional 2,200 medical practitioners, 9,000 nurses, 4,000 diagnostic and allied health professionals, 500 paramedics and 6,400 support staff will be needed.

By 2065-66 these demands for workers will grow further with an additional 10,200 medical practitioners, 41,800 nurses, 19,400 diagnostic and allied health professionals, 1,720 paramedics and almost 30,000 support staff will be needed.

**FIGURE 22: FUTURE NSW HOSPITAL WORKFORCE DEMAND PROJECTIONS**




Source: Impact Economics and Policy Modelling (see Appendix Two for methodology)

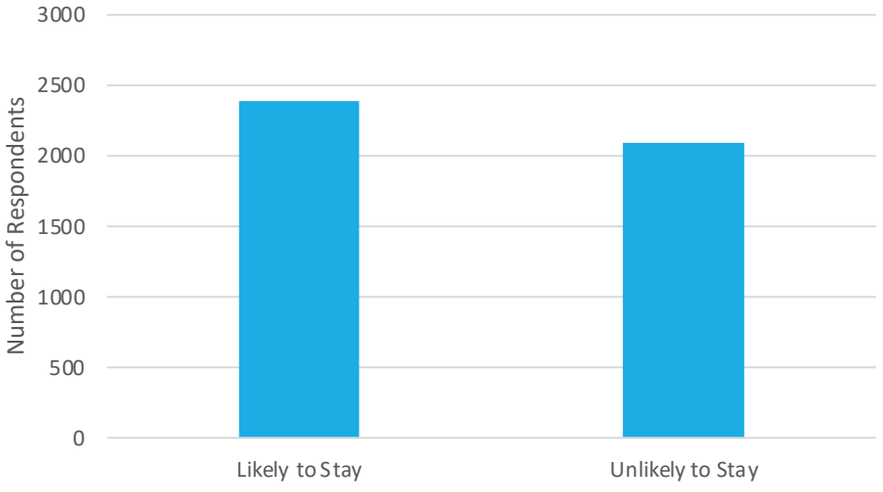
## 3.3 WHAT IS DRIVING SHORTAGES?

A number of factors are driving workforce shortages, including poor conditions and pay which make working in the health sector an unattractive and unsustainable career option. NSW has also seen a much larger increase in casual employment in the health sector since 2014 than either Victoria or Queensland.

### 3.3.1 Pay and Conditions

Impact Economics and Policy undertook a survey of almost 4,500 members of the Health Services Union NSW QLD and ACT, and found that ***46 per cent were either unsure or definitely intended to leave their occupation within five years***. The number of workers looking to leave was relatively consistent across the professions covered and the place of work, indicating that the issue is widespread across the hospital and aged care sector.

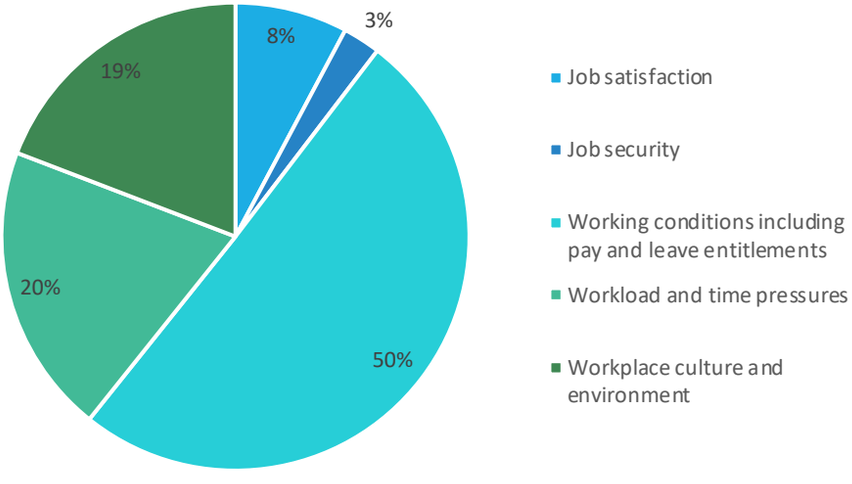
**FIGURE 23: STAY IN HEALTH SECTOR OCCUPATION FOR NEXT FIVE YEARS**




Source: Impact Economics and Policy Survey of Health Service Union members (see Appendix Three for full results).

The main reason for those that are definitely going to leave their health care occupation in the next five years was working conditions, including pay, with 50 per cent of those likely to leave in the next five years saying this was the main factor.

**FIGURE 24: MAIN REASON FOR LEAVING HEALTH SECTOR OCCUPATION**




Source: Impact Economics and Policy Survey of Health Service Union members (see Appendix Three for full results).

Addressing the pay and conditions of the health care workforce will be a priority if we are to address current and future shortages.

### 3.3.2 Training

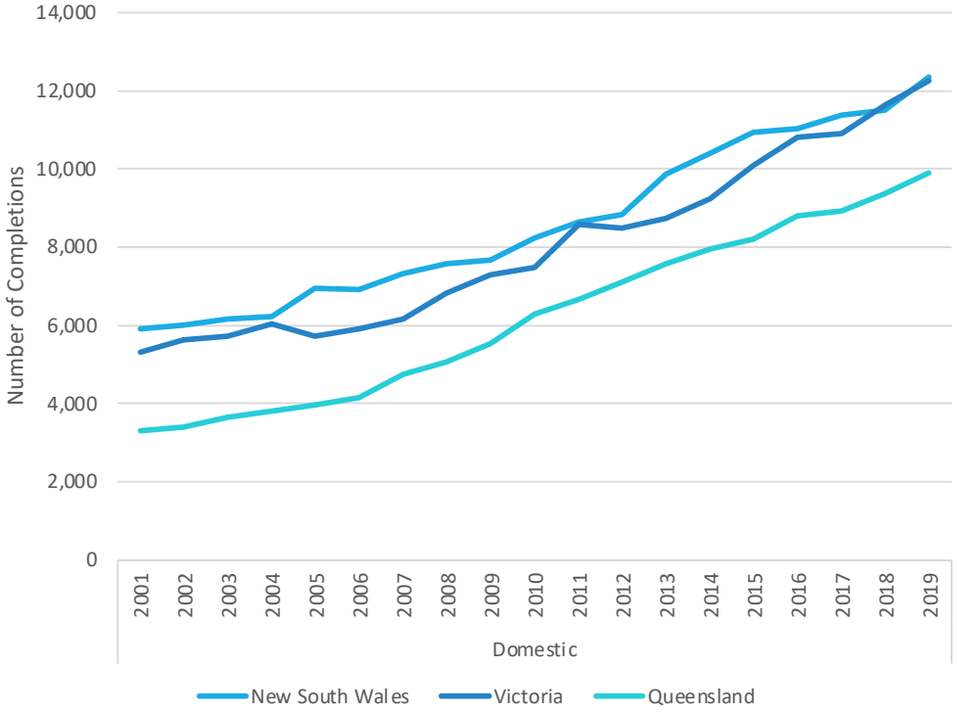
Ensuring that enough workers are being trained for tomorrow while also supporting the workers of today to stay in the health care workforce is critical to addressing skill shortages, and stopping the key workers we have from leaving the industry due to burn out.

> ***The stress and workload of the job doesn't reflect the pay. It's becoming apparent to me that I'm considering if it's all worth it. To think of doing this until retirement scares me. I don't think I'd physically, let alone mentally, last.***
>
> **Survey Respondent, Female, 25-34, Allied Health Worker**

The increasing need for health sector workers has been known for decades, with countless reports highlighting the issues and need for careful workforce planning. However, in NSW there has not been the same increase in graduates as seen in Victoria or Queensland over the past decade.

From 2010 to 2019 there was a 50 per cent increase in the number of graduates from health related degrees in NSW, but this was 13 per cent less growth than in Queensland and 21 per cent less growth than in Victoria. ***Despite having over 20 per cent more people, NSW now has the same number of domestic graduates from health related disciplines as Victoria.***

**FIGURE 25: NUMBER OF COMPLETIONS BY YEAR - HEALTH**




Source: Department of Education, Skills and Employment - Higher Education Statistics Data Cube (uCube) which is based on the student and staff data collections.

The current shortage raises serious questions about the decision to abolish the Australian Health Workforce Agency in 2014, a decision that has undermined important national leadership and coordination of Australia's health workforce needs.

## CASE STUDY TIM EGAN

When Tim Egan, 74, set out for his daily walk along Tabourie Beach on the NSW South coast on 23 June 2022 he could never have envisaged the six-day ordeal he was about to endure.

While walking, Mr Egan slipped and fell on some rocks, badly injuring his right elbow. He was driven by a friend to the nearest hospital, Milton Hospital, where an x-ray revealed his injuries were too serious to be treated there. Arrangements were made to transfer Mr Egan to Shoalhaven District Base Hospital, where he was advised he would be operated on that afternoon.

What followed were more than 5 days of miscommunication and confusion as Mr Egan was left unattended in the Shoalhaven Emergency Department, and transferred between his home and the hospital 7 times. He was finally transferred to St. George Hospital in Sydney, where his elbow was operated on after what amounted to a 130 hour wait. When staff at St. George Hospital requested Mr Egan's medical records from Shoalhaven Hospital, they were told there was no record of him having attended the hospital.

Mr Egan remains upset about the lack of care he received at the Shoalhaven Emergency Department.

***"At no time during the hours that I spent sitting in the Emergency Department at Shoalhaven Hospital, was I attended to by either a doctor or nurse, or offered any form of medication to relieve my pain," said Mr Egan. "I did have scans of my elbow done in the presence of the surgeon who was to operate on me, but he was apparently happy to see me sent home to Lake Tabourie."***

***"When my surgeon at St George Hospital eventually operated he found the tendon hanging off the bone and fragments of bone floating around the elbow area. Not once did a doctor or nurse come and check me at Shoalhaven Hospital – who knows what additional damage may have been done between leaving Milton Hospital and eventually arriving at St George Hospital more than 5 days later."***

Mr Egan believes his experience was due to serious shortages of staff in the hospital.

***"An employee I spoke to, who had been working at Shoalhaven Hospital for 17 years, described my treatment by the hospital as 'absolutely disgraceful.' He said over the past 7 years it seemed that administrative staff were almost outnumbering medical staff at the hospital."***

"I have nothing but the utmost admiration for the nurses and doctors in the hospital system. The nurses from my observations are being run off their feet."

## 3.4 FULLY UTILISING OUR CURRENT HEALTHCARE WORKFORCE

Our ability to meet our current and future health care needs requires using the resources and people available in the most efficient way possible. In many cases the scope of practice of medical practitioners and other health care professionals overlap, allowing some of the tasks undertaken by medical practitioners to be undertaken by other health care professionals. For example, nurse practitioners can undertake colonoscopies in place of gastroenterologist, helping meet significant demand for these services and shorten wait times. This can help alleviate shortages and supply constraints and can also be more cost effective for the health system as a whole.[41]

In Australia, there has been ongoing and significant resistance across a number of areas regarding the ability of non-medical practitioners to operate to their full scope of practice where it overlaps with the scope of practice of medical practitioners.

Rather than evidence based decision making and resource allocation, as occurs in the United Kingdom with recommendations from the National Institute of Clinical Excellence covering scope of practice[42], there has been a tendency in Australia for inertia due to the vocal opposition of doctors groups and the failure to train and properly resource sufficient supplementary workforces. Examples of this include pharmacists and midwives.

### 3.4.1 Allowing Pharmacists to Prescribe Medicines

The NSW, QLD and Victorian Governments have recently announced trials to allow pharmacists to prescribe vaccinations and certain medications.[43] These reforms are consistent with arrangements that have been in place in the United Kingdom, the United States and parts of Canada for decades.[44]

Expanding pharmacist's scope of practice aims to lower costs to the health system by reducing GP visits, increase the convenience for consumers, and give already busy general practitioners more time to spend on high-value care.[45]

Evidence from the UK and Canada points to both lower costs and higher quality of care for patients.[46]

However, these reforms continue to face significant opposition from doctors' groups that claim allowing pharmacists these additional powers will undermine patient care and safety, and incentivise more prescribing because pharmacists financially benefit.[47]

---

**41** Riegert M, Nandwani M, Thul B, Chiu AC, Mathews SC, Khashab MA, Kalloo AN. Experience of nurse practitioners performing colonoscopy after endoscopic training in more than 1,000 patients. Endosc Int Open. 2020 Oct;8(10):E1423-E1428. doi: 10.1055/a-1221-4546. Epub 2020 Sep 22. PMID: 33015346; PMCID: PMC7508647.

**42** https://www.nice.org.uk/about/what-we-do

**43** Jackson Webb, F and Mountain, W (2022). Should pharmacists be able to prescribe common medicines like antibiotics for UTIs? We asked 5 experts, The Conversation: https://theconversation.com/should-pharmacists-be-able-to-prescribe-common-medicines-like-antibiotics-for-utis-we-asked-5-experts-195277

**44** Tonna, A. (2008). An international overview of some pharmacist prescribing models.

**45** Dalton K, Byrne S. Role of the pharmacist in reducing healthcare costs: current insights. Integr Pharm Res Pract. 2017 Jan 25;6:37-46. doi: 10.2147/IPRP.S108047. PMID: 29354549; PMCID: PMC5774321.

**46** Tonna, A. (2008). An international overview of some pharmacist prescribing models.

**47** Australian Medical Association (2022), Media Release: Pharmacist prescribing a dangerous proposition which won't fix workforce issue: https://www.ama.com.au/media/pharmacist-prescribing-dangerous-proposition-which-wont-fix-workforce-issue

### 3.4.2 Midwifery Led Maternity Care

Women benefit from continuity of care during pregnancy, with improved birth outcomes and less complications.[48] This is true whether that care is led by an obstetrician or a midwife.[49] Midwifery led care is also associated with lower rates of medical intervention, including caesarean births[50], reduced rates of pre-term labour and still birth.[51]

Despite the potential benefits on increasing the role of midwifes in obstetrics care in Australia, there has been widespread opposition from doctors' groups.[52] Instead, GP led care is preferred where obstetric led care is not available.[53] Currently only 10 per cent of Australian women are estimated to have access to midwifery led care options[54], compared to 50 per cent of women in the United Kingdom.[55] Expanding access to these models in Australia could help reduce high and climbing levels of caesarean section in Australia, which are associated with higher costs and poorer long term outcomes for women and babies.

## 3.5 REFORM PRIORITIES

Building and maintaining the health care workforce will require addressing low pay across the sector, and a continued focus on ensuring changes in needs are addressed through appropriate increases to training places and the application of best practice evidence to scope of practice.

These reforms and properly valuing the work of the health care workforce are also important in broader objectives to address the gender pay gap, which is partly driven by the low wages of much of the care workforce.

**48** Perdok, H., Verhoeven, C., van Dillen, J. *et al.* Continuity of care is an important and distinct aspect of childbirth experience: findings of a survey evaluating experienced continuity of care, experienced quality of care and women's perception of labor. *BMC Pregnancy Childbirth* **18**, 13 (2018). https://doi.org/10.1186/s12884-017-1615-y

**49** *Ibid*

**50** Chapman, A., Nagle, C., Bick, D. *et al.* Maternity service organisational interventions that aim to reduce caesarean section: a systematic review and meta-analyses. *BMC Pregnancy Childbirth* **19**, 206 (2019). https://doi.org/10.1186/s12884-019-2351-2

**51** Ibid

**52** Australian Medical Association (2021),Media Release: General Practitioners: Maternity Care Position Statement https://www.ama.com.au/articles/general-practitioners-maternity-care-position-statement

**53** Ibid

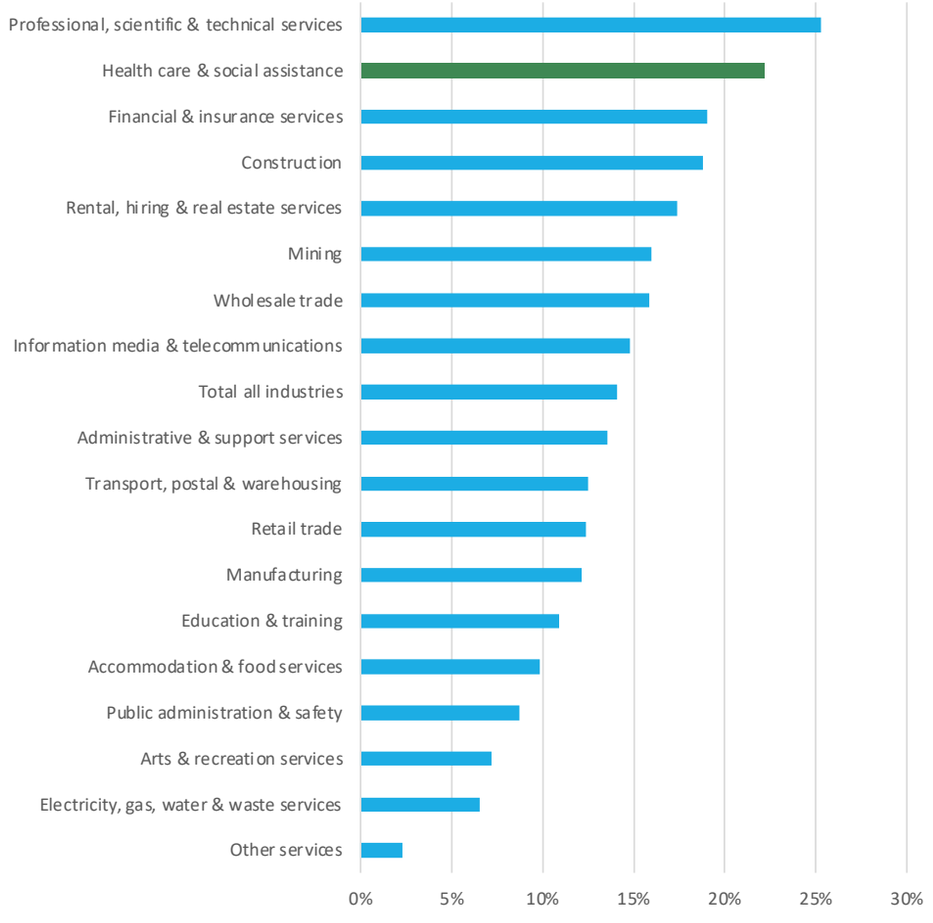
**54** Cummins, A., Coddington, R., Fox, D., & Symon, A. (2020). Exploring the qualities of midwifery-led continuity of care in Australia (MiLCCA) using the quality maternal and newborn care framework. *Women and Birth*, *33*(2), 125-134.

**55** Edmonds JK, Ivanof J, Kafulafula U. Midwife Led Units: Transforming Maternity Care Globally. Ann Glob Health. 2020 Apr 28;86(1):44. doi: 10.5334/aogh.2794. PMID: 32377509; PMCID: PMC7193683.

### 3.5.1 Improving Pay and Conditions

The health and social care workforce is heavily gendered, with 75 per cent of the workers female. However, it has one of the largest enduring gender pay gaps with women earning 22 per cent less than men across the industry.

**FIGURE 26: GENDER PAY GAP BY INDUSTRY**

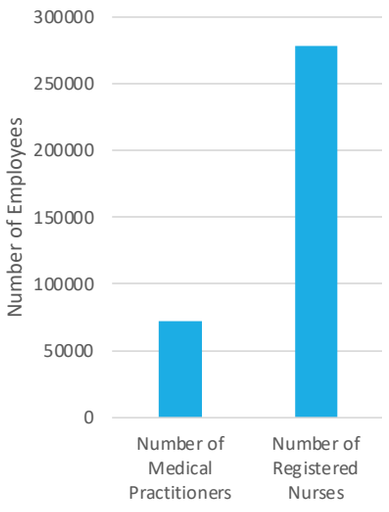



Source: ABS (2022), Average Weekly Earnings and Impact Economics and Policy calculations

There is also a large disparity between professions within the industry, with the total income of medical practitioners almost equivalent to that of nurses despite there being four times the number of nurses than medical practitioners.[56]

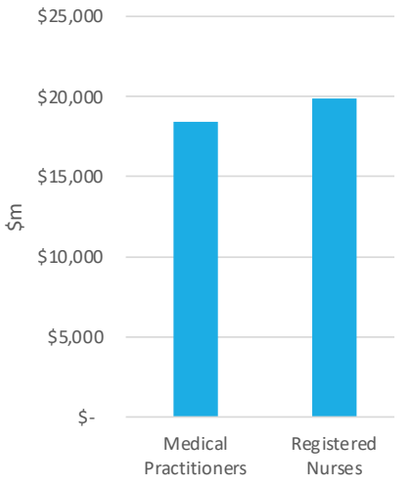
56 Impact Economics and Policy analysis using 2019-20 ATO Tax Statistics

**FIGURE 27: TOTAL NUMBER IN EMPLOYMENT 2019-20**




**Source: ATO (2022), 2019-20 Taxation Statistics**

**FIGURE 28: TOTAL TAXABLE INCOME 2019-20 ($M)**




**Source: Impact Economics and Policy calculations using ATO (2022), 2019-20 Taxation Statistics**

Improving the pay and conditions of non-medical staff in the health system would help attract and retain the necessary workforce for the future, and address the gender pay gap more broadly.

**Recommendation Two:**

Undertake a national review of pay and conditions in the health care workforce to underpin future supply of workers.

### 3.5.2 National Co-ordination of Workforce Planning

Since the Australian Health Workforce Agency was abolished in 2014 there has been a lack of national leadership to address the issues facing the health workforce. These issues are only going to become more acute in NSW, with an additional 25,000 workers needed over the next 10 years.

The health workforce is also changing with a need to focus on new models of care, adapt to the digitisation of health care and address the ageing population and rise in chronic disease.

**Recommendation Three:**

Re-establish the National Health Workforce Agency, a national body to co-ordinate health workforce planning across states and territories.

**Recommendation Four:**

Establish a new independent body to provide guidance on best practice models of care, scope of practice, new drugs and medical procedures.

### 3.5.3 National Institute of Clinical Excellence

Decisions around scope of practice are currently heavily politicised, which is potentially undermining the best practice application of evidence relating to scope of practice and models of care.

In the United Kingdom the National Institute for Clinical Excellence provides advice on best practice across health and social care, including approval of drugs for reimbursement and implementation of models of care.

There is scope for establishing a similar body in Australia to drive consistent and evidence based models of care across Australia. Such a body could also incorporate current health technology assessment processes undertaken by the PBAC and MBAC, and would also deliver benefits of streamlining processes.

# 4. UNDERINVESTMENT IN COMMUNITY HEALTH CARE, AND LACK OF INCENTIVES FOR COORDINATION OF CARE ACROSS DISCIPLINES

The rising prevalence of chronic conditions represents one of the most fundamental demand shifts in health care over the past 40 years, and will continue to drive expenditure and demand in the health system unless addressed.

There is broad consensus – including among Australian governments – that Australia's health system must be reoriented to shift its focus from treating patients who are already unwell to preventing chronic diseases and risk factors before they occur.[57] For those that do need care integrated models of care, that put patients at the centre, and are backed by the evidence have been supported by all levels of government since the mid 1990s.[58] However Australia's heavy reliance on fee for service in primary health care, and a lack of investment in preventative health is undermining attempts for this realignment.

The lack of investment and the wrong incentives for care are undermining the five aims of health care:

**Patient Care** – Rather than being kept healthy in the community, patients are experiencing worst health outcomes requiring hospitalisation and greater interventions

**Healthy Populations** – The wrong incentives for care and underinvestment in prevention are resulting in a rise in chronic conditions

**Efficient health care** – The lack of investment in prevention and management of chronic conditions leads to higher health care costs due to preventable admissions

**Sustainable Workforce** – Increasing rates of chronic disease and preventable admissions placing additional pressures on workforce, undermining sustainability

---

**57** Productivity Commission 2017, *Shifting the Dial: 5 Year Productivity Review*, Report No. 84, Canberra. Available from https://www.pc.gov.au/inquiries/completed/productivity-review/report.; National Health and Hospitals Reform Commission 2009, *A Healthier Future for All Australians – Final Report, NHHRC, Barton. Available from* https://apo.org.au/sites/default/files/resource-files/2009-07/apo-nid17921.pdf.

*;* Australian Health Ministers' Advisory Council, 2017, *National Strategic Framework for Chronic Conditions*. Australian Government. Canberra. Available from https://www.health.gov.au/sites/default/files/documents/2019/09/national-strategic-framework-for-chronic-conditions.pdf; Australian Government Department of Health 2021, *National Preventive Health Strategy 2021-2030,* Canberra: Australian Government. Available from https://www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030.

**58**

**Equity in Access** – Burden of chronic diseases falls more heavily on lower socio-economic groups

Investing more in prevention, and providing integrated, patient-centred care in the community, would lead to better access to healthcare and better health for all Australians. It would benefit the whole health system, reducing pressures and costs, and help ensure its long-term economic viability and sustainability. This realignment also has wider benefits for society and the economy by keeping people participating in work for longer, and improving quality of life and social participation for individuals, families and communities.

Increased investment and action on prevention of chronic diseases is also a global public health objective. The World Health Organization has identified rising chronic diseases as one of the major global challenges in the 21st century,[59] and reducing premature mortality from chronic diseases by a third by 2030 (relative to 2015 levels) is a key target of the UN's Sustainable Development Goals.[60]

It has been estimated that as much as 38 per cent of Australia's chronic disease burden could be prevented by addressing risk factors such as tobacco use, overweight and obesity, unhealthy diets and alcohol use.[61] This requires a combination of prevention interventions, including:

- population-level policies and strategies to address social, economic and commercial determinants of health, create healthier environments, and reduce risk factors
- primary level interventions, such as mass media campaigns and vaccination, and
- secondary level screening programs to detect diseases early.

Evidence shows that combining strategies to address multiple risk factors provides the greatest health benefits. This reflects the complexity of chronic disease, which means that interventions are needed across multiple levels and sectors of the system.[62]

## 4.1 IMPACT OF LACK OF INVESTMENT AND THE WRONG INCENTIVES- PREVENTABLE ADMISSIONS

It is estimated that close to half of all Australians are living with one or more preventable chronic health conditions, including cancer, cardiovascular disease, arthritis, asthma, diabetes, chronic kidney disease, and mental health conditions,[63] an increase from 42 per cent of people in 2007–08.[64] One in five Australians were estimated to have two or more chronic health conditions in 2017-18,[65] and this is likely to have increased.

---

**59** World Health Organization (WHO) 2013, *Global Action Plan for the Prevention of Non-Communicable Diseases 2013-2020, Geneva: WHO. Available from* https://www.who.int/publications/i/item/9789241506236.

**60** United Nations, Sustainable Development Goals, *SDG Target 3.4. Available from* https://www.un.org/sustainabledevelopment/sustainable-development-goals/

**61** Australian Institute of Health and Welfare, 2021. *Australian Burden of Disease Study 2018 – Key findings.* Cat. no. BOD 30. Canberra: AIHW. Available from https://www.aihw.gov.au/reports/burden-of-disease/burden-of-disease-study-2018-key-findings/contents/about

**62** Howse, E, Crosland, P, Rychetnik, L, Wilson, A, 2021. The value of prevention: An Evidence Check rapid review brokered by the Sax Institute for the Centre for Population Health, NSW Ministry of Health. Sydney, Australia: The Australian Prevention Partnership Centre. Available from https://preventioncentre.org.au/wp-content/uploads/2021/10/The-value-of-prevention-Evidence-Review-March-2021.pdf

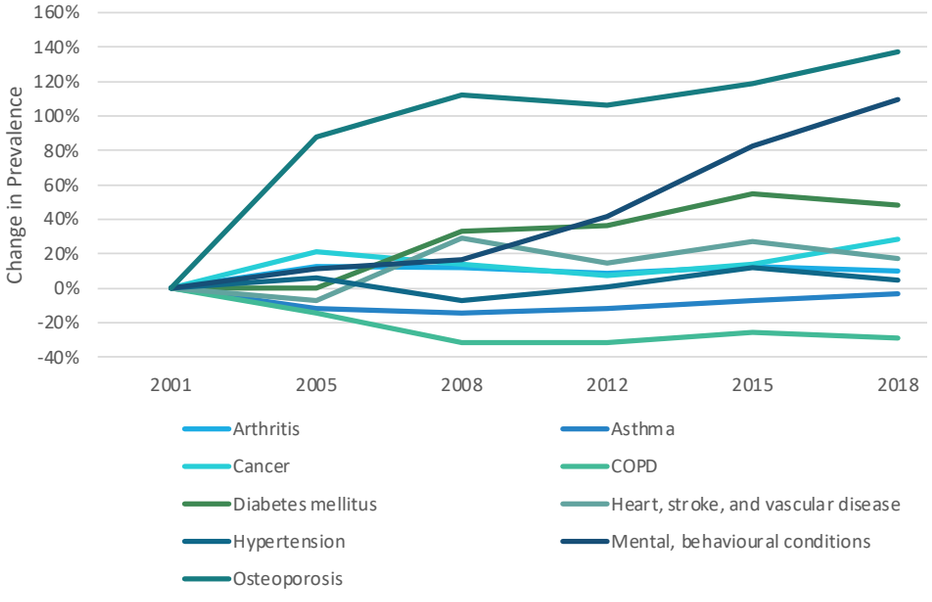
**63** Australian Bureau of Statistics (ABS) 2022, Health conditions prevalence, ABS website. Available from https://www.abs.gov.au/statistics/health/health-conditions-and-risks/health-conditions-prevalence/2020-21.

**64** Australian Bureau of Statistics (ABS) 2018. National Health Survey: First Results, 2017-18. ABS cat. no. 4364.0.55.001. Canberra: ABS. Available from https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey-first-results/latest-release.

**65** Australian Institute of Health and Welfare (AIHW) 2022, Chronic conditions and multimorbidity webpage, AIHW website. Available from https://www.aihw.gov.au/reports/australias-health/chronic-conditions-and-multimorbidity,

Although Australians' life expectancy has increased to 81.2 years for males and 85.3 years for females,[66] Australians live an average of almost eleven years in poor health, amounting to 13 per cent of their lives, due mainly to preventable chronic health conditions. This is the highest number of years spent in poor health of all OECD countries.[67]

**FIGURE 29: RISING PREVALENCE OF CHRONIC DISEASES**




Source: Graph adapted from Breadon, P., Romanes, D., Fox, L., Bolton, J., and Richardson, L. (2022). *A new Medicare: Strengthening general practice*. Grattan Institute.

## *Chronic diseases are responsible for 9 out of 10 preventable deaths in Australia,[68] and 85 per cent of years lost to poor health or premature death.[69]*

This is fundamentally changing the health care needs of Australians and is placing unprecedented and increasing pressure on the health system. More people living with one or more chronic health conditions drives increasing health care costs, as people need more medicines and health care services over long periods.

The rise in chronic conditions and the failure of our health system to properly address both the drivers and impacts, is leading to an increase in the number of preventable admissions. The health system spends about $38 billion each year providing healthcare to people with chronic health conditions, including $2 billion on preventable hospitalisations.[70] This is more

**66** AIHW 2022, Deaths in Australia web report, AIHW website. Available from https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/life-expectancy.

**67** Productivity Commission 2017, *Shifting the Dial: 5 Year Productivity Review*, Report No. 84, Canberra. Available from https://www.pc.gov.au/inquiries/completed/productivity-review/report.

**68** Australian Institute of Health and Welfare 2020. Australia's health 2020 snapshots. Australia's health series no. 17. Canberra: AIHW. https://www.aihw.gov.au/reports-data/australias-health/australias-health-snapshots

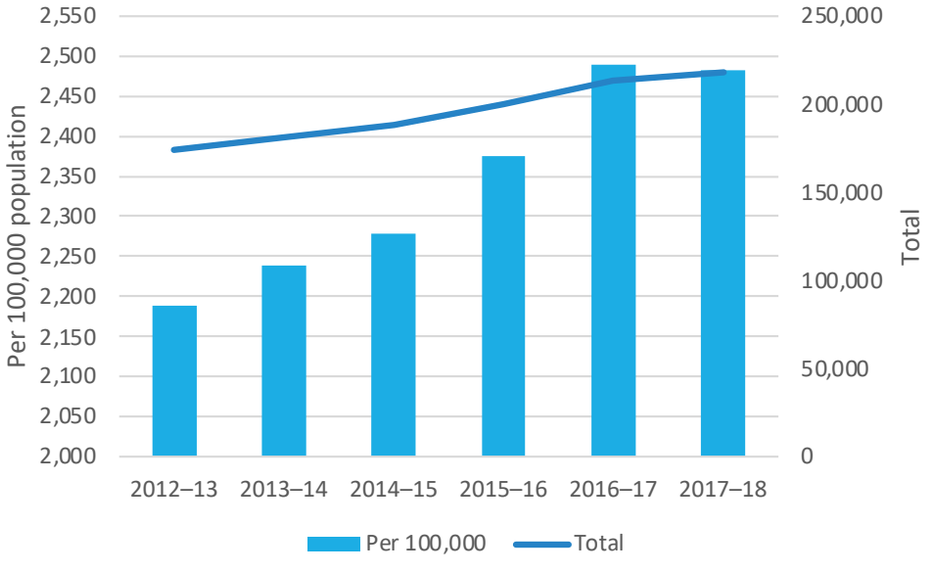
**69** Global Burden of Disease Collaborative Network 2020, Global Burden of Disease Study 2019, Seattle, US. Available from https://vizhub.healthdata.org/gbd-results/.

**70** Productivity Commission 2021, *Innovations in Care for Chronic Health Conditions*, Productivity Reform Case Study, Canberra. Available from https://www.pc.gov.au/research/completed/chronic-care-innovations.

than a third of Australia's health expenditure, and will only increase. The economic impact of chronic disease is far greater when broader non-health sector costs, such as residential care and lost productivity, are taken into account.[71]

***Latest estimates show that in 2017-18 there were 217,865 preventable hospital admissions in NSW, which was an increase of 25 per cent since 2012-13.***[72] These are additional bed days and reflect substantial additional costs for the NSW health system, with each admission costing approximately $5,200 this equates to over $1.1 billion in avoidable costs per year to the NSW health system.[73]

**FIGURE 30: NUMBER OF PREVENTABLE HOSPITAL ADMISSIONS IN NSW**




Source: AIHW (2019), Potentially Preventable Admissions

**71** Productivity Commission 2021, *Innovations in Care for Chronic Health Conditions*, Productivity Reform Case Study, Canberra. Available from https://www.pc.gov.au/research/completed/chronic-care-innovations.

**72** Australian Institute of Health and Welfare (2019), Potentially Preventable Hospitalisations in Australia by age groups and small geographic areas, 2017-18, AIHW, Australian Government.

**73** Impact Economics and Policy calculations using AIHW (2022), Admitted Patient Care 2019-20: Costs and Funding.

## LEVELS OF PREVENTION[74]

Evidence shows that a wide range of interventions across the different levels of prevention are cost-effective, improve health outcomes, and provide wide benefits for the community.[75]

Opportunities for prevention can be categorised into four levels according to stages in the disease continuum:

### Primordial prevention

Primordial prevention strategies involve population-based interventions to create social and environmental conditions that can prevent the development of risk factors and causation of diseases. Generally, primordial prevention interventions require government or community intervention to protect the population from risks to health or expose the population to health promoting conditions. This may include addressing socio-economic and environmental conditions that affect health, such as policies to increase housing availability, local planning policy and infrastructure to increase the availability of fresh, healthy food and improve walkability, or population-wide public health interventions, such as water fluoridation.

### Primary prevention

Primary prevention strategies involve interventions to reduce risks and risky behaviours, and to promote behaviours that are protective of health, before chronic diseases or risk factors occur, such as through mass media campaigns, education and vaccination. It involves reducing risk in the whole population, and in higher risk groups and people. Examples include: regulation of unhealthy product advertising, food labelling, and tobacco plain packaging; social marketing and mass media campaigns, (e.g. obesity prevention and Quit smoking campaigns); fiscal policies, such as tobacco and alcohol taxes; and settings-based health promotion (e.g. in schools and workplaces).

### Secondary prevention

Secondary prevention involves early detection of diseases to prevent disease progression, particularly through screening programs.

### Tertiary prevention

Tertiary prevention involves managing chronic diseases to minimise impacts on health and quality of life, and to prevent further disease progression.

**74** Howse, E, Crosland, P, Rychetnik, L, Wilson, A, 2021. The value of prevention: An Evidence Check rapid review brokered by the Sax Institute for the Centre for Population Health, NSW Ministry of Health. Sydney, Australia: The Australian Prevention Partnership Centre. Available from https://preventioncentre.org.au/wp-content/uploads/2021/10/The-value-of-prevention-Evidence-Review-March-2021.pdf; National Preventive Health Strategy

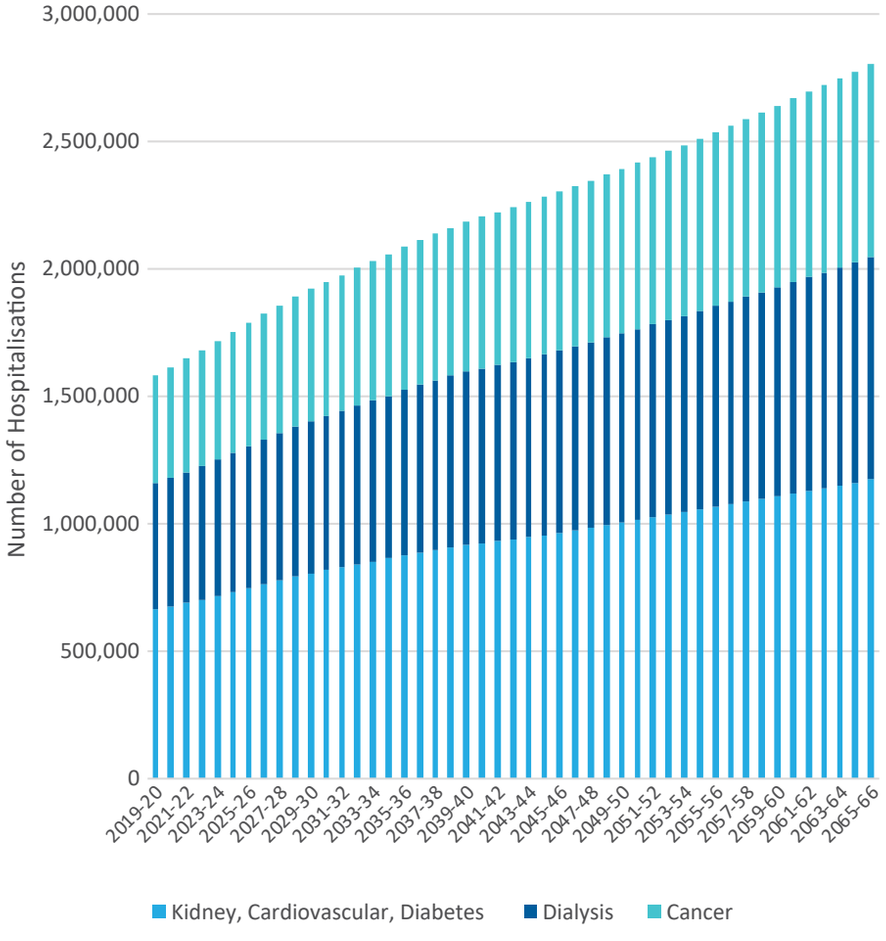
**75** World Health Organization (WHO) 2013, *Global Action Plan for the Prevention of Non-Communicable Diseases 2013-2020, Appendix 3. Geneva: WHO. Available from* https://www.who.int/publications/i/item/9789241506236.

## 4.2 FUTURE IMPACTS ON HEALTH SYSTEM SET TO RISE WITHOUT ACTION

As noted, the prevalence of chronic diseases has increased dramatically over the past five decades, with more Australians now living with chronic disease than ever before.

While the impact of this is already being felt, it will only grow over time with Impact Economics and Policy modelling showing that the number of hospital admissions associated with just three chronic conditions will increase by 1.2 million over the next forty years, and account for close to fifty per cent of all presentations by 2065-66.

**FIGURE 31: FORECAST INCREASE IN HOSPITALISATIONS DUE TO CHRONIC CONDITIONS**




Source: Impact Economics and Policy Modelling (see Appendix Two for Details)

## 4.3 WHAT ARE THE DRIVERS OF RISING IMPACT OF CHRONIC DISEASE ON HEALTH SYSTEM?

The rising impact of chronic disease is driven by increases in the underlying risk factors, and a health system that is fundamentally not designed to to prevent and treat chronic conditions, relying too heavily on fee for services payment mechanisms. Reform has been slow and piecemeal, and not kept up with the scale of the issues facing the health system.

### 4.3.1 Lack of Investment in Prevention

More than a third (38 per cent) of Australia's chronic disease burden, and half (54 per cent) of all Australian chronic disease deaths, are driven by key modifiable risk factors that affect people's health: tobacco use, overweight and obesity, unhealthy diets, high blood pressure, and alcohol use.[76]

***The risk factors that contribute the most to Australia's chronic disease burden are tobacco use (8.6 per cent), overweight and obesity (8.4 per cent), dietary risks (5.4 per cent), high blood pressure (5.1 per cent), and alcohol use (4.5 per cent).***[77]

The most recent national data shows:

- Two-thirds of Australian adults (67 per cent), and one quarter of Australian children and adolescents (25 per cent) are overweight or obese.[78]
- More than one in ten Australians (11 per cent) smoke daily.[79]
- More than half of Australian adults (55 per cent) did not meet physical activity guidelines in 2017-2018.[80]
- Only 6 per cent of Australian adults and 8 per cent of Australian children ate the recommended amount of both fruit and vegetables in 2020-2021.[81]

Yet Australia spends little in comparison to other advanced nations of public health and prevention. In 2014 the Commonwealth Government abolished the Australian National Preventative Health Agency.

Even accounting for the increase during the pandemic, ***Australia spent just 0.2 per cent of its GDP on public health during 2020, compared to the almost 1 per cent of GDP that Canada spent.***[82] Overall Australia spends less that 2 per cent of its entire health budget on public health and prevention, and spends less than many OECD countries.[83]

---

**76** Australian Institute of Health and Welfare (AIHW) 2021, Australian Burden of Disease Study 2018 - Key Findings web report. AIHW website, available from https://www.aihw.gov.au/reports/burden-of-disease/burden-of-disease-study-2018-key-findings/contents/key-findings#preventable.

**77** Australian Institute of Health and Welfare (AIHW) 2021, Australian Burden of Disease Study 2018 - Key Findings web report. AIHW website, available from https://www.aihw.gov.au/reports/burden-of-disease/burden-of-disease-study-2018-key-findings/contents/key-findings#preventable.

**78** Australian Bureau of Statistics (ABS) 2017-18, National Health Survey: First results, ABS Website.

**79** Australian Institute of Health and Welfare 2022. *Alcohol, Tobacco & Other Drugs in Australia*, Canberra: AIHW. Available from https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/drug-types/tobacco.

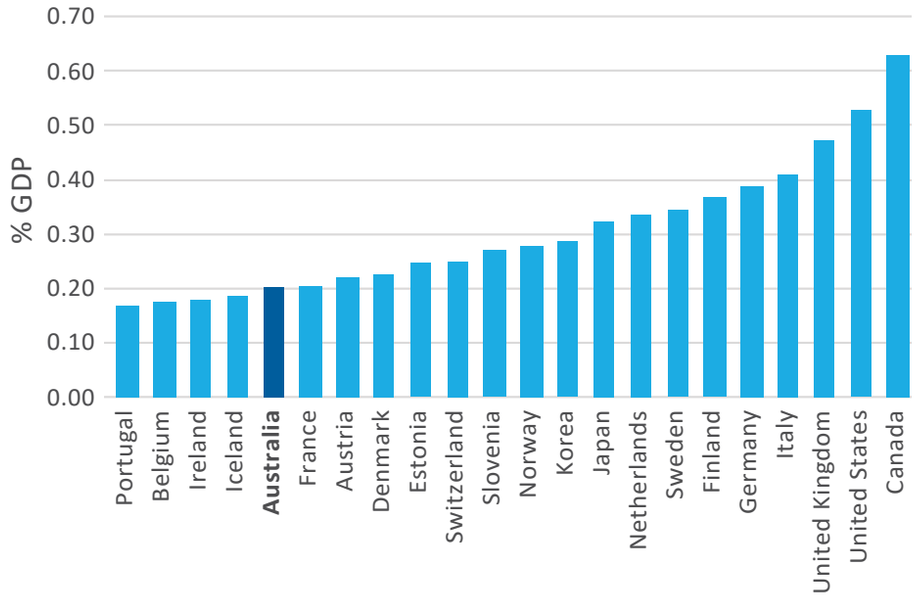
**80** Australian Institute of Health and Welfare 2020, Insufficient Physical Activity web report. AIHW website. Available from https://www.aihw.gov.au/reports/risk-factors/insufficient-physical-activity/contents/insufficient-physical-activity

**81** Australian Bureau of Statistics 2020-21, Dietary behaviour, ABS Website.

**82** AIHW (2022), Health Expenditure Australia 2019-20 and Canadian Institute for Health Information (2022), Public and Private Sector Health Expenditures by Use of Funds: https://www.cihi.ca/en/public-and-private-sector-health-expenditures-by-use-of-funds

**83** AIHW (2022), Health Expenditure Australia 2019-20

**FIGURE 32: SPENDING ON PREVENTION AS % OF GDP (2019)**




Source: OECD Health Stats, https://stats.oecd.org/Index.aspx?DataSetCode=SHA

Given one third of the disease burden in Australia is preventable, including from obesity and smoking, this lack of investment in prevention is undermining the health of Australians and contributing to a high number of preventable admissions.[84]

### 4.3.2 Fee for Service Payment System

Australia relies on fee for service payment system for primary health care, which provides a rebate for every service provided and is not linked to outcomes. At the hospital level activity based payments reward treatment episodes, rather than keeping people healthy and out of hospital. Importantly for people with chronic conditions, whether at the primary or tertiary care level, the funding system does not provide support for multidisciplinary care.[85], [86]

The reliance on fee for service funding arrangements encourages overservicing and allows fraudulent billing, but does not provide support for person-based care focused on preventing chronic conditions and avoiding hospitalisations.

In particular, these funding arrangements do not create incentives for providers to:

- Avoid high-cost activities (such as tests, specialist referrals and hospital admissions)
- Use lower cost care methods such as delegating to nurse practitioners
- Refer patients to allied health services such as physiotherapists that are not covered by the MBS
- Provide preventative advice and care.[87]

---

**84** Crosland P, Ananthapavan J, Davison J, Lambert M, Carter R. The health burden of preventable disease in Australia: a systematic review. Aust N Z J Public Health. 2019 Apr;43(2):163-170. doi: 10.1111/1753-6405.12882. Epub 2019 Mar 4. PMID: 30830711.

**85** Breadon P, Romanes D, Fox L, Bolton J, and Richardson L 2022, *A new Medicare: Strengthening general practice*. Grattan Institute. Available from https://grattan.edu.au/report/a-new-medicare-strengthening-general-practice/

**86** Equity Economics and Rare Voices Australia (2022), Rare Metabolic Disease Workforce White Paper: Towards a Strengthened Rare Disease Workforce for Australia, February 2022

**87** Productivity Commission 2017, *Integrated Care,* Shifting the Dial: 5 year Productivity Review, Supporting Paper No. 5, Canberra. Available from https://www.pc.gov.au/inquiries/completed/productivity-review/report.

## RARE DISEASES

It is estimated that 8 per cent of Australians are born with or develop a rare disease over their lifetime. These are often complex conditions requiring specialist, rather than generalist care.[88]

Patients with rare diseases are often under the care of specialist physicians located in public hospitals, however these physicians struggle to secure funding to provide the multidisciplinary care required to support the health of patients, keeping them out of hospital and in the community.[89] While such models exist they are often due to individual physicians working around barriers, rather than systematic funding support for gold standard models of care proven to improve health and reduce rates of hospitalisation.

Previous research has highlighted that activity-based funding fails to capture activity associated with coordination tasks that are essential to deliver complex multidisciplinary care. Nor does activity based funding reward avoided hospitalisations.[90] Instead, activity based funding tends to support a more outdated, overly simplified transactional approach where time spent in face-to-face or telehealth services with patients is all that is tallied.[91]

### 4.3.3 Under-utilisation of non-GP and allied health workforce

More effective use of a wider range of health professionals– including nurses, nurse practitioners, midwives, allied health practitioners, pharmacists, oral and dental health, and mental health professionals – would lead to more accessible and higher quality care, and better health outcomes.[92,93]

Internationally, other high-income countries make much better use of their non-GP and allied health workforce in primary care. For example, in other countries, pharmacists and paramedics play a greater role in primary health care than in Australia.

**88** Equity Economics and Rare Voices Australia (2022), Rare Metabolic Disease Workforce White Paper: Towards a Strengthened Rare Disease Workforce for Australia, February 2022

**89** Ibid

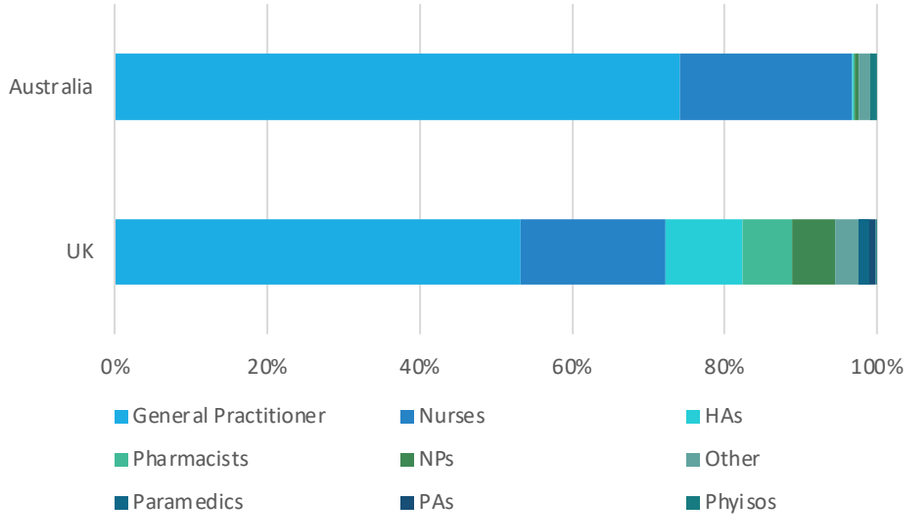
**90** Ibid

**91** Ibid

**92** Australian Government (2022) *Australia's Primary Health Care 10 Year Plan 2022-2032, Australian Government, Canberra. Available from* https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032.

**93** Breadon P, Romanes D, Fox L, Bolton J, and Richardson L 2022, *A new Medicare: Strengthening general practice*. Grattan Institute. Available from https://grattan.edu.au/report/a-new-medicare-strengthening-general-practice/

**FIGURE 33: COMPOSITION OF PRIMARY HEALTH CARE WORKFORCE**




Source: Breadon, P., Romanes, D., Fox, L., Bolton, J., and Richardson, L. (2022). A new Medicare: Strengthening general practice. Grattan Institute

Internationally pharmacists perform tasks such as writing and re-issuing prescriptions, ordering tests, conducting basic screening, implementing chronic disease management plans, managing minor illnesses, and providing prenatal and palliative care. Paramedics are involved with running injury and illness clinics, conducting home visits, implementing care plans, and providing health screening and prevention services.[94]

However, in Australia, the primary healthcare workforce – including nurses, nurse practitioners, allied health professionals, and pharmacists – do not work to their full scope of practice as part of multidisciplinary teams.[95] Analysis has found that regulatory and funding arrangements limit the contributions of the broader non-GP and allied health workforce to primary care, including chronic disease prevention and management.[96] As noted above, any changes to scope of practice are often heavily politicised, with significant opposition from doctors' groups.

**94** Breadon P, Romanes D, Fox L, Bolton J, and Richardson L 2022, *A new Medicare: Strengthening general practice*. Grattan Institute. Available from https://grattan.edu.au/report/a-new-medicare-strengthening-general-practice/

**95** Australian Government (2022) *Australia's Primary Health Care 10 Year Plan 2022-2032, Australian Government, Canberra. Available from* https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032.

**96** Productivity Commission 2017, *Integrated Care,* Shifting the Dial: 5 year Productivity Review, Supporting Paper No. 5, Canberra. Available from https://www.pc.gov.au/inquiries/completed/productivity-review/report; Breadon P, Romanes D, Fox L, Bolton J, and Richardson L 2022, *A new Medicare: Strengthening general practice*. Grattan Institute. Available from https://grattan.edu.au/report/a-new-medicare-strengthening-general-practice/

## ISSUE IN FOCUS

### OBESITY

Australia has among the highest rates of childhood and adult obesity in the world. This is a major threat to the sustainability of the health system.

Two-thirds (67 per cent) of Australian adults now have overweight (36 per cent) or obesity (31 per cent).[97] This a dramatic increase from 57 per cent of Australian adults in 1995, driven mainly by increases in rates of obesity, which have risen from 19 per cent of Australian adults in 1995 to 31 per cent today.[98]

One quarter (25 per cent) of Australian children and adolescents are overweight or obese.[99] The percentage of Australian children and adolescents aged 7 to 15 years that are overweight or obese tripled between 1985 and 1995.[100]

In New South Wales, more than half (57.8 per cent) of adults and nearly a quarter (23 per cent) of children have overweight or obesity. The adult obesity rate increased from 18.6 per cent to 23.2 per cent over the 10 years from 2012 to 2021.[101]

Obesity is a major risk factor for various chronic diseases, including coronary heart disease, stroke, diabetes, chronic kidney disease, and at least 13 types of cancer.[102]

Overweight or obesity in childhood is associated with poorer health and educational outcomes, increased health care costs and increased risk of having overweight or obesity as adults.[103]

Overweight and obesity caused 8.4 per cent of Australia's total burden of disease in 2015 – second only to smoking (9.3 per cent) as a modifiable risk factor for ill health, and the leading risk factor contributing to non-fatal burden (living with disease).[104] Overweight and obesity is also a major contributor to health inequalities – it causes a greater burden of disease for lower socio-economic groups, and is responsible for about 14 per cent of the health gap between Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians.[105]

---

**97** Australian Bureau of Statistics (ABS) 2017-18, National Health Survey: First results, ABS Website.

**98** Australian Institute of Health and Welfare (AIHW) 2022, Overweight and obesity web article, AIHW website. Available from https://www.aihw.gov.au/reports/australias-health/overweight-and-obesity.

**99** Australian Bureau of Statistics (ABS) 2017-18, National Health Survey: First results, ABS Website.

**100** Xu J, Hardy LL, Guo CZ, and Garnett SP. The trends and prevalence of obesity and morbid obesity among Australian school-aged children, 1985–2014. Journal of Paediatrics and Child Health, 2018; 54(8):907-912.

**101** Centre for Epidemiology and Evidence, NSW Ministry of Health. NSW Population Health Survey (SAPHaRI), HealthStats NSW website. Available from https://www.healthstats.nsw.gov.au/#/indicator?name=-beh-bmi-cat-oo-phs&location=NSW&view=Trend&measure=prevalence&groups=Body%20mass%20index&compare=Body%20mass%20index&filter=Body%20mass%20index,Overweight%20or%20obese,Obese,Overweight

**102** Obesity Evidence Hub 2022, Health impacts of obesity: an overview webpage, Obesity Evidence Hub website. Available from https://www.obesityevidencehub.org.au/collections/impacts/health-impacts-of-obesity.

**103** Australian Institute of Health and Welfare 2020. Overweight and obesity among Australian children and adolescents. Cat. no. PHE 274. Canberra: AIHW. Available from https://www.aihw.gov.au/reports/overweight-obesity/overweight-obesity-australian-children-adolescents/summary

**104** Australian Institute of Health and Welfare (AIHW) 2022, Overweight and obesity web article, AIHW website. Available from https://www.aihw.gov.au/reports/australias-health/overweight-and-obesity.

**105** Australian Institute of Health and Welfare 2022, *Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2018.* Australian Burden of Disease Study series no. 26, catalogue number BOD 32, AIHW. Available from https://www.aihw.gov.au/reports/burden-of-disease/illness-death-indigenous-2018/summary

### 4.3.4 Governance of Health System Leading to Lack of Integrated Care

Integrated care means funding, organising and delivering services in a way that increases connections between services, and addresses barriers and fragmentation between care levels.[61] It associated with a number of benefits: [62]

- connected health and social care that is patient-centred and ongoing rather than episodic
- a system that is easier to navigate and empowers people to self-manage their conditions
- better patient experiences and health outcomes, and
- increased system efficiency.

However the split in funding and delivery responsibilities between state, federal and local governments in Australia undermines efforts to strengthen integrated care models.

## 4.4 PRIORITIES FOR REFORM

To avoid the capacity of the health system being overwhelmed by soaring chronic diseases and further widening of health inequalities, Australia must act to fundamentally reorient and redesign the system – to create an integrated person-centred system with a strong prevention focus.

Priorities for change should increase investment in preventive and community health care, and overhaul the system to address fragmentation of services and the dated fee-for-service funding model. This would lead to better health for all Australians, reduce hospital attendances and admissions, relieve pressures on the health system, and result in significant savings for the health system and the economy.

### 4.4.1 Increase investment and focus on prevention and community health

The NSW and Australian governments should increase the health system's focus on prevention of chronic disease across all levels of healthcare. This requires a substantial increase in investment in prevention to at least 5 per cent of health expenditure – to meet the target set out in the Australian Governments National Preventive Health Strategy and to bring Australia in line with other OECD countries. The Australian Government should also introduce a range of population-based policies across the levels of prevention to help prevent chronic diseases and risk factors, including options such as a sugar-sweetened beverage tax to help prevent and reduce obesity.

A significant increase in funding is needed to support the growth and development of the primary healthcare sector and improve equality of access, particularly in rural, regional and remote areas of NSW - as recommended by the NSW *Inquiry into Health and Hospital Services in Rural, Regional and Remote New South Wales*.

This should include funding for a substantially increased number of non-GP and allied health workers in these areas, as well as other communities at need – to provide support to GPs to deliver multidisciplinary team-based care to prevent and manage chronic diseases.

**Recommendation Five:**

Government's should increase spending on prevention to 5 per cent of health budget

### 4.4.2 Restructure funding models and remove barriers to multidisciplinary team-based care

There is a need to shift away from fee-for-service funding models for primary care to multi-disciplinary team-based care in the community, with a greater role for allied health professionals, pharmacists and nurses.

Funding models for primary care should be reviewed and redesigned to create strong incentives for person-based care focused on preventing and managing chronic diseases. They should also be designed to create incentives for doctors to minimise costs – including by delegating tasks to nurses and nurse practitioners, referring patients to a range of allied health professionals, and avoiding specialist referrals and hospitalisations.

Medicare and Pharmaceutical Benefits Scheme funding and regulatory barriers must be removed to enable full use of the skills of a wider range of health professionals in primary care – including nurses, nurse practitioners, midwives, allied health practitioners, pharmacists, and mental health professionals.

**Recommendation Six:**

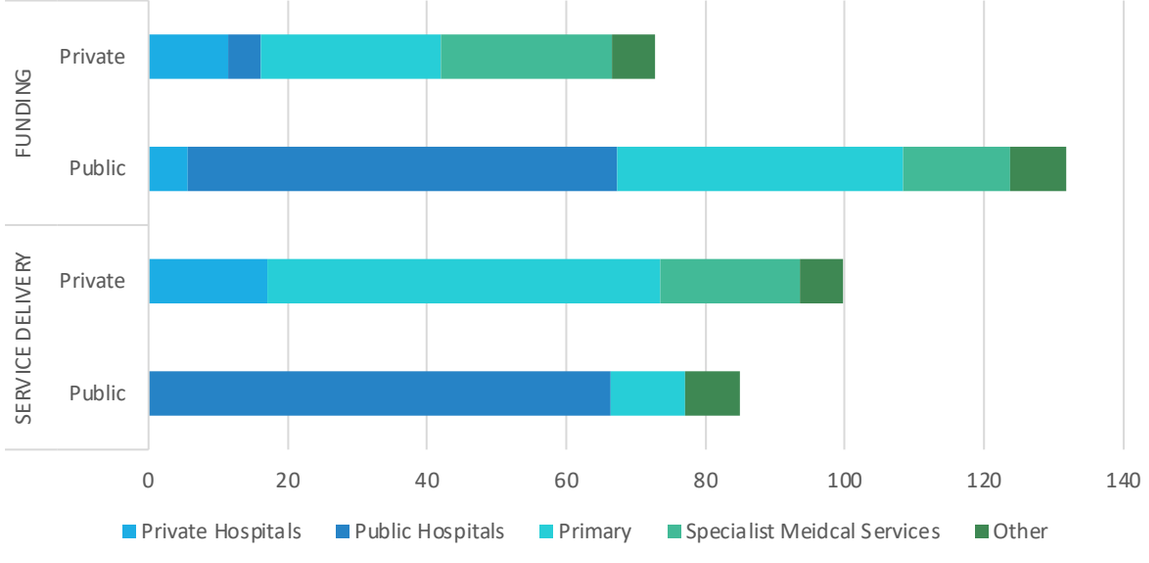
Government should develop new funding mechanisms for health care that shift away from fee for service towards outcome or capitation based payments

# 5. FRAGMENTATION BETWEEN PUBLIC AND PRIVATE HEALTH SYSTEMS

Australia's health system relies on public and private funding and provision of health care services. While 65 per cent of health care services are directly funded by government, the majority of health care services are delivered by the private sector through both private hospitals and privately operating medical practitioners.

This arrangement and the inherent imperfections in the market for health care services means particular care is needed to ensure that incentives facing providers align with the preferences of funders and patients. In particular, because providers have more information than patients supplier induced demand can lead to overservicing. Australia's reliance on fee for service models of payment exacerbates this issue, incentivising providers to deliver more health care services than optimal to maximise income.

**FIGURE 34: PUBLIC AND PRIVATE MIX OF PROVISION OF SERVICES AND FUNDING ($), 2019-20**




Source: Impact Economics and Policy analysis using data from AIHW (2022), Health Expenditure 2019-20 – excludes spending on capital and research.

The dual systems of public and private funding and provision leads to fragmentation of care, significant waste of resources, undermines the equity objectives of Australia's universal system and incentivises overservicing. All these impacts undermine the five aims of health care:

**Patient Care:** Overservicing and lack of oversight on clinical care can lead to poor outcomes for patients in the private sector, while the diversion of resources from the public to the private sector can undermine access to care in the public hospital system.

**Healthy populations:** Provides access to those with private health insurance with subsidised access to allied health care, with heavily rationed access through the public system undermining cost-effective allocation of these resources.

**Cost of Care:** Incentives to overservice and cream skim in the private sector can lead to higher costs of care.

**Equity:** Provides greater access to elective surgery and allied health care services for those with private health insurance which is concentrated in higher income groups, that have lower health care needs.

**Sustainable Workforce:** Higher salaries for health professionals in the private system leads to shortages in the public system of key skills, undermining sustainability.

## 5.1 IMPACT OF PUBLIC-PRIVATE FRAGMENTATION – LOST ECONOMIC OUTPUT DUE TO LONG WAIT TIMES FOR ELECTIVE SURGERY

While all Australians are entitled to free public health insurance, there are also government incentives to take out private health insurance to cover both in hospital and out of hospital health services.[106] The Government spends approximately $7 billion a year on the subsidies for private health insurance on the basis of taking pressure off the public hospital system.

Yet since reforms were progressively introduced to lift private health insurance coverage, there has continued to be a growth in public hospital wait times.[107]

Patients in the public hospital system often have to wait months or even years for necessary surgery in the public hospital system in Australia, whereas they can access treatment almost immediately in the private system. These public wait times have costs in terms of poor health outcomes, pain and suffering but also lost productivity in the workplace.[108]

Wait times have grown because the supply of surgery in the public system has not kept up with demand. Over the period 2010-2019 the public waiting list for surgery increased by 36 per cent, while the number of surgeries performed increased by just 12 per cent.

A number of studies have attempted to quantify the economic impacts of wait times for elective surgery, with both short term impacts as individuals wait for surgery and cannot undertake work, and long term impacts in terms of lower probabilities of re-engagement with work.[109]

A 2019 Canadian Study put the total direct cost of elective surgery wait times in Canada due to lost productivity at $2.8 billion a year. This excluded increased health care costs and the cost of lost productivity from carers.

Applying a similar methodology to NSW, but assuming costs only accrue to those of working age, the total cost of elective surgery waiting times in the public hospital system is estimated at $391 million in 2021-22.

**99,985**
**Elective Surgery Wait List**

**58 days**
**waiting for semi-urgent surgery**

**$391 million**
**total cost in lost productivity**

**106** The Commonwealth Fund (2020), International Health System Profiles: Australia, https://www.commonwealthfund.org/international-health-policy-center/countries/australia

**107** Ibid

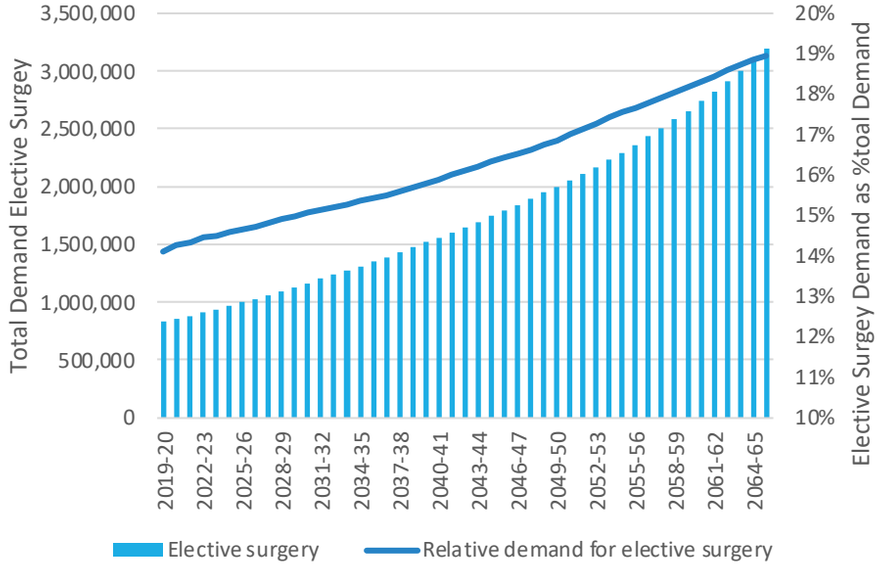
**108** Jack K, Evans C, Bramley L, Cooper J, Keane T, Cope M, Hendron E. Identifying and Understanding the Non-Clinical Impacts of Delayed or Cancelled Surgery in Order to Inform Prioritisation Processes: A Scoping Review. Int J Environ Res Public Health. 2022 May 3;19(9):5542. doi: 10.3390/ijerph19095542. PMID: 35564937; PMCID: PMC9103788.

**109** Ibid

## 5.2 WAITING LISTS WILL CONTINUE TO GROW

Impact Economics and Policy forecasts that both the absolute and relative demand for elective surgery will continue to grow over time driven by demographic shifts. In the absence of additional resources this will lead to huge and unsustainable increases in elective surgery waiting lists. By 2065-66 NSW public hospitals will need to perform 750,000 elective surgeries to keep up with demand, over 500,000 more than they currently perform.

**FIGURE 35: GROWTH IN ELECTIVE SURGERY DEMAND**




Source: Imapct Economics and Policy Modelling (see Appendix Three for methodology)

## 5.3 DRIVERS OF PUBLIC-PRIVATE FRAGMENTATION

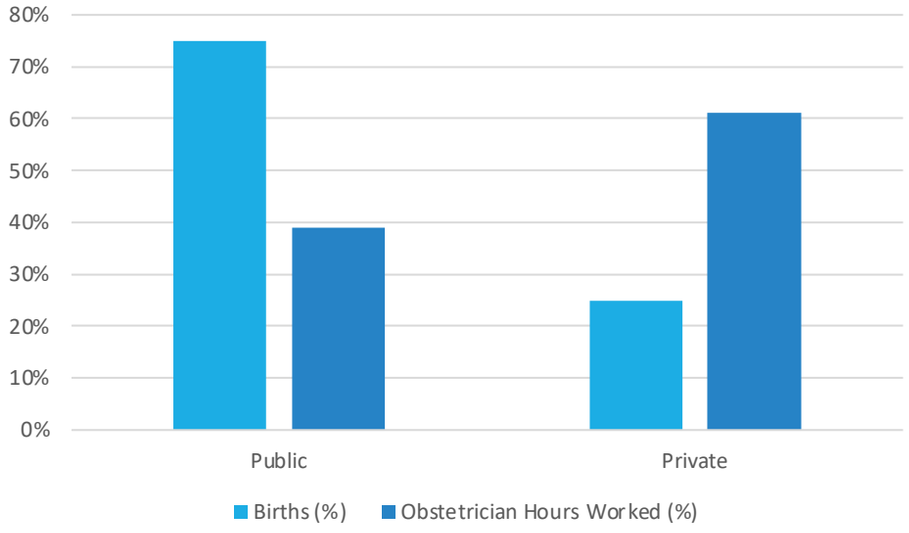
Ideally Australia's public and private systems would complement each other, driving higher quality care, greater access and efficiency. However a number of systematic factors undermine the dual operation of the systems, leading to fragmentation, lower quality care and access and higher costs.

### 5.3.1 Diversion of resources to the Private System

The dual private and public system in Australia, and the ability to earn significantly higher salaries in the private versus the public sector has created an imbalance in the workforce across the sectors.

For example, while 75 per cent of women give birth in the public system, only 39 per cent of obstetrician time is spent working in the public system. As a result, while the 25 per cent of Australian women receiving care in the private system generally benefit from continuity of care led from an obstetrician, the three quarters of Australian women giving birth in the public system each year do not have such routine access.

**FIGURE 36: BIRTHS AND OBSTETRICIAN HOURS WORKED BY HOSPITAL SECTOR (%)**




Source: Impact Economics and Policy Calculations using AIHW (2022) and National Health Workforce Dataset – Hours Clinical Public by Hours Clinical Private (2022)

### 5.3.2 Cream Skimming by the Private System

There is an incentive for private providers to select the lower cost patients, and divert higher cost patients to the public system. This is referred to as cream skimming and in health systems where private hospitals coexist with tax-funded public hospitals, it can arise not just because of their different roles but also of differences in how workers in the public and private sectors are remunerated.[110]

Evidence using data from Victoria indicates this is an issue in the Australian health care system.[111] Patients with higher disease severity are more likely to be transferred to public hospitals, and lead to longer hospital stays than patients transferred from private to other private hospitals. This means private providers earn greater profits, while the public system is left to deal with higher cost patients.

### 5.3.3 Adverse Selection in Private Health Insurance undermining sustainability

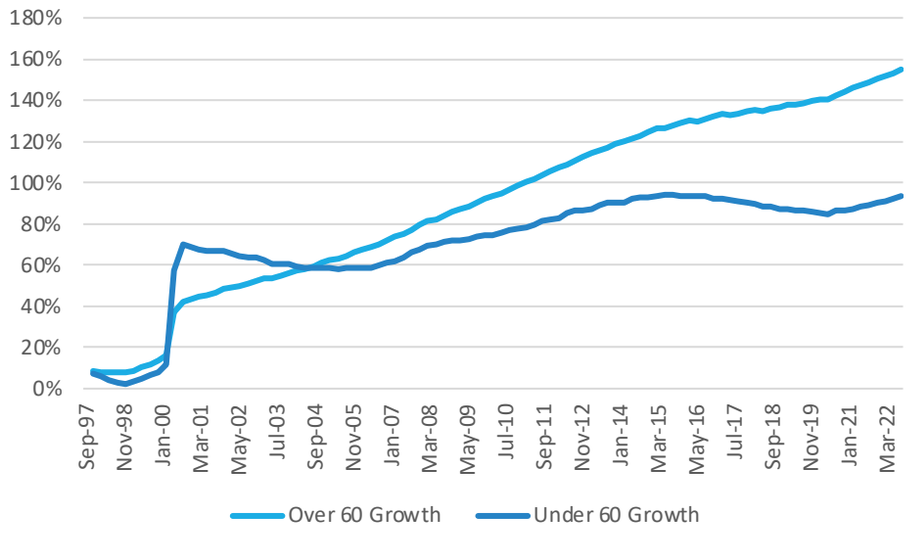
Relying on private health insurance to fund private hospital services also creates a number of issues in terms of sustainability, as younger and healthier people are less likely to take out insurance compared to older and less healthy people. As the population ages this will continue to drive up premiums, leading to more young and healthy people dropping insurance, which drives up costs further and creates the so called 'death spiral' of private health insurance.

Trends in Australia already indicate this is an issue, with people dropping insurance or taking out the lowest level of cover and then continuing to rely on the public system if and when they need care.

**110** González, P. (2005). On a policy of transferring public patients to private practice. Health Economics, 14(5), 513-527.

**111** Cheng TC, Haisken-DeNew JP, Yong J. Cream skimming and hospital transfers in a mixed public-private system. Soc Sci Med. 2015 May;132:156-64. doi: 10.1016/j.socscimed.2015.03.035. Epub 2015 Mar 19. PMID: 25813730.

**FIGURE 37: GROWTH IN INDIVIDUALS WITH GENERAL HOSPITAL COVER SINCE 1997, BY AGE**

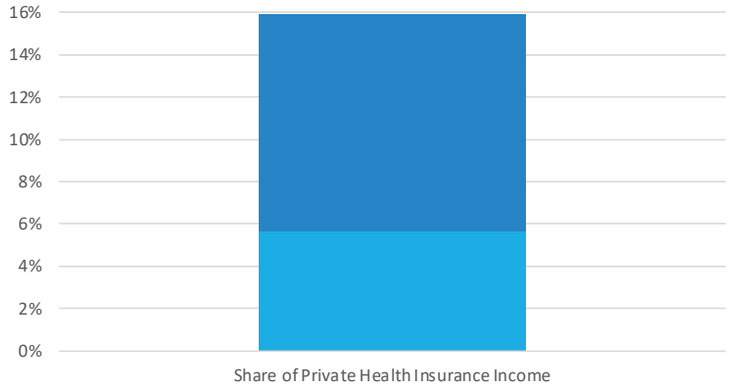



Source: Impact Economics and Policy analysis using APRA Quarterly Private Health Insurance Trends September 2022

### 5.3.4 High Administration Costs in the Private System

In NSW 4.2 million individuals have private health insurance[112], representing $9.5 billion in premiums each year.[113] ***Approximately 10 per cent of the $9.5 billion in Private Health Insurance income is spent on administration and a further 3.8 per cent on profits, representing a total of $1.5 billion that is being diverted from core health care spending.***[114]

**FIGURE 38: SHARE OF PRIVATE HEALTH INSURANCE INCOME ON ADMINISTRATION COSTS AND PROFIT**




Source: APRA (2022)

**112** Impact Economics and Policy calculations based on APRA (2022), Quaterly Private Health Insurance Statistics: https://www.apra.gov.au/quarterly-private-health-insurance-statistics

**113** Ibid

**114** Ibid

## 5.4 REFORMS PRIORITIES

### 5.4.1 Reforms to Fee for Service

As noted earlier in this report Australia's reliance on fee for service payment mechanisms incentivises providers to deliver too many services, and drives up costs without necessarily leading to better health outcomes. It also incentivises providers to offer services in certain locations where they can charge more and make higher incomes, leading to the shortages of health care workers in the regions.

Reforms to the payment system, away from fee for service and towards outcome or capitation based payments could drive greater efficiencies and better align incentives.

### 5.4.2 Moving to Full Universal Public Insurance for Hospital Cover

While there will always be a role for private health care and private hospitals in the provision of health care, the ongoing viability of private health insurance as a funder is of concern.

One option previously floated is to replace subsidies for individuals to take out private health insurance with direct support for the use of private healthcare, through a new hospital benefit.

As occurs now for public hospitals, private hospitals would be paid an efficient price by government to treat patients. Private hospitals would benefit by only having one payer, rather than currently dealing with 38 different private health insurers.

Access for public patients to elective surgery would be improved through full utilisation of Australia's health care resources, and it would allow competition based on quality between publicly and privately run hospitals leading to improvements in care across the system.

Individuals would still be free to insure for any gap, with lower premiums reflecting government support for private hospital care.

**Recommendation Seven**:

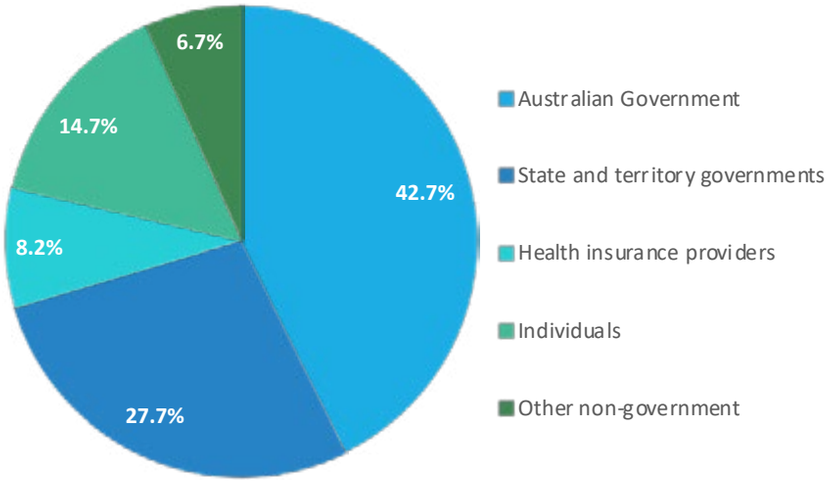
Government should remove subsidies for private health insurance, and instead directly support use of private health care through a new hospital benefit payment.

# 6. FRAGMENTATION BETWEEN THE COMMONWEALTH AND STATES AND TERRITORIES

Under Australia's federated system the Commonwealth and States and Territories have different roles and responsibilities.

There is no single public funder of health care services in Australia with all levels of government responsible for providing health care. The Commonwealth Government funds general practice, pathology, radiology, pharmaceuticals specialist and aged care services. It does not have a direct role in service delivery outside specialised defence health services.

**FIGURE 39: SHARE OF HEALTH EXPENDITURE, 2019-20**




Source: AIHW (2022), Data Tables for 2019-20 Health Expenditure Australia: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/data

States on the other hand not only fund but also deliver health services, including public hospitals, ambulance services, public dental care, community health services and mental health care. Local governments also play a role in the delivery of community health and preventive health programs, including immunisation and the regulation of food standards.

The involvement of three levels of government, without adequate governance alignment, does not support the development of fully integrated models of care, and leads to cost shifting between levels of government. This has the impact of undermining the five aims of health care:

**Patient Care:** Cost shifting can result in patients not receiving treatment in the most appropriate place, undermining quality and outcomes

**Healthy Populations** – Insufficient incentives for each level of government to invest in prevention and lack of integration across systems, undermining healthy populations

**Efficient health care** – Because care is not being undertaken in the most appropriate setting and there is an underinvestment in prevention and care integrations, leads to higher health care costs

**Sustainable Workforce** – Lack of national planning and coordination can lead to critical skill shortages, undermining sustainability of workforce

**Equity in Access** – Lower socio-economic groups less able to address service gaps in public provision through higher out of pocket costs.

The arrangements leave the fiscally less able level of government, the states and territories, responsible for the delivery of critical parts of the health system. This requires significant transfers between the Commonwealth and State Governments to ensure they are able to deliver basic health services.

## 6.1 IMPACT OF COST SHIFTING – CAPACITY OF HOSPITALS STRETCHED

As our public hospital system is stretched beyond breaking point, it is critical that only people that need to be receiving hospital level care are occupying beds. The extent to which this is not occurring adds to health system costs, and wait times for elective surgery and for emergency care. This is because public hospitals can not admit patients if beds are being occupied by people that could be cared for in alternative settings.

Figures from NSW show that each day in NSW there are almost 1000 hospital beds occupied by people that would otherwise be in aged care facilities or receiving NDIS assistance. This is equivalent to one Royal Prince Alfred Hospital filled with these patients, and over fifty per cent of NDIS patients have delayed discharges with an average length of stay of 100 days[AJ1] .

These long stayers that could be in aged care or receiving supports under the NDIS are costing the NSW health system over $500 million per year.

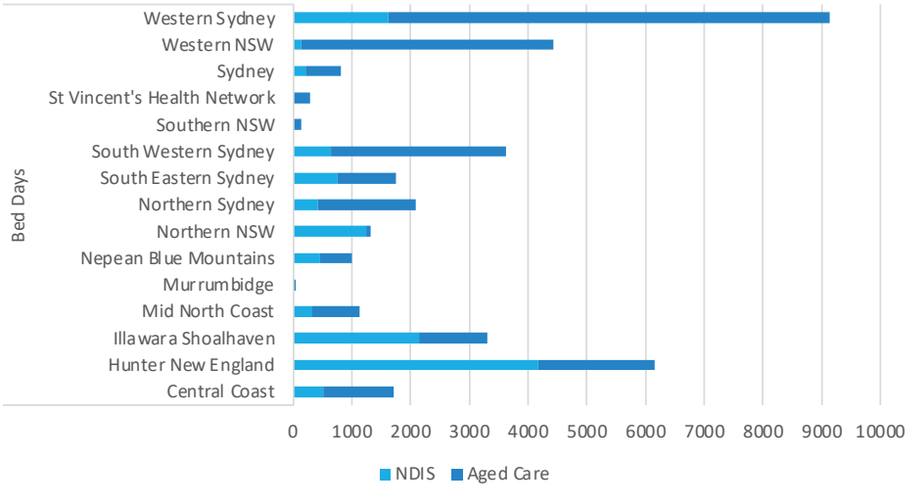
- 335 beds by NDIS participants awaiting plan approvals[115]
- 799 beds by people that should be in Aged Care facilities[116]

In 2022-23 alone Impact Economics and Policy estimates that the costs of this misallocation of resources was $500 million across NSW public hospitals, and an additional 56,000 people could have been admitted to hospital during the period – helping to address the wait times in emergency departments and for elective surgery.

**115** Based on figures for Victoria and nationally as NSW figures not available

**116** Based on figures using data from Illawara Shoalhaven provided by NSW Department of Health.

**FIGURE 40: EXCESS DAYS OF NDIS AND AGED CARE PATIENTS IN NSW PUBLIC HOSPITALS**

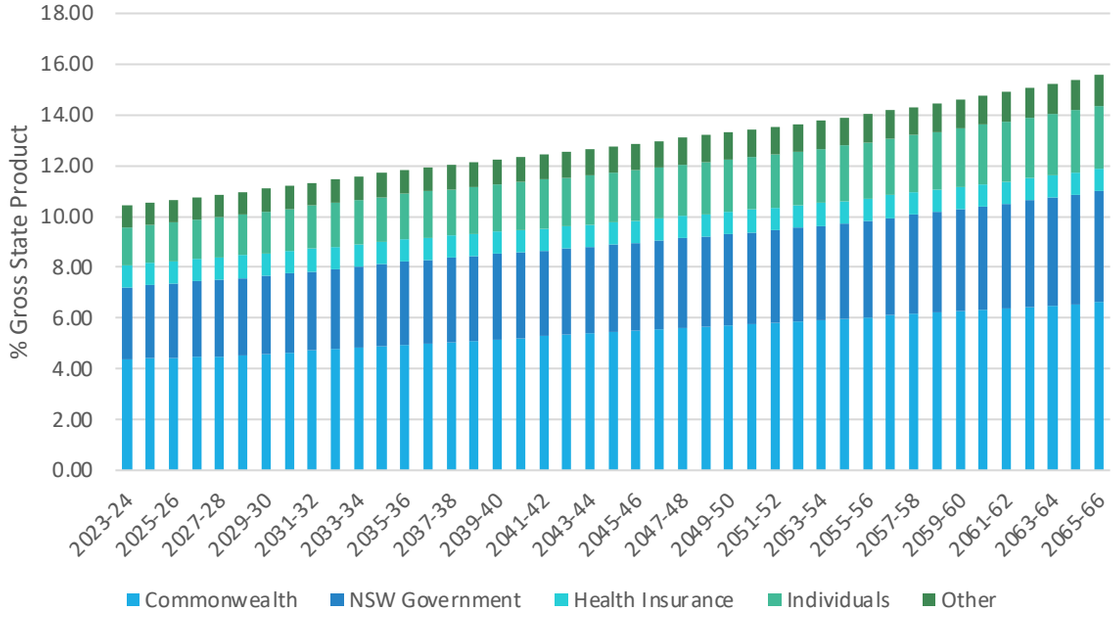



## 6.2 NSW GOVERNMENT SHARE OF HEALTH FUNDING WILL CONTINUE TO GROW

As the population ages and health service use increases, the NSW Government's share of that funding will continue to grow driven by the cost of delivering public hospital services. While both Commonwealth and the NSW Government face increasing health care costs, the greater burden will fall on the NSW Government.

Over the next forty years the NSW Government spending on health care will grow from 25.1 per cent of total spending in 2019-20 to 28.2 per cent by 2065-66, and account for 4.4 per cent of gross state product. Meanwhile Commonwealth Government spending will decrease from 44.5 per cent of total spending in 2019-20 to 42.6 per cent in 2065-66.

**FIGURE 41: CHANGING SHARES OF TOTAL HEALTH EXPENDITURE OVER TIME (% GROSS STATE PRODUCT)**




Source: Impact Economics and Policy Modelling (see Appendix for methodolodgy)

## CASE STUDY LOUANNE RIBOLDI

**Role -** Chief of Operations Royal Freemasons' Benevolent Institution

Louanne Riboldi has never seen a crisis like the one currently unfolding in the New South Wales health system.

As Chief of Operations at the Royal Freemasons' Benevolent Institution, and with a career in the aged care sector spanning twenty-five years, Louanne has a front-row seat to challenges facing the system, particularly in how it cares for our oldest and often most vulnerable citizens.

***"We are beyond a crisis. We're nearly at catastrophe point."***

The collision of workforce issues, COVID-19 and complex administrative requirements in the last few years has left aged care and the people that need it in a precarious position.

***"People get into aged care for whatever reason, but they stay because they get that satisfaction of establishing a relationship with someone and being able to provide care for them. If you have a system that doesn't allow you to do that, then all it is, is just bloody hard work."***

***"Our workers, the registered workers and the carers want to provide quality of life to people that have come into aged care, they really do and that's not valued enough in society."***

The treatment of aged care workers, and the additional pressures they currently face means that for many centres, recruitment cannot keep pace with the speed at which people are leaving the profession.

***"They get abused. Our staff get abused. There's no respect there for another person who's doing their best at the time."***

***"In one of our local villages, they've lost 60 staff out of 170 in the last year, and we've got a list of where they've gone and why. We've been able to recruit possibly, I don't know, about 24 to replace them."***

***"It's a vicious circle. We lose more people, and it makes it even harder to attract people because the system is broken."***

For Louanne, these concerns equate to an industry whose front-line workers have been left feeling unsupported by the health system.

***"I think decision makers in health need to realise the contribution that aged care workers, including the registered nurses, make because until this is changed and we can attract people, we're in trouble."***

## 6.3 DRIVERS OF FRAGMENTED CARE BETWEEN STATE AND COMMONWEALTH GOVERNMENTS

### 6.3.1 Lack of Coordinated Governance Structures

At the heart of the health systems fragmentation is our national Constitution. With six states, two territories and one central government responsible to varying degrees for the delivery and funding of community, primary, secondary and tertiary health care. Without unified and coordinated governance structures to overcome these arrangements Australia's system is not adequately supporting integrated care models.

Any high quality integrated care system involves integration of all services throughout the entire health care system, including community, primary, secondary and tertiary, to deliver high quality care and good health outcomes. This requires greater linkages across the system, funding incentives that support efficient, patient-centred, high quality and continuous care; and sufficient funding, time and staff.[63]

The need to address the health system's capacity to deal with the rise in chronic disease is not new, and governments have been attempting reform, with some success. For example, the creation of primary health networks (PHNs) has made some progress in building the foundations required for better integrated care, and improving efficiency and collaboration. However, there is a need to embed partnerships between PHNs and Local Health Networks.[117]

However, innovation is often achieved because of the commitment of individuals, who find ways to work around systemic barriers, such as funding models, poor linkages and gaps in services.[118]

> ***Any given person in the current system may try to integrate services — developing care plans, communicating with fellow clinicians and involving allied health professionals, following up on hospital admissions and linking to family members to deliver quality outcomes. But they are swimming against the tide of a system that frustrates that model — funding models that discourage this mode of practice, incompatible information systems, poor linkages between the various health professionals, and gaps in the availability of services, among other obstacles.***[119]

**117** Productivity Commission 2021, *Innovations in Care for Chronic Health Conditions*, Productivity Reform Case Study, Canberra. Available from https://www.pc.gov.au/research/completed/chronic-care-innovations.

**118** Ibid

**119** Productivity Commission 2017, *Integrated Care,* Shifting the Dial: 5 year Productivity Review, Supporting Paper No. 5, Canberra, p 4. Available from https://www.pc.gov.au/inquiries/completed/productivity-review/report

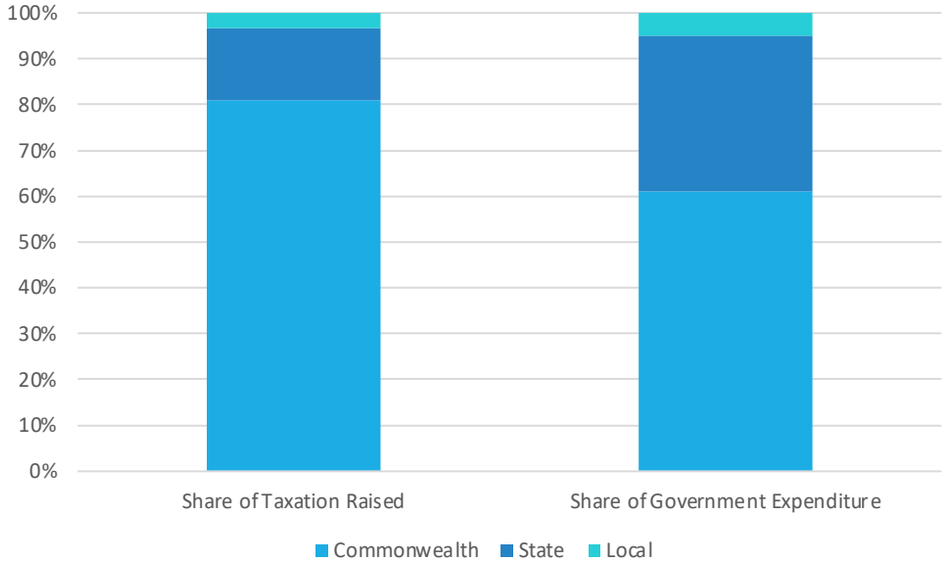
Too often due to the lack of integrated governance structures, people still experience:

- a fragmented system, with a disjointed mix of providers and services failing to work together
- difficulty navigating the system and finding the services they need
- care that is not coordinated
- long wait times and difficulty accessing services.[120]

### 6.3.2 Imbalance in Commonwealth-State Funding Power

The State and Territory Governments do not possess revenue raising capacity to meet all the costs of the services they deliver, creating a need for a significant reliance on transfers from the Commonwealth Government.

**FIGURE 42: VERTICAL FISCAL IMBALANCE**



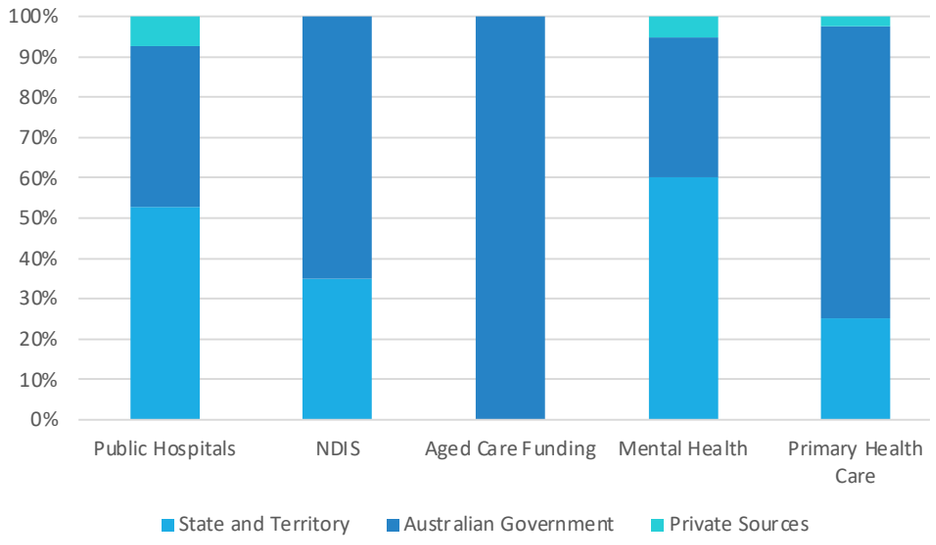

Source: Australian Bureau of Statistics (2022), Government Financial Statistics – Annual, 2020-21

### 6.3.3 Incentives to Shift Costs

With split responsibilities to fund different components of the health system incentives are created to shift costs to other levels of government, reducing the overall efficiency of the system.

**120** Commonwealth of Australia Department of Health (2016) *Primary Health Care Advisory Group Final Report: Better Outcomes for People with Chronic and Complex Health Conditions.* Canberra, ACT: Commonwealth of Australia.

**FIGURE 43: FUNDING SHARE OF HEALTH SERVICES, 2019-20**




Source: AIHW (2022), Data Tables for Australia's Health Expenditure

## 6.4 REFORM PRIORITIES

### 6.4.1 National Governance Framework

National governance frameworks would be strengthened through the establishment of two bodies recommended in this report, a National Health Workforce Agency and a National Centre for Clinical Excellence. These bodies would provide national leadership and governance of healthcare.

However, health care delivery could be further strengthened through greater devolution to local health bodies, jointly funded and overseen by all levels of government, allowing better service integration and helping overcome the current fragmentation of funding and service delivery.

**Recommendation Eight:**

Strengthen national governance frameworks, and look to further strengthen the role of local health networks in health care delivery to overcome the current fragmentation between levels of government.

# 7. CONCLUSION

Australia and NSW have the foundations of a great health system, with a highly professionalised workforce and principles of universality underpinning the efficient and effective delivery of health care. But those foundations are starting to crack with the ongoing fragmentation of care, and lack of systematic approach to health reform. The pandemic has exposed the best of our health care workforce, but the worst of a health system that is showing serious signs of strain.

Piecemeal approaches that fail to account for the interconnections between delivering a high quality, affordable and equitable health system will not address the systematic failings and falling health system performance. Wait times will not improve, and equity of access will continue to deny too many Australians access to health care.

Reforms are needed, that take a whole of system approach and should be informed by a Royal Commission. Notwithstanding the need for a wholesale review, a number of reforms drawing on the long history of reviews into various aspects of the health system could be implemented. Reforms such as re-establishing a national body to co-ordinate health workforce planning across states and territories; and establishing a national body to provide guidance on best practice models of care, scope of practice, new drugs and medical procedures.

Incentives facing providers also need reform – we should not be incentivising more treatment, but shift to a system that encourages keeping people healthy and out of hospitals. This requires new funding mechanisms for health care that shift away from fee for service towards outcome or capitation based payments.

The time for delaying, blocking and not progressing much needed reforms to our health system are over. The costs are rising, and not just in terms of financial costs but in terms of poorer health outcomes for Australians that rely on the health system to keep them and their loved ones safe and healthy.

# 8. APPENDIX ONE
# A HISTORY OF REVIEWS

Going back as far as 1987 reviews of Australia's health system have called out the issues with fragmentation and a lack of focus on keeping people healthy. Leveraging the work of Australian Health Policy Collaboration in 2019, over twenty major reviews and reports into Australia's health care system over the past forty years were identified.[121]

The reviews have consistently identified major concerns in relation to the health system's financial sustainability, gaps in services and inequities in access and health outcomes, and the capacity of the system to meet rising demands from chronic diseases.

**TABLE 2: SELECTION OF MAJOR REVIEWS OF AUSTRALIA'S HEALTH SYSTEM**

| Title | Main Findings |
|---|---|
| Strengthening Medicare, The Commonwealth of Australia (2022) | Current funding system for primary care is not fit for purpose. Need to move from fee for service models of care for primary care towards mixed payment systems. |
| Intergenerational Report 2021, The Commonwealth of Australia, Department of Treasury (2021) | Health forecast to account for 21 per cent of Commonwealth spending by 2021 with real per person spending expected to double over the next 40 years. |
| Royal Commission into Aged Care Safety and Quality (2021) | Highlighted the issues with current health system, and recommended new model of care based on capitation rather than fee for service for general practitioners. |
| The New Frontier - Delivering better health for all Australians, Standing Committee on Health, Ageing and Sport (2021) | Focused on health care needs of the 2 million Australians living with rare diseases, but highlighted impact of fragmentation across state and territories on care impacting access to diagnosis and treatment. |
| Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) | Found that Australia's fragmented funding and governance systems for health care — reflecting Australia's system of government and its hybrid private-public nature — do not achieve the best possible outcomes for Australia's health care expenditure. Recommended reforms to incentives to promote efficient prevention and chronic illness management throughout the health system. |
| Reimagining health reform in Australia: Taking a systems approach to health and wellness, PWC (2016) | Argued for a rejuvenated national health reform agenda to tackle the system's existing complexities. These included the fragmentation of responsibilities for administration and funding between different layers of government, as well as the need both to allocate efficiently the funding that already exists and attract new funding from other sources. |
| Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, Productivity Commission Preliminary Findings Report Preliminary Findings (2016) | Highlighted role of Government stewardship in ensuring health services meet standards of quality, suitability, and accessibility, and provide people the support needed to make choices, ensuring that appropriate consumer safeguards are in place, and encouraging adoption of ongoing improvements to service provision. |

**121** Calder, R; Dunkin R; Rochford C; Nichols T, 2019. Australian health services: too complex to navigate. A review of the national reviews of Australia's health service arrangements. Australian Health Policy Collaboration, Policy Issues Paper No. 1 2019, AHPC. Available from **https://www.vu.edu.au/sites/default/files/australian-health-services-too-complex-to-navigate.pdf**

| Title | Main Findings |
|---|---|
| Health Care Quality Review of Australia, OECD (2015) | The OECD reported that fragmentation of services, slow take up of digital health, the inflexible nature of fee-for-service funding, and the complex split between Commonwealth and state funding and responsibilities, were contributing to poor coordination and continuity of care for patients. |
| Medicare Benefits Schedule (MBS) Review (2015-2020) | The MBS Review considered how MBS items could be better aligned with contemporary clinical evidence and practice, to improve health outcomes. The review ran from 2015 to 2020. The Australian Government is progressively considering and implementing the recommendations. |
| Private Health Insurance Consultations (2015-2016) | To consider how to encourage increased efficiency of private health insurance, enhanced value of private health insurance to consumers, increased effectiveness of Government incentives and improved financial sustainability of the private health sector. |
| Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015) | Due to governance arrangements, primary care operates as a disparate set of services rather than an integrated service system and cannot respond effectively to changing pressures (demographic, burden of disease, emerging technologies, changing clinical practice) or coordinate care within and across various elements of the broader health system. |
| Efficiency in Health, Commission Research Paper, Productivity Commission (2015) | The health care system's institutional and funding structures compromise its performance, meaning that larger-scale reforms may be required to make real and enduring inroads into allocative and dynamic efficiency. There is need for a comprehensive and independent review to examine: private health insurance; investment in preventive health; financial incentives, including ongoing investigation of reform options to expand the evidence base, including trials, consultation and evaluation; and, current regulatory arrangements. |
| 2015 Intergenerational Report – Australia in 2055, The Commonwealth of Australia, Department of Treasury (2015) | To assess the long-term sustainability of current Government policies and how changes to Australia's population size and age profile may impact economic growth, workforce and public finances over the following 40 years. |
| Contributing lives, thriving communities, National Mental Health Commission, (2014) | No level of government 'owns' mental health, which in turn has made it difficult to ensure ac countability for mental health outcomes. Services are poorly integrated, overseen by different parts of government and based on widely different organising principles that are not working towards a common goal. Cross-portfolio interactions are particularly complex. For example, disability, income support and employment services are all Commonwealth responsibilities and yet states incur costs if people need care in public hospitals, interact with the justice system, or become homeless. |
| Reform of Federation, Issues Paper 3, Health (2014) | The complex split of government roles means no single level of government has all the policy levers needed to ensure a cohesive system. This affects patients with chronic and complex conditions - who move from one health service to another - and creates a challenge of providing better integrated and coordinated care. |
| Review of Medicare Locals, (2014) | To determine if Medicare Locals were achieving the goal of becoming effective coordinators of primary health care development and service delivery, with a specific attention on performance metrics, governance arrangements, the role of general practice in primary care, the relationship between administrative and clinical functions, regional integration, market failure and tendering or contracting arrangements |
| National Commission of Audit – Towards Responsible Government (2013) | The complex arrangements between Commonwealth and states and territories for public hospitals result in a lack of clarity when it comes to political responsibility and accountability. This creates an ineffective duplication of service delivery, an absence of proper program evaluation on Commonwealth programs, a lack of subsidiarity and both horizontal and vertical fiscal imbalance. |

| Title | Main Findings |
|---|---|
| Building a 21st Century Primary Health Care System, Department of Health and Ageing (2010) | To provide the platform on which to build an effective and efficient primary health care system and provide a roadmap to guide current and future policy, planning and practice in the Australian primary health care sector. |
| Intergenerational Report 20010, The Commonwealth of Australia, Department of Treasury (2010) | Health spending forecast to increase to 7 per cent by 2049-50. Flags the role of hospital funding reform to help lower long term costs and improve sustainability. |
| Australia: The Healthiest Country By 2020, National Preventative Health Taskforce (2009) | Provided a strategy (focusing initially on obesity, tobacco and excessive consumption of alcohol) of primary prevention in both health and non-health sectors to prevent Australians dying prematurely. |
| Healthier Future for All Australians, National Health and Hospital Reform Commission (2009) | Lack of clarity of accountability and definition of responsibilities which creates the environment for a blame game. While there is no 'magic bullet' solution for health care system problems, some problems can only be improved by reforming governance arrangements. |
| Intergenerational Report 2007, The Commonwealth of Australia, Department of Treasury (2007) | Commonwealth spending on health care will account for 7.3 per cent of GDP by 2046-47, up from 3.8 per cent of GDP in 2006-07. |
| Intergenerational Report 2002-03, The Commonwealth of Australia, Department of Treasury (2002) | To assess the long-term sustainability of current Government policies and how changes to Australia's population size and age profile may impact economic growth, workforce and public finances over the 40 years. |
| Private Health Insurance, Industry Commission (1997) | Recommended a broad public inquiry into Australia's health system, encompassing; health financing, including state/federal cost shifting incentives; integrated health systems and coordinated care; the role of co-payments; competitive neutrality between players in the system; market power exerted by players in the medical system. |
| Looking Forward to Better Health, Better Health Commission (1987) | A lack of national focus on illness prevention. Medical schools not training students to promote health, research into illness prevention is fragmented and sparse, national funding for illness prevention is small and erratic and information and skills sharing is limited. |

Source: The majority of these reviews were identified in Australian health services: too complex to navigate. A review of the national reviews of Australia's health service arrangements. Australian Health Policy Collaboration, Policy Issues Paper No. 1 2019, AHPC. Available from https://www.vu.edu.au/sites/default/files/australian-health-services-too-complex-to-navigate.pdf

The Productivity Commission's 2017 *Shifting the Dial: 5 Year Productivity Review,* which highlighted serious problems with the quality of health care experienced by many Australians, and deep fault lines emerging in the system. The Productivity Commission outlined a litany of problems and areas needing significant improvement, including:

- the system's focus on crisis rather than patients' experience of care
- fragmented services and poorly coordinated care pathways
- weakly defined and poorly integrated roles of private health insurance and public health insurance
- quality of care problems, including significant health inequalities, and excessive use by doctors and specialists of contraindicated medicines and practices, and
- wasteful expenditure, with resources being used in the wrong places with no or little effect on health outcomes.[122]

The OECD's 2015 Health Care Quality Review of Australia found that the health system is too complex for people to navigate. The OECD reported that fragmentation of services, slow take up of digital health, the inflexible nature of fee-for-service funding, and the complex split between Commonwealth and state funding and responsibilities, were contributing to poor coordination and continuity of care for patients. The OECD highlighted major health inequalities, particulary for people in rural and remote areas and Aboriginal and Torres Strait Islander people, resulting from workforce shortages and maldistribution, and Australia's failure to use its workforces strategically to deliver healthcare across the country.[123]

Many of the reviews recommended a full-scale inquiry into the system that includes review of public and private health care service provision, division of Commonwealth and state responsibilities, and funding and payment models. Such a review has not yet been undertaken.[124]

### 8.4.1 Reviews of the NSW Health System

In addition to these major national reviews, there have been a number of reviews of the NSW health system with two parliamentary reviews in 2022 exploring the current crisis.

In December 2022, the NSW Legislative Council Inquiry, Impact of Ambulance Ramping and Access Block on the Operation of Hospital Emergency Departments in New South Wales was tabled. The Inquiry found that worsening patient flow problems are contributing to significant emergency department overcrowding and ambulance ramping in metropolitan and regional NSW, and placing people in NSW at risk. Delays for ambulances in transferring patients to hospital prevent them from responding to further emergency calls. Emergency Departments are being forced to change their processes and procedures, and can no longer prioritise the needs of patients – resulting in compromised care, poorer outcomes, and loss of dignity and privacy for patients.[125]

The Inquiry also found that access blocks, ambulance ramping, and emergency department overcrowding in the NSW health system are driven by stress on the system from natural disasters, including bushfires, floods and the pandemic, an ageing population and increasing

**122** Productivity Commission 2017, *Shifting the Dial: 5 Year Productivity Review*, Report No. 84, Canberra. Available from https://www.pc.gov.au/inquiries/completed/productivity-review/report.

**123** OECD 2015, *OECD Reviews of Health Care Quality: Australia 2015: Raising Standards, OECD Reviews of Health Care Quality, OECD Publishing, Paris,* https://doi.org/10.1787/9789264233836-en.

**124** Calder, R; Dunkin R; Rochford C; Nichols T, 2019. Australian health services: too complex to navigate. A review of the national reviews of Australia's health service arrangements. Australian Health Policy Collaboration, Policy Issues Paper No. 1 2019, AHPC. Available from https://www.vu.edu.au/sites/default/files/australian-health-services-too-complex-to-navigate.pdf

**125** New South Wales. Parliament. Legislative Council. Portfolio Committee No. 2 - Health. Report no. 60. Impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales, Parliament of New South Wales, available from https://www.parliament.nsw.gov.au/lcdocs/inquiries/2892/Report%20No.60%20-%20Portfolio%20Committee%20No.%202%20-%20Health%20-%20Ambulance.pdf

chronic diseases, as well as long-term structural problems in the NSW health system, which is no longer fit for purpose. These problems, which pre-date the pandemic, include:

- issues affecting primary care access – which lead to non-urgent patients who should be seen by GPs or other primary care providers presenting at emergency departments
- avoidable presentations and admissions from residential aged care residents and NDIS clients who cannot access the treatment they need in their communities, and delayed discharge of patients from hospitals
- hospitals routinely operating at 100 per cent capacity due to staffed bed shortages, which prevents them from responding to 'surge flow' or unexpected demand.
- fragmented state and federal funding and flawed funding models, which encourage states and territories to limit the care they provide to stay within Commonwealth funding caps
- Federal funding responsibilities, which limit access to primary care services, aged care and the NDIS, with significant impacts on patient flow
- MBS funding, which limits the funding of healthcare services that could help ease patient flow problems, such as by hospital pharmacists and paramedics
- inadequate pay and conditions of NSW healthcare staff, which risks loss of staff to other states.[126]

> ***Patients are suffering because their care is compromised by a health system that is not functioning as well as it should. The committee heard troubling examples about patients' health deteriorating in ambulances and overcrowded EDs or suffering a loss of dignity through being treated in inappropriate spaces.*** [127]

Earlier in 2022, the NSW Legislative Council Portfolio Committee's Inquiry into Health and Hospital Services in Rural, Regional and Remote New South Wales reported that people and families in NSW are being let down by the health system. The Inquiry found that – largely because of major health workforce issues – people in in rural, regional and remote areas of NSW have poorer access to health and hospital services and more chronic disease, significantly worse health outcomes, and higher rates of premature death than people in metropolitan areas. Common issues reported to the Committee included emergency departments with no

**126** New South Wales. Parliament. Legislative Council. Portfolio Committee No. 2 - Health. Report no. 60. Impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales, Parliament of New South Wales, available from https://www.parliament.nsw.gov.au/lcdocs/inquiries/2892/Report%20No.60%20-%20Portfolio%20Committee%20No.%202%20-%20Health%20-%20Ambulance.pdf

**127** New South Wales. Parliament. Legislative Council. Portfolio Committee No. 2 - Health. Report no. 60. Impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales, Parliament of New South Wales, Chair's Foreword, p viii. Available from https://www.parliament.nsw.gov.au/lcdocs/inquiries/2892/Report%20No.60%20-%20Portfolio%20Committee%20No.%202%20-%20Health%20-%20Ambulance.pdf

doctors, severe shortages of nurses and midwives, poor quality care, people being looked after by non-health professionals, and excessive wait times for treatment.[128]

> ***We heard stories of emergency departments with no doctors; of patients being looked after by cooks and cleaners; of excessive wait times for treatment; and of misdiagnoses and medical errors.***[129]

The Inquiry found that these issues stemmed from systemic problems including critical health workforce shortages and maldistribution, the Commonwealth/state divide in provision of health funding, which leads to service gaps and duplication, significant under-resourcing of health and hospital staff, and lack of transparency and accountability in governance. The Inquiry noted that previous reviews, inquiries and analyses of the system have failed to bring about the fundamental systemic changes needed, and people in rural and regional NSW are now at breaking point.

**128** New South Wales. Parliament. Legislative Council. Portfolio Committee No. 2 – Health. Report no. 57. *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*. Parliament of New South Wales, 2022. Available from https://www.parliament.nsw.gov.au/lcdocs/inquiries/2615/Report%20no%2057%20-%20PC%202%20-%20Health%20outcomes%20and%20access%20to%20services.pdf.

**129** New South Wales. Parliament. Legislative Council. Portfolio Committee No. 2 – Health. Report no. 57. *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*. Parliament of New South Wales, 2022, Chair's Foreword, p xi. Available from https://www.parliament.nsw.gov.au/lcdocs/inquiries/2615/Report%20no%2057%20-%20PC%202%20-%20Health%20outcomes%20and%20access%20to%20services.pdf,

# 9. APPENDIX TWO
# HEALTH SYSTEM COST AND RESOURCE MODELLING METHODOLOGY

Projections for the demand for health services (in terms of both volume and value) are derived using a framework that follows the methodology in the NSW 2021 Intergenerational Report. This framework incorporates projections for population, per capita income, age-specific expenditure for health services (specifically, age cost indexes), prices and other factors (for example, technological change). Projections are derived for both NSW and Australia. The methodology also assumes consistency with a 'dynamic equilibrium' relationship between life expectancy and morbidity: while years in ill-health increase as life expectancy increases, the severity of illness decreases – such that, overall, the proportion of years in good/poor health is constant as life expectancy increases.[130]

For population, projections for NSW and Australia are derived from actual population estimates (ABS, National, state and territory population), and projections (ABS, Population Projections, Australia - middle scenario) for fertility rates, mortality rates, inter-state migration, and net overseas migration. The framework is calibrated to recent long-term projections in the Australian 2021 Intergenerational Report for fertility rates and net overseas migration, and calibrated to recent short-term forecasts in the 2022-23 Commonwealth Government Budget (October 2022) for population growth and net overseas migration. Population projections are derived for gender and age cohorts.

For workforce/employment, projections for NSW and Australia are derived from the population projections, the long-term projections for participation rates and unemployment rates in the Australian 2021 Intergenerational Report, and short-term forecasts for the participation rate, the unemployment rate, and employment growth in the 2022-23 Commonwealth Government Budget (October 2022).

For per capita income, projections are derived from Australian GDP/NSW GSP estimates (ABS, Australian National Accounts), long-term projections for productivity growth in the Australian 2021 Intergenerational Report, and short-term (derived) forecasts for productivity growth in the 2022-23 Commonwealth Government Budget (October 2022).

Age-cost indexes are derived from age-cost index estimates in the 2021 Intergenerational Reports (Australia and NSW), which comprise the relative cost of health services by age (for various components of the health system). The total age-cost index is a weighted average of component indexes by the (volume) share of services in the health system. The age-cost indexes shift over time (that is, they are dynamic), where the overall shift in the total age-cost index (and components) is calibrated to the shift in the total age cost index incorporated in the NSW 2021 Intergenerational Report.

Relative prices for separate components of Australian and NSW health services are derived from Australian Institute of Health and Welfare (Health expenditure Australia 2019-20). Projections for aggregate health system prices are a weighted average of components (by share of services in the health system), and are calibrated to the long-term projections for

**130** Cheung J. et al (2021), *Ageing and health expenses in New South Wales - revisiting the long-term modelling approach, NSW 2021 Intergenerational Report: Treasury Technical Research Paper Series.*

aggregate prices in the Australian economy (in the Australian 2021 Intergenerational Report). Short-term changes in aggregate prices are calibrated to (derived) forecasts in the 2022-23 Commonwealth Government Budget (October 2022).

Projections for the volume of demand for various components of health services (for Australia and NSW) are derived from the population projections, by age and gender, and data from the Australian Institute of Health and Welfare. For each of the components of health services, data from the Australian Institute of Health and Welfare is used to derive baseline estimates for the per capita usage of various hospital services, with estimates varying by age (and gender where available). Other demand factors also vary depending on the nature of the health service – specifically the relative influence of per capita income, and technological change. Projections for the value of health services incorporate the aforementioned projections for the prices of separate components.

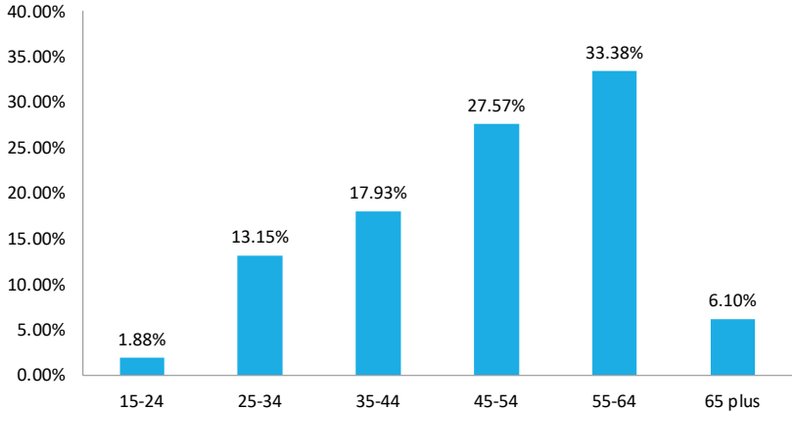
The projections for the volume of demand of health services are used to derive a number of secondary projections, including; the number of required public hospital beds, the number of required new hospital facilities, the number of required staff in public hospitals, demand for chronic disease admissions (which accounts for co-morbidity).

Projections for health system expenditure are derived for both NSW and Australia. This includes expenditure by the Australian and NSW governments (including federal funding for the NSW health system), but also private expenditure by households, health insurers, and other sources. Spending projections are also derived for the various components of health services. Total Commonwealth Government spending is calibrated to the long-term projections in the Australian 2021 Intergenerational Report, while total health expenditure in Australia and NSW is anchored by the aforementioned projections for the total value of health services

# 10. APPENDIX THREE FULL SURVEY RESPONSES

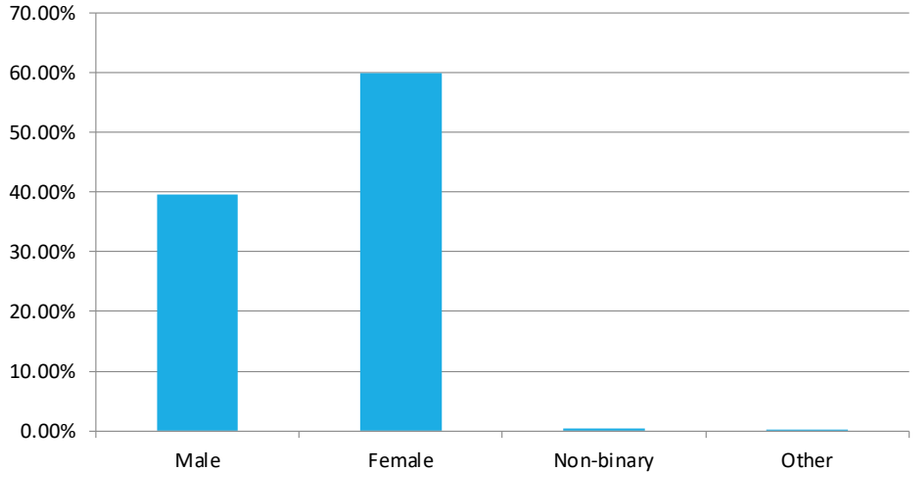
A Survey of Health Service Union NSW QLD and ACT members was undertaken using survey monkey, and it asked six questions with results provided below.

Question One **What is Your Age?**



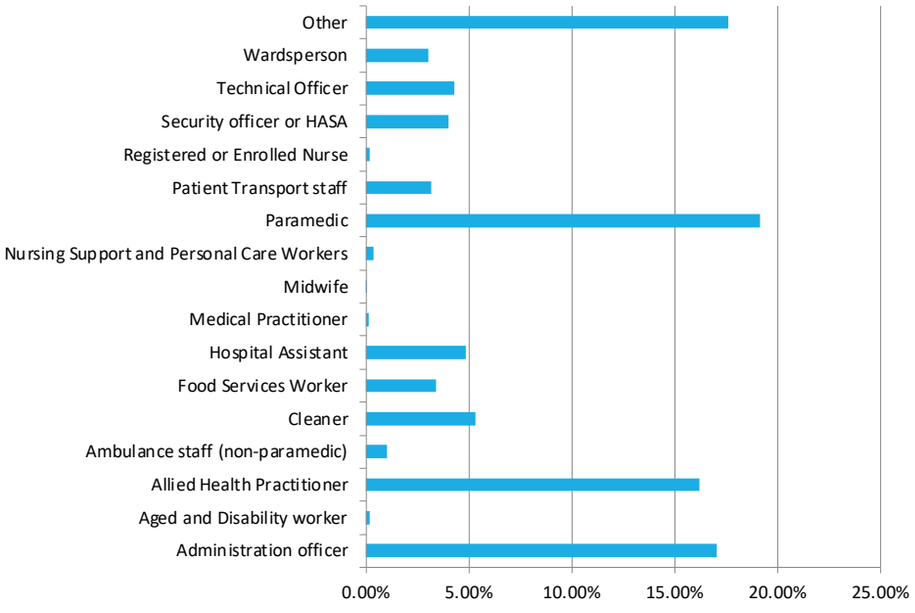

Responses: **4,479**

Question 2 **What is your gender?**

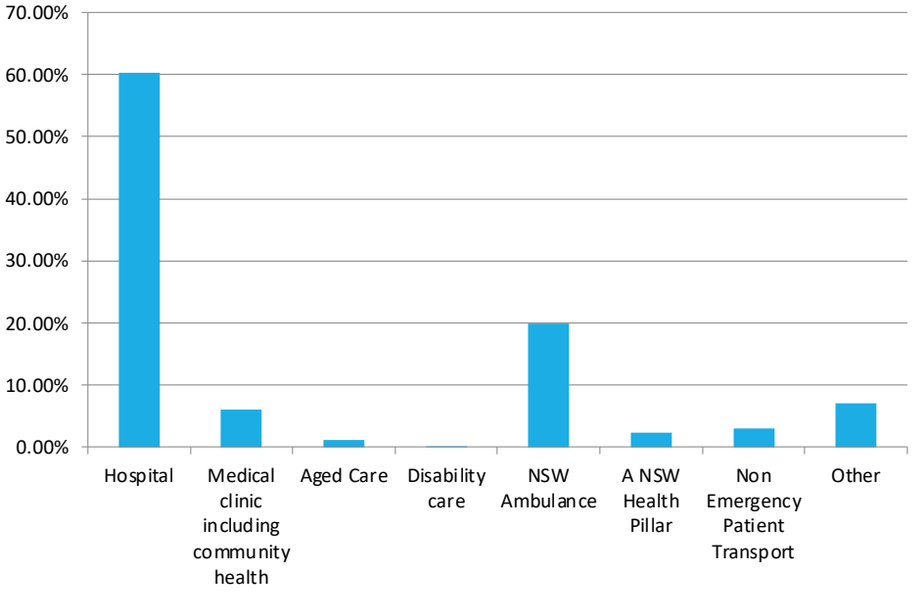



Responses: **4,479**

Question 3 **What is your job?**

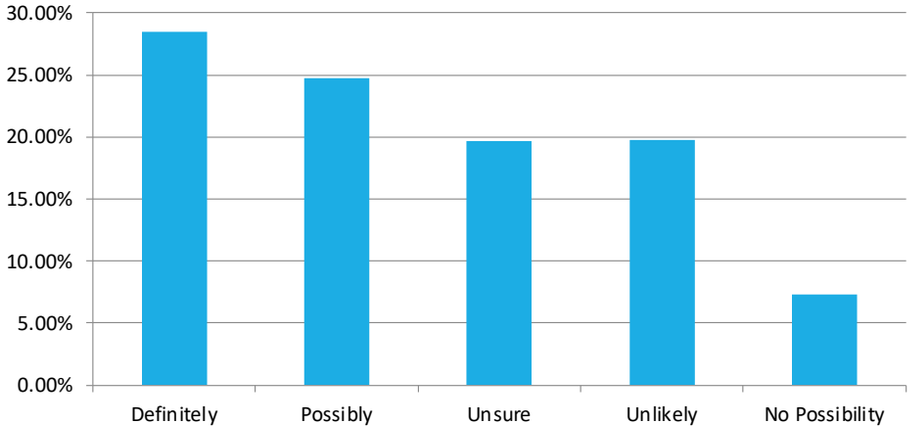



Responses: **4,486**



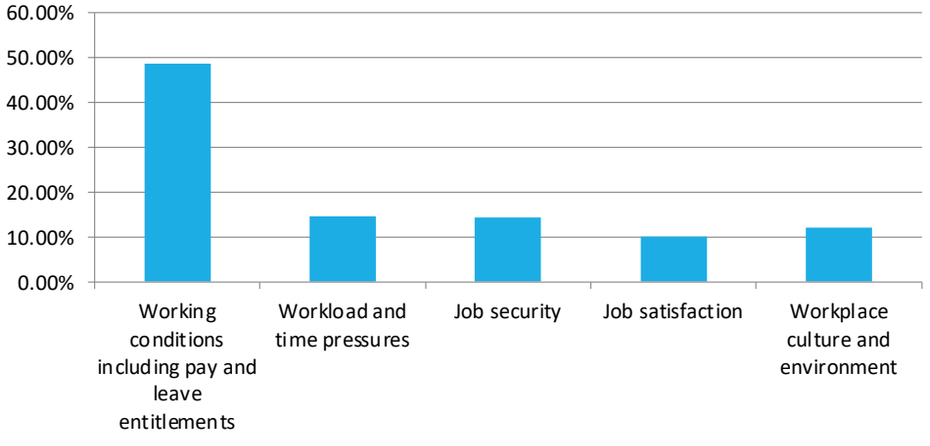

Responses: **4,482**

Question 5 - **How likely to stay in your current occupation for the next five years?**




Responses: **4,480**

Question 6 **What is the most important consideration in your decision?**




Responses: **4,464**

# Reform Critical

## A Fragmented Health System at Breaking Point