New South Wales

Special Commission of Inquiry into Healthcare Funding

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Mr Richard Beasley SC
Commissioner
Special Commission of Inquiry into Healthcare Funding

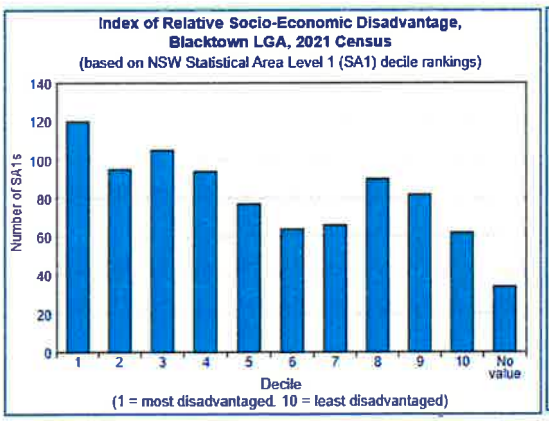
Email: submissions.hfi@specialcommission.nsw.gov.au

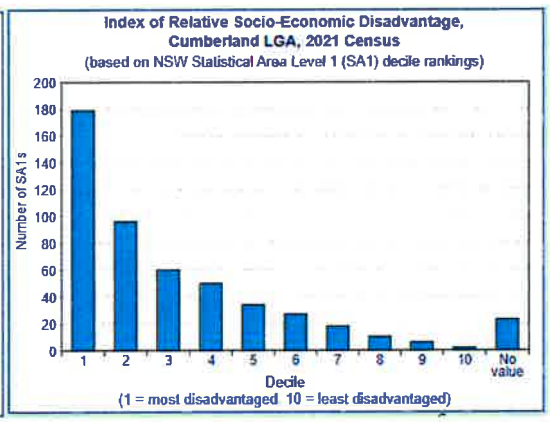
Dear Commissioner Beasley

Thank you for the opportunity to provide a submission to the Special Commission of Inquiry into Healthcare Funding. I'd like to share my thoughts and ideas on behalf of Western Sydney Local Health District (WSLHD) and to put forward suggestions to improve equity of access to health care for all who live in our District, therefore we are particularly focussed on **how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services now and into the future.**

Who we are

Western Sydney Local Health District (WSLHD) has the responsibility and privilege to treat, protect and foster the health of a unique and diverse community that is vibrant and flourishing yet also has pockets of entrenched socio-economic disadvantage and vulnerability. WSLHD has some of the most disadvantaged communities in the state. For example Cumberland and Blacktown LGAs when we look at the Index of Socio-Economic Disadvantage or the SEIFA score (derived from general socioeconomic indices) that measures the relative disadvantage of a Statistical Area shows both of these LGAs have high proportions of the most disadvantaged.





Western Sydney Local Health District (WSLHD) is home to a culturally diverse community, with one of the largest urban populations of Aboriginal people in Australia and high levels of people who were born in another country and do not speak English at home.

NSW	WSLHD	Blacktown LGA	Cumberland LGA	Paramatta LGA	The Hills Shire LGA
Population 8,072,163	Population 1,052,990	Population 396,776	Population 235,439	Population 228,901	Population 191,876
3.6% Aboriginal (278,043 persons)	1.6% Aboriginal (16,531 persons)	3.1% Aboriginal (11,812 persons)	0.7% Aboriginal (1,516 persons)	0.9% Aboriginal (2,001 persons)	0.6% Aboriginal (1,207 persons)
31.0% born overseas (2,502,370 persons) Top 5 countries: India, China, Philippines, Republic of South Korea, Nepal	49.9% born overseas (499,241 persons) Top 5 countries: India, China, Philippines, Republic of South Korea, Nepal	46.8% born overseas (176,116 persons) Top 5 countries: India, Philippines, New Zealand, Fiji, China (excludes SARs and Taiwan)	57.3% born overseas (125,305) Top 5 countries: India, China (excludes SARs and Taiwan), Lebanon, Nepal, Afghanistan	55.1% born overseas (120,381 persons) Top 5 countries: India, China (excludes SARs and Taiwan), Republic of South Korea, Philippines, Hong Kong (SAR of China)	41.2% born overseas (77,439 persons) Top 5 countries: India, China (excludes SARs and Taiwan), England, Philippines, Republic of South Korea
28.2% speak a language other than English at home (2,276,350 persons)	54.3% speak a language other than English at home (538,565 persons) Top 5 languages: Mandarin, Arabic, Hindi, Cantonese, Punjabi	49.3% speak a language other than English at home (183,588 persons) Top 5 languages: Punjabi, Hindi, Tagalong, Arabic, Gujarati	71.0% speak a language other than English at home (153,498 persons) Top 5 languages: Arabic, Mandarin, Nepali, Cantonese, Tamil	58.9% speak a language other than English at home (127,099 persons) Top 5 languages: Mandarin, Cantonese, Korean, Hindi, Arabic	39.8% speak a language other than English at home (74,379 persons) Top 5 languages: Mandarin, Cantonese, Hindi, Korean, Arabic

Source: WSLHD Social and Health Atlas[3] *SAR=Special Administrative Region

WSLHD has a strong and vibrant Pasifika community and has the second largest population of refugees in NSW. We have a large population of asylum seekers from Sri Lanka, Iran, Bangladesh, stateless, Iraq, Pakistan and Afghanistan (Refugee Council of Australia, Statistics on people seeking asylum in the Community, NSW, 2022).

Western Sydney is also growing at a significantly faster rate than other areas of the state with the population to grow by a further 28.3 percent between 2021 and 2031, whilst the rest of NSW will only grow by 10.7 percent.

Criteria	Western Sydney LHD	NSW
Estimated population 2021	1,144,280	8,072,163
Estimated population 2031	1,467,610	8,933,640
Population growth % (2021-2031)	28.3%	10.7%

Epidemiology and Health Analytics (WSLHD). Social Health Atlas: Western Sydney Local Health District, https://www.wslhd.health.nsw.gov.au/SocialHealthAtlas/

It is important we don't make assumptions and generalisations. WSLHD understands the community we serve do not deserve a blanket stereotype. Cultural richness only serves to enhance the communities of WSLHD, strengthen the multiculturalism for which western Sydney is known, bring a strong sense of family and community to western Sydney and provide a gateway to vibrant cultures for the people of NSW.

How this creates challenges in the current funding model

Providing health services to communities of socioeconomic disadvantage comes with significant cultural, social and fiscal challenges. If not managed well there is potential to further entrench inequity in these communities. There are a number of key challenges.

Current ABF model is a one-size fits all solution

The current Activity Based Funding (ABF) model applies a universal approach (one size fits all) and will potentially put those from a lower socioeconomic background further behind in measures of health and wellness if there is not serious consideration of how to apply an equity lens to health funding going forward. The model is geared towards the general population.

NWAU

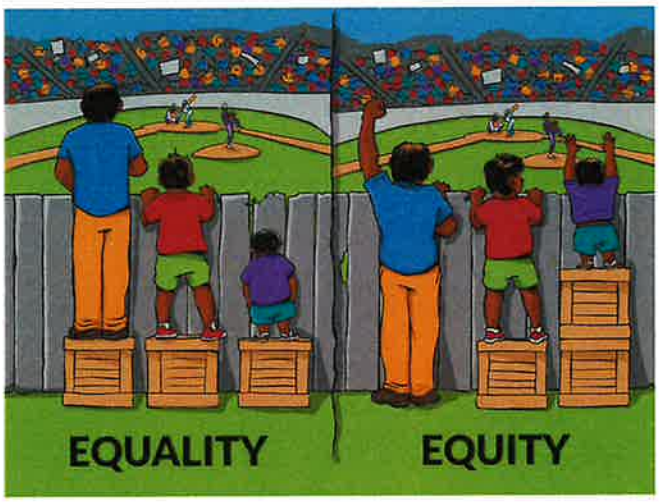
A National Weighted Activity Unit (NWAU) is a measure of health service activity expressed as a common unit. This allows it to be compared, as a general unit across different services department presentations, admissions or outpatient episodes, weighted for clinical complexity. Whilst it is useful in one sense to have a common unit across health it assumes that each person it is applied to is the same. The challenge with this assumption is it does not fully account for co-morbidities, disability, low health literacy, socio-economic disadvantage and general levels of psycho-social supports.

Admissions

The ABF model does not ensure the right services are accessed by the right people, nor does it create an environment for coordination between care providers and across the care continuum.

Queensland Health's Future Funding review stated the health benefits are not well captured under the ABF. Services under this model can lead to compartmentalisation of care and move away from patient centred care.

Under an ABF model funding is allocated on equality, while our costs are driven by inequity. There needs to be a consideration of technical efficiency and allocated efficiency in any funding model.



It was estimated in the 2020 'Estimating the Economic Burden of Low Health Literacy in the Blacktown Community in Sydney, Australia: A Population-Based Study' by Western Sydney University that the overall direct health care costs incurred due to Low Health Literacy (LHL) by chronic diseases in Blacktown alone was estimated to be between $8.5 million and $9.3 million in 2020 and projected to increase to $15.3 million and $16 million in 2030.

Non-English Speaking Background

Currently there is no data collected on every occasion of care or interaction with the health system for someone who is from a non-English speaking background and understandably there is no assessment or indicator for socioeconomic disadvantage or low health literacy during their

interaction. However, there are other indicators that we can reach for that show that it takes longer to treat people of non-English speaking background, who don't have access to strong primary care services and are therefore presenting to hospital with more complex health concerns that take longer to address.

In 2022/23 in WSLHD the average cost for an encounter for a person who did not utilise an interpreter was $954.13. The average cost for an encounter for a person who utilised an interpreter rises to $3,516. Whilst direct comparisons cannot be made given the limited utilisation of interpreter services, costing information within WSLHD reflects a significant cost burden for non-English speaking background patients. It is important to note that whilst 54 percent of the WSLHD population speak a language other than English at home, only 4 percent of admitted patients accessed interpreter services in 2022/23.

Western Sydney citizens have high levels of socioeconomic disadvantage, who also have complex health concerns and interact with our health system differently.

The Australian Institute of Health and Welfare found in the period 2021–22 people living in the second lowest socioeconomic (second most disadvantaged) areas were most likely to visit an ED, accounting for 23 percent of ED presentations (390 presentations per 1,000 people.) This was followed by people who lived in areas classified as being of lowest socioeconomic status – who presented at a rate of 378 presentations per 1,000 population.

Health Literacy

A study in 2020 by Western Sydney University 'Estimating the Economic Burden of Low Health Literacy in the Blacktown Community in Sydney, Australia: A Population-Based Study' found that 20 percent of Blacktown LGA residents reported low levels of active engagement with health care providers, with 14 percent reporting a limited understanding of the health information required to take action towards improving health or making health care decisions.

In communities that are prevalent in WSLHD there are higher rates of readmission to hospital particularly the Pasifika community.

28-day hospital readmission, top 12 COBs, 2016-17 to 2020-21

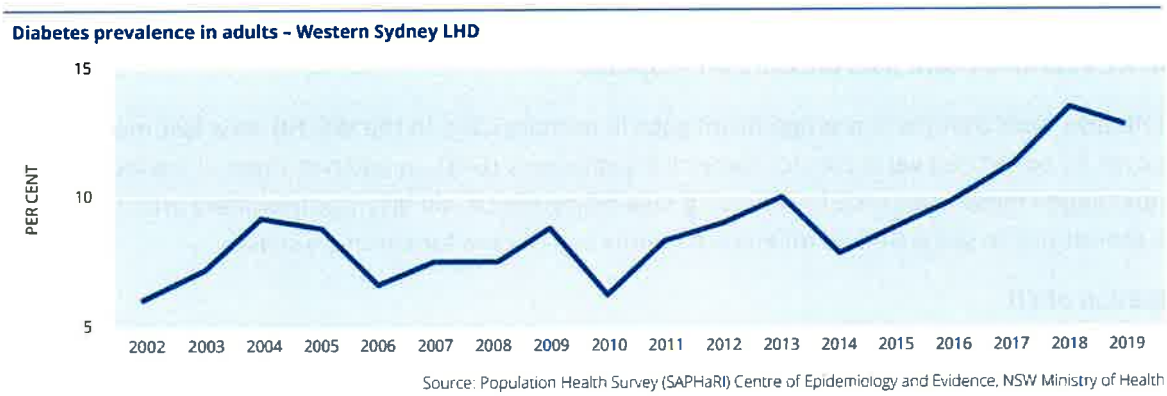
COB	Readmissions	% of admissions
Philippines	21,471	41.8
Lebanon	17,877	33.6
Samoa	14,703	78.1
Fiji	14,445	49.0
India	13,080	18.1
China	13,021	24.1
Tonga	10,186	73.7
New Zealand	8,822	30.1
England	8,244	20.9
Italy	6,256	31.1
Türkiye	6,250	37.0
Hong Kong	5,731	40.9

Aust born: 22.0% of admissions are readmitted within 28 days

Source: NSW Combined Admitted Patient Epidemiology Data, SAPHaRI, Centre for Epidemiology and Evidence, NSW Ministry of Health
Produced by Epidemiology and Health Analytics, WSLHD

Diabetes

In western Sydney, with its diverse population and areas of significant disadvantage, diabetes rates are substantially higher than national and state averages. Recent state-wide data presented in *Diabetes: A Case For Change* indicates that NSW rates of diabetes have increased to 11 percent and western Sydney rates are above this at approximately 12 percent and has been on the increase. We have an additional 38 percent of people living in the WSLHD catchment that are classified as high risk of Diabetes (Western Sydney Diabetes Annual Report 2022).



Chronic Disease

WSLHD has a dedicated Chronic & Complex Care service which provides healthcare to elderly people in the community with chronic health conditions. Clients are seen either in their home or in a Community Health Centre for a range of services by a range of health professionals including Nursing, Dietitians, Occupational Therapists, Physiotherapists, Podiatrists, Social Workers, Speech Pathologists and Aged Care Workers. WSLHD Chronic and Complex Services in WSLHD perform about 170,000 appointments a year. The service continues to experience increasing demand for services with an average of 825 new referrals each month in the 2022/23 financial year. This was a 13 percent increase in total referrals from the previous year.

Cardiovascular Disease

WSLHD also has a very high levels of Cardiovascular Disease (CVD) and the associated health burdens that brings. In particular Blacktown LGA has considerably higher rates of CVD-related hospitalisation,

CVD-related death, and diabetes-related hospitalisation than the State average, followed by Cumberland. Rates of CV risk factors such as smoking, hypertension, physical inactivity, obesity, and diabetes are particularly elevated in Blacktown and Cumberland.

	Blacktown	Cumberland	The Hills Shire	Parramatta	NSW
Life expectancy at birth (years), 2018*	Males: 80.4 Females: 84.6	Males: 81.3 Females: 86.2	Males: 82.9 Females: 85.2	Males: 82.7 Females: 87.1	Males: 81.5 Females: 85.7
Cardiometabolic indicators					
CVD hospital separations (2015/16-2019/20),* *DSER (per 100,000 persons)*	1,925.1	1,831.9	1,958.7	1,487.1	1,831.7
CVD deaths, (2015-19),* *DSER (per 100,000 persons)*	145.3	138.8	124.6	111.7	126.9
Diabetes hospital separations, (2015/16-2019/20),* *DSER (per 100,000 persons)*	4,917.9	4,523.9	3,249.3	3,326.3	3,687.2
Prevalence of CV risk factors					
Current smoking (%)**	14.2%	15.8%	7.7%	10.6%	11.4%
High Blood Pressure (%)**	23.2%	24.3%	22.5%	23.6%	23.1%
Insufficient Exercise (%) **	74.3%	76.3%	62.3%	66.7%	65.3%
Obesity(%)**	34.0%	28.4%	25.6%	23.0%	30.9%

* Epidemiology and Health Analytics (WSLHD). Social Health Atlas: Western Sydney Local Health District, ; 2023 [Available from: https://www.wslhd.health.nsw.gov.au/SocialHealthAtlas/.

**Heart Foundation. Interactive Australian Heart Maps 2023 [Available from: https://www.heartfoundation.org.au/health-professional-tools-(2)/interactive

Absence of primary care puts pressure on hospitals

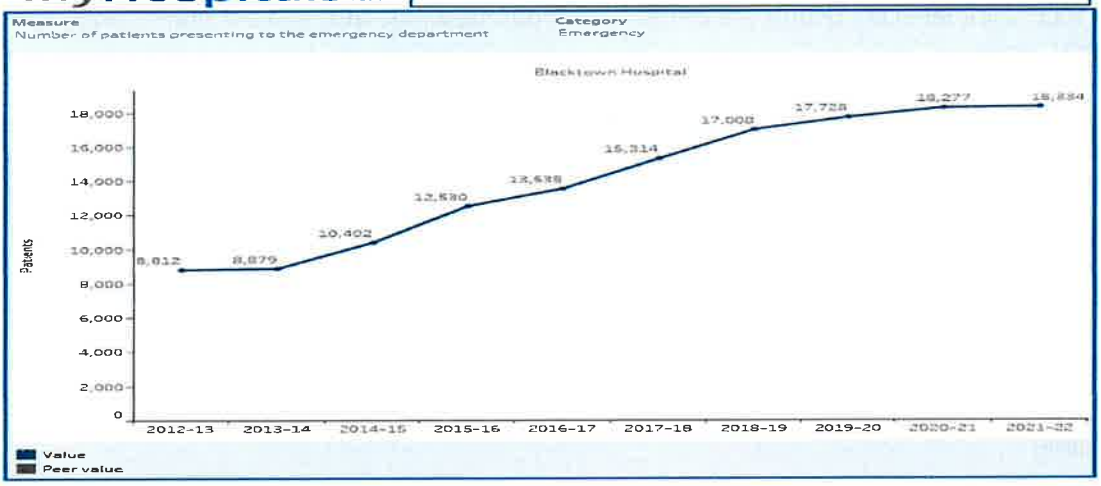
WSLHD also finds that there are significant gaps in primary care. In the WSLHD area last month there was over 90 advertised vacancies for General Practitioners (GPs). In addition there is a widely acknowledged move towards GPs removing bulk billing which will disproportionately affect those who cannot pay to see a GP and maintain a continuum of care for chronic diseases.

Utilisation of ED

There have been significant increases in presentations to emergency departments across WSLHD over the last 10 years which is indicative of more than population growth.

MyHospitals

Emergency department presentations, 2012–13 to 2021–22



Source AIHW National Non-admitted Patient Emergency Department Care Database

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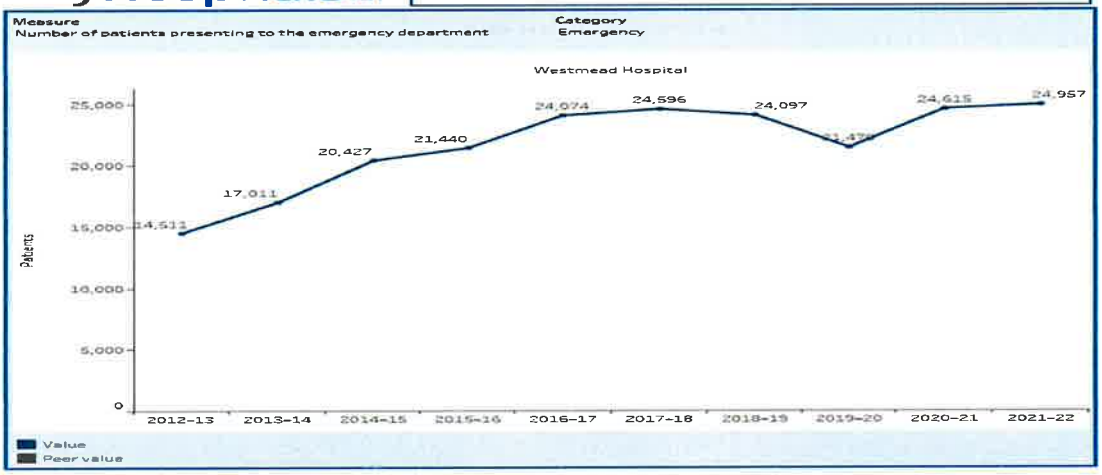
Emergency department presentations, 2012–13 to 2021–22



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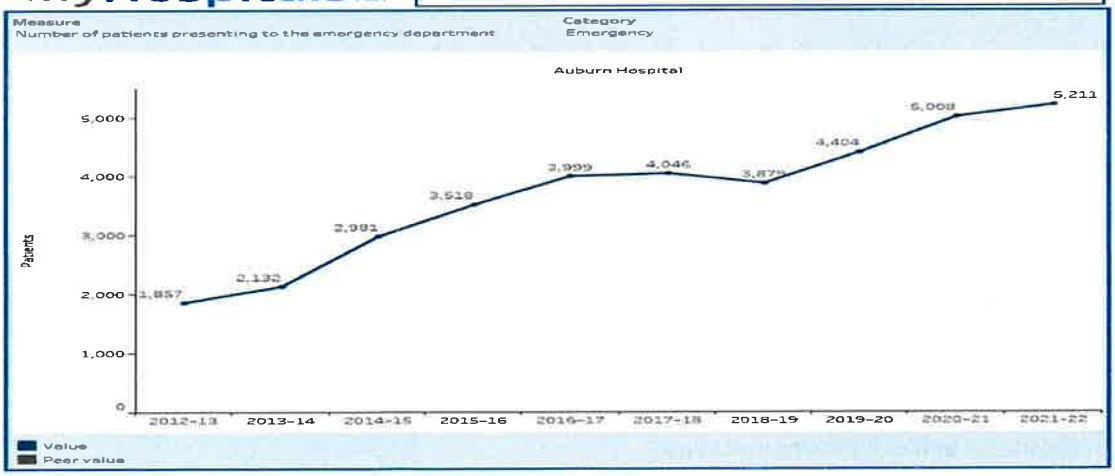

Source: AIHW National Non-admitted Patient Emergency Department Care Database.

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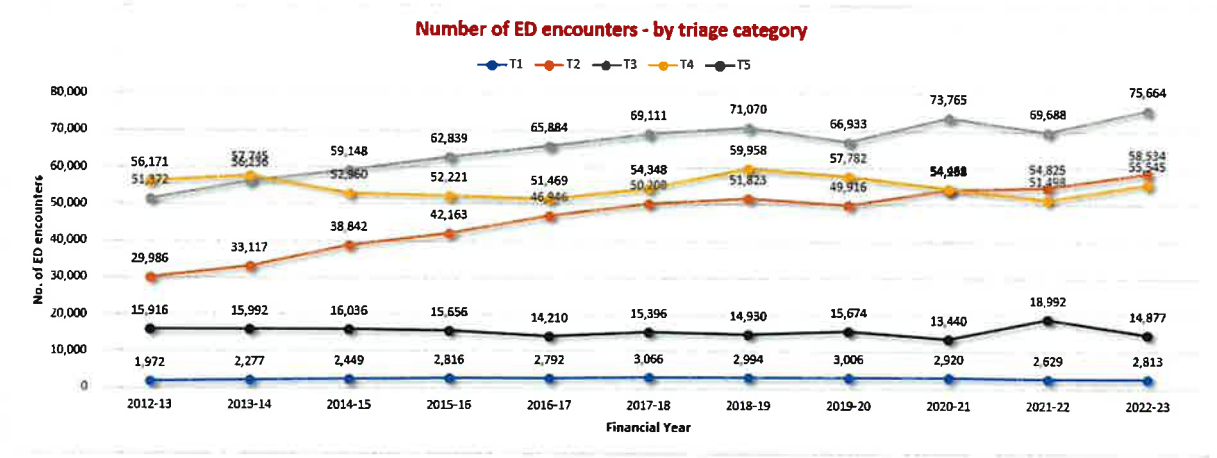
With increased attendances we are also seeing increased acuity. With people being increasingly unable to access primary care people are presenting to our hospitals, later and are more unwell by the time they reach us.

There has been a steady year on year increase especially in the number of Triage Category 2 and 3 presentations to WSLHD EDs over the last 10 years. People in Triage Category 2 are considered to be suffering from a critical illness or in very severe pain, this can include people with serious chest pains or having difficulty breathing, in Triage Category 3 people have a potentially life-threatening condition.

The graph below also shows a sharp increase after 2019/20 in WSLHD which is indicative that the lack of access to health care over the COVID-19 pandemic also drove people to access emergency care with health conditions that had significantly progressed and needed higher levels of time intensive care.



In refugee populations in western Sydney there is also a lack of trust in government services and in accessing assistance, including in the health system. This leads to a delay in accessing care which can impact on acuity when patients present to hospital.

Other sources are considering adjustments for population need

Queensland Health's Future Funding review

In 2020 there was a review conducted in Queensland to consider a funding model for Hospital and Health Services (HSSs) that supported a sustainable and effective health system and specifically a model that would drive equity of funding based on population need within specific regions. The design principles for the development of the review into funding models focussed strongly on equity noting that everyone should have a fair opportunity to attain their full health potential regardless of social, economic or demographic variables. A number of models were reviewed and it was suggested a hybrid model of Activity Based Funding (ABF) and Population Based Funding was the most appropriate to achieve these objectives.

Independent Health and Aged Care Pricing Authority (IHACPA)

The Pricing Framework for Australian Public Hospital Services 2023–24 (the Pricing Framework) is the key strategic document underpinning the National Efficient Price Determination and National

Efficient Cost Determination for the 2023–24 financial year. The accompanying Pricing Framework for Australian Public Hospital Services 2023–24 – Consultation Report details feedback received during the public consultation period held in June/July 2022. (Pricing Framework for Australian Public Hospital Services 2023–24 | Resources | IHACPA).

During the consultation period '*stakeholders supported investigation of an adjustment for socioeconomic status, noting the need to capture social determinants in health data and the potential influence of socioeconomic status on the costs of service delivery including inpatient lengths of stay*'.

Stakeholders also noted that '*the Indigenous adjustment should account for geographical, socioeconomic and cultural barriers to accessing care, potentially longer consultation times and higher rates of premature discharge or patients leaving against medical advice*'.

Recommendations

WSLHD believes the ABF model should take into account the impact of socio economic disadvantage on consumers and be weighted to allow appropriate care for those who need additional assistance in accessing heath care that is culturally appropriate and does not discriminate based on your socioeconomic status.

We acknowledge that the position put forward by WSLHD is not unique to our district and the trend of high levels of socio-economic disadvantage, a high burden of chronic health conditions and the significant costs of health care delivery in these environments extends across NSW. Measures to address funding sources being directed at people, communities and areas of greatest need is therefore suggested to encompass all who are affected.

There could be further consideration of a funding model where the first cut of the budget was based on population need. Funding could be allocated on a per capita basis adjusted for need for example for Aboriginal and Torres Straight Islander peoples and for socioeconomic status.

The adjustments could also take into account morbidity and premature death, rural and remote locality and incidents of chronic disease. After this first cut and layering of the budget, the allocation could then be distributed via the general ABF model.

A hybrid model could provide the benefits of Activity Based Funding for example technical efficiency, with the additional improvements of population based funding including better coordination of services across the entire health system and increased equity.

Thank you for considering my submission.

Yours sincerely

Graeme Loy

Chief Executive