New South Wales

Special Commission of Inquiry into Healthcare Funding

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THE UNIVERSITY OF SYDNEY

Menzies Centre for Health Policy and Economics

MENZIES CENTRE FOR HEALTH POLICY AND ECONOMICS

SUBMISION TO THE

Special Commission of Inquiry into Healthcare Funding

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Thank you for the opportunity to provide a submission to the Special Commission of Inquiry into Healthcare Funding (the Inquiry). This submission has been developed by staff of the Menzies Centre for Health Policy and Economics (MCHPE) based at the University of Sydney. The submission highlights recent contributions to the literature that relate to the Inquiry's terms of reference.

About the Menzies Centre for Health Policy and Economics

The MCHPE conducts health policy research, analysis, advice and education. The MCHPE focuses on improving public health outcomes through policy innovation and practical implementation. With a program of community engagement, the MCHPE plays an integral role in encouraging informed debate about how Australians can influence health policy to ensure that it is consistent with their values and priorities; and policies that are able to deliver safe, high-quality health care that is sustainable in the long term.

Our understanding of the Inquiry's role and its terms of reference

The Inquiry is tasked with identifying opportunities to deliver higher quality, more timely, and more accessible patient-centred care. The Inquiry will examine:

- the existing governance and accountability structure of NSW Health;
- the way NSW Health funds health services delivered in public hospitals and community settings; and
- strategies available to address escalating costs, limit wastage and identify areas of improvement in financial management.

The terms of reference (ToR) cover a wide range of important topics that are central to health system performance including equity, efficiency, and sustainability. We believe that the comprehensiveness of the ToR does impose a risk to the ultimate success of the Inquiry. Namely, that:

(i) it will have insufficient time and resources to deliver on the Government's remit; and

(ii) that it will distract from the central question of system-based thinking that is urgently required within the NSW health system.

In the timeframe available for public submissions, our contribution focuses on key aspects of the ToR that we believe we can provide evidence-based commentary on. Should any of the issues raised in our submission invoke further questions, we would welcome the opportunity to conduct further consultations and work alongside the Inquiry to provide further evidence– beyond this public consultation phase.

The complex mix of Commonwealth and State funding and implications for Local Health Districts

The signing of the National Health Reform Agreement (NHRA) in 2011 has led to fundamental changes in the way public hospitals are funded and the financial risks that jurisdictions face. The NHRA drives the contribution that the Commonwealth Government pays Local Hospital Districts (LHDs) on the basis of their activity and the National Efficient price (NEP).

Prior to the NHRA, Australian Health Care Agreements (formerly Medicare Agreements) determined the amount of the Commonwealth Government contribution to jurisdictions. These bi-lateral five-year agreements were essentially block-funded grants. Over various renditions, the method for calculating the block grant changed. However, over the five-year interval of these grants, jurisdictions faced considerable financial risk in terms of costs and activity. Namely, if costs, activity, or both rose over the course of the five-year interval there were limited instruments for the Commonwealth's contribution to increase accordingly.

The NHRA introduced activity-based funding (ABF) on a national basis and re-distributed some of the financial risks of funding public hospitals from jurisdictions to the Commonwealth. The Commonwealth Government's contribution is directly tied to each jurisdiction's activity as well as the cost per episode. Although for the latter,

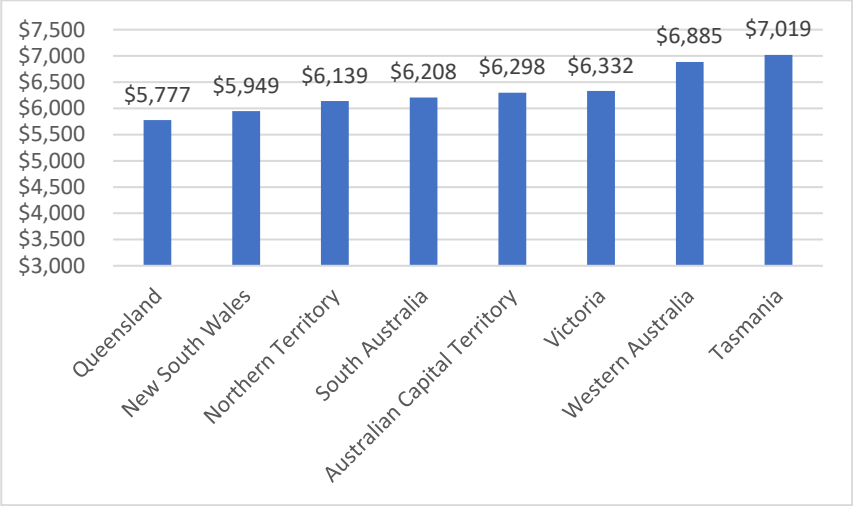
the Commonwealth's contribution is connected to the nationally determined efficient price per unit of hospital activity.

The national efficient price (NEP) is based on the average cost of delivering hospital activities – as collected on an annual basis through the National Hospital Costs Data Collection (NHCDC). The NEP is determined each year as a new wave of NHCDC data becomes available and is therefore responsive to cost changes. Whilst there is a three-year lag between the NHCDC and the NEP determination, costs are indexed to account for historical cost changes.

Average cost in NSW hospitals have, over recent years, been below the national average. As shown in Figure 1, average cost per national weighted activity unit (the metric used to measure hospital activity) in NSW is the second lowest nationally.

As the NEP is set on a national average basis, having lower than average cost implies that NSW does relatively well out of the NHRA. Compared to its cost base, the Commonwealth's contribution per unit of activity is relatively higher for NSW than for states like Western Australia and Tasmania. This also implies that states with higher-than-average costs have to contribute a greater proportion of their own funding towards the cost of public hospitals and states like Queensland NSW contribute a lower proportion. This is part of the intended design of the NHRA.

Figure 1: Average cost per national weighted activity unit – 2020-21



Source: IHACPA, 2023

The Commonwealth's contribution is directly tied to the amount of activity that takes place in each jurisdiction and also accounts for the complexity of that activity. However, the Commonwealth's contribution is set at 45% of the growth in volume and NEP. Jurisdictions contribute remaining costs. The NHRA therefore not only creates incentives for jurisdictions to ensure activity is delivered efficiently (at least cost per unit) but also, from a jurisdictional expenditure perspective, to contain activity growth.

As system managers, NSW Health sets its own efficient price for the activities that local hospital districts (LHDs) produce. Whilst there is no clear transparency on how this State Efficient Price (SEP) is set, it is well below the NEP. For example, in the 2022-23 financial year the SEP was $5,095 whereas the NEP was $5,797 per NWAU (Sydney LHD, 2022). Although other forms of funding are be provided, LHDs in NSW receive lower remuneration for their activity through the SEP than the NEP.

LHDs are therefore under considerable pressure to, not only manage the cost of care but also to generate revenue through other means as well as shift costs to other parts of the health system. For example, the 2022-23 Sydney Local Health Service agreement sets an own revenue target of around $300 million, or around 15% of its overall revenue. In turn, pursuing these targets may have unintended consequences on patients through less than optimum care or higher financial costs to the system.

Radiation oncology: a case study of unintended consequences

A good example of such potential unintended consequences are recent trends in radiation oncology. This is a field where there is significant interaction between public and private provision of care as well as state and federal financing with patients often caught up in the middle. In terms of provision, states and territories manage public facilities and patients most often face zero out of pocket costs when treated in such facilities – although there are media reports of some notable exceptions. Funding arrangements for these facilities are opaque and vary across the country but can include funding through the NHRA or through the MBS. When funded through the NHRA, the rules of Commonwealth and State contributions discussed above apply.

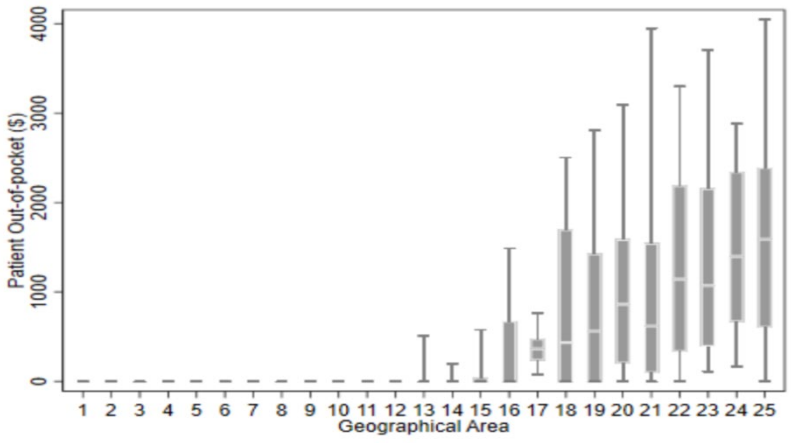
As most radiation oncology services are delivered on an outpatient basis – there is little private health insurance funding involved as private health insurance, through federal legislation, is specifically prohibited from funding any outpatient medical services that are funded under the Medicare Benefits Schedule (MBS). For patients treated at private facilities, the Commonwealth is the major source of funding through the MBS but patients also contribute through out of pocket (OOP) costs for any fees charged above the MBS benefit.

Recent trends across Australia have shown a greater reliance on privately provided radiation oncology. A 2020 report noted that the Commonwealth Government Radiation Oncology Grant Program has supported capital investment in the vast majority of facilities since 1988. Between 2013 and 2020, this program has supported 41 additional radiation oncology capital purchases across Australia. However, 39 of these have been in privately operated facilities. A further nine facilities were planned – eight of which are private, and one is public (DOH 2020).

With the increasing reliance on privately provided radiotherapy services, there is also a shift of funding source to the Commonwealth through MBS funding including the Extended Medicare Safety Net as well as to patients. Whilst the majority of MBS funded radiation oncology services are bulk billed, this rate has been falling over recent years. In NSW, the bulk-billing rate peaked in 2016-17 and stood at 81.2 per cent. In 2022-23, it has declined to 76.8 per cent. Over this same period, the average patient contribution for each service that is not bulk-billed has increased by 50 per cent. However, these averages do not provide the full picture of the burden that some patients face in meeting the cost of their radiation oncology care. Figure 2 shows the distribution of OOP cost that patients face over an episode of radiation oncology across 25 different geographic areas where public and private facilities operate across NSW (see Liu et al 2023 for further details).

The geographic areas on the right-hand side of Figure 2 are geographic areas with private provision whereas those on the left-hand side are geographic areas with publicly provided areas. The average radiation oncology cost for patients in some areas exceed $1000 for a 30-day episode of care and some face even higher costs. Alongside the growing reliance of private provision come greater concerns on the costs faced by patients.

Figure 2: Distribution of patient out-of-pocket costs per radiation oncology episode across NSW geographic areas



Source: (Liu et al., 2023)

Services provided by the State and Territories including public hospitals are a critical element in ensuring free universal access to high quality health care. In moving to alternative models of service provision with funding dependent on the MBS subsidy, it is important that there remains access to the service which does not involve copayments from patients.

Furthermore, greater outsourcing of services to the private sector also risks greater workforce competition for the public sector; particularly when the private sector can offer higher wages as a result of the different funding streams and rules.

Aligning the health care system to changing patients needs: the role of funding

The increasing prevalence of chronic diseases pose well recognised challenges to the Australian health care system to deliver greater continuity and integrated care across primary, acute and social care. In particular, the fractured nature of each sector and the lack of incentives across the federal public/private health funding divide have failed to put patients' needs at the centre. Various approaches, led by the federal government, to improving chronic disease care have been trialled and have been based on building a co-ordination role into primary care practice, essentially where a (non-GP) care co-ordinator is introduced to manage multidisciplinary services. Examples include the Coordinated Care Trials (1995-1999), the Diabetes Care Project (2011-2014) and, more recently, the Health Care Home trial (2017-2021).

Despite these efforts, it is reasonable to conclude that the various payment reforms that have been associated with these trials have failed to live up to expectations as evidenced by none of the approaches progressing beyond the trial phase. The payment sums involved have been relatively small compared to total practice revenue; substantial cost recovery on new programs has depended on reducing hospitalisations over the short term and this has proved difficult to achieve. In a collective sense, there has been no systematic effort to learn from these experiences in designing, implementing, evaluating and scaling up these trials to make them business as usual. This presents an enormous gap in Australia's health policy architecture because among the many trial failures there are also a number of examples where new models of care have shown positive health and economic outcomes (see for example Andrews et al 2009; Hamar et al 2013; Hamar et al 2018).

Given the fractured nature of Australia's health care funding and financing arrangements, the NHRA is a key platform that enables jurisdictions to come together to trial health care reform. The main focus of such reforms is to create the right incentives for all agents (providers, payers and patients) to use health care resources effectively, efficiently and equitably. Ultimately, the intent is to improve health outcomes and patient experiences, discourage unnecessary care and waste, reduce avoidable hospitalisations and encourage high quality care. More importantly it should not take a "burning platform", such as the emergence of COVID in 2019 and the telehealth response that occurred as a consequence, to drive the change necessary to meet the intent we have listed here.

The six long term reforms and other issues highlighted in the NHRA includes welcome references to evaluation, 'monitoring' and trials of new initiatives. Despite these references, there remain significant barriers that prevent the NHRA from meeting it aims. Health care reform cannot have a demonstrable impact on the objectives of the NHRA without rigorous evaluation based on the best available data and a thorough understanding of the root causes of seemingly persistent challenges.

These barriers have meant that reforms and programs are evaluated but do not create the new knowledge required to make initiatives sustainable and scalable. As such, Australia is often caught in a vicious cycle of policy trial and error. Rather than incrementally learning and building on the knowledge of successive policy initiatives, the trajectory of reform is lost. Whilst these issues are not unique to any state or territory, NSW can play an important role in a national conversation to address these issues; particularly when discussion on the next round of national health reform takes place before 2025. With its initiatives in value-based care and its Agency for Clinical Innovation, NSW is in a strong position to help bridge the gap between clinical innovation and funding reform at a national level which, in turn will bring benefits to NSW.

For the reasons outlined above, we support calls to establish a new national centre for innovative trials, evaluation and funding reform in health care. Such an institution could form a collaborative hub for Commonwealth, state and territory governments, Local Health Districts, Primary Health networks, universities and other stakeholders to develop ensure consistent and efficient access to data for research, connectiveness

between government and researchers and become a national centre of excellence for improving methodologies, disseminating research findings and working with stakeholders on the design and implementation of reform.

Should you require additional information or wish to discuss any of the issues raised in this submission, please do not hesitate to contact us.

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