New South Wales

Special Commission of Inquiry into Healthcare Funding

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to the NSW Special Commission of Inquiry into Healthcare Funding

A number of significant factors are required to work in unison to ensure the safe delivery of high quality, timely, equitable and accessible patient-centred care to the people of NSW. As the *Letters Patent* establishing the Inquiry identify, clinical staffing is one key issue. The funding of operational costs across health services, and particularly in public hospitals, is another key issue. I would like to draw the Inquiries attention to a third, often overlooked area- capital funding for the capacity and effective functioning of NSW public hospitals (hereafter known as hospitals). Capital aligned with clinical services enables patient access to appropriate care in effective and efficient hospitals, linked to primary care. This is solely a state responsibility under the National Health Reform Agreement 2020-2025(COAG (Council of Australian Governments) 2020).

Addressing:

A. The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future.

Funding

Funding is a primary enabler for health service delivery. Operational or recurrent costs of patient care in hospital are provided by shared Commonwealth-State arrangements under health agreements dating from 2011. The Independent Health and Aged Care Pricing Authority (IHACPA) identifies the efficient price based on patient cost data delivered from each hospital(IHACPA 2023b).

Activity based operational funding is patient centred. IHACPA funds hospitals for the efficient treatment of a patient according to their diagnosis related group (DRG) and complexity (weighting), and the specific costs associated with delivering care for 91-95% of patients. Other patients (5%-9%) are funded through block grants to hospitals(IHACPA 2023b).

Per patient costs covering patient medical, nursing and allied health and other staff salaries and on-costs, medical and other supplies, diagnostic services, operating and procedure room costs, emergency department costs, patient travel payments, hotel costs, corporate costs and depreciation and lease costs are collected and published(IHACPA 2023b). From that data on hospital separation costs IHACPA determines the Efficient Price to be paid for each patient according to the diagnosis group, state and complexity. Additional patient factors are considered in the final payment to enhance equity and access(IHACPA 2023a). Depreciation on capital is excluded from the DRG payment.

This is a highly accountable system of operational funding for hospitals based on the patient, the treatment and the outcome(Auditor General Australia 2019). The Administrator of the National Health Funding Pool reports that payments to the Local Health Networks (LHN) are monthly based on submitted data and estimates of demand. Payments are reported publicly(National Health Funding Body 2023).

Hospital patient operational funding is based on nationally consistent, audited, granular data providing an agreed understanding of costs at the hospital, regional and state level. A patient specific micro-economic efficiency economic model managed over 10 years has reduced the rate of increase in costs of hospital care through a transparent and detailed understanding of where the money goes per

patient treated(IHPA 2012; SCRGS Steering Committee for the Review of Government Service Provision 2023).

Since 2011 Australia has successfully adjusted the funding focus for hospitals from funding institutions to resourcing effective patient care through activity-based funding. Changing the method of operational funding to focus on the patient and the diagnosis with hospital efficiency has resulted in more financially sustainable public hospitals (Biggs 2018). NSW has retained an average cost per weighted separation of less than $5000 over the past 5 years.(SCRGS Steering Committee for the Review of Government Service Provision 2023)

Capital is the second critical element of hospital funding. In this context capital is usually defined as "the stock of durable goods used in the provision of hospital services (buildings, equipment, etc), and 'Investment' is the creation of these goods'' (Deeble 2002). So, for hospitals capital is hospital facilities, medical equipment and information and communications technologies, now including data management systems (ICT). While technically a capital item, the value of land is not included as capital in line with prevailing standards(Deeble 2002; IHACPA 2023b; Productivity Commission 2009, 2010; SCRGS Steering Committee for the Review of Government Service Provision 2023).

Unlike the **distribution** and reporting conventions of operational funding for hospitals, mechanisms for capital funding for hospitals remain largely unreformed since World War II. Capital funding remains solely the responsibility of each state.

However, on the recommendation of a national review of health and hospital services (NHHRC 2009),Commonwealth capital funding for hospitals was provided in partnership with the state between 2009 and 2014(Health and Hospitals Fund 2008-2012; Auditor- General Australia 2012). Since the HHF was defunded in 2014 (Hockey J (Australian Treasurer) 2014; Hockey 2014) Commonwealth funding for hospitals has been linked to elections. In 2018 the Morrison government announced the Community Health and Hospitals Program (CHHP). Announcements of capital funds for health projects were made by the Prime Minister with limited supporting health evidence. The CHHP was found to have allocated funds on a political basis for hospital and other projects but was '' undermined by deliberate breaches of the Commonwealth Grants Rules and Guidelines and failure to advise government where there was no legislative authority for grant expenditure'' (page 8(Auditor General Australia 2023). In addition to the concerns about inappropriate funding for some projects, there is concern that scarce capital funding for hospitals was denied to many areas where there were increasing patient requirements. Some winners, but many losers.

Within NSW, health facilities, medical equipment and other capital costs are prioritised at hospital, regional and on a statewide basis. An agreed list of priorities from hospitals, other health services, medical research, mental health, community health and aged care are advanced at the local level and are ranked and prioritised at the state level. The Minister, Treasurer and the Premier are involved in refining priorities.(Kerr and Hendrie 2018)

State Infrastructure Strategy is developed and agreed with Treasury. However, '' NSW Health's ability to effectively test and analyse its capital investment options has been compromised by unclear decision-making roles and responsibilities between its Health Infrastructure and the Ministry of Health agencies.''(NSW Auditor General 2020).

Above Treasury, the influence and decision making of political figures in determining the allocation of capital for hospitals in the budget process further weakens the relationship between effective clinical care, sustainability and equitable patient access to appropriate care. Insight into political influence on capital allocation for hospitals by the Member for Wagga Wagga and two former Premiers of NSW

identified an unedifying process with political objectives rather than clinical priorities. Funding for Wagga Wagga Base and Tumut Hospitals was achieved through badgering and political threats '' BEREJIKLIAN: I just spoke to Dom [Treasurer Dominic Perrottet] –and I said put the 140 in the budget. He goes no worries. He just does what I ask I ask him to – ''…'' BEREJIKLIAN: Can you text Brad [Brad Hazzard Minister for Health] – can you stress and text Brad cause I've–I've got you now got you the one seventy million in five minutes. You can at least get a few hundred thousand from Brad just keep texting him. If you keep bothering him, he'll fix it okay.'' (Page 167(Independent Commission Against Corruption 2023)

2022-23 Allocation of capital funds for hospitals

Rather than a system of funding to ensure continuous improvement in clinical services, diagnostic and treatment services, NSW has a prioritised project by project system for capital funding which means most hospitals fail to benefit from technological and service upgrades over 4 year tranches. For each community hospitals are the technological flagships of their health system, providing access to a range of diagnostic and treatment options not available elsewhere. So a failure to invest in hospital capacity and scope, often over a decade or more, restricts local patient access to appropriate care when they need it.

Of the 222 public hospitals in NSW only 47 (21%) had received an allocation of capital in 2022-23 Budget. Or viewed from another perspective, after capacity issues around COVID and at the threshold of major technological and climate change, almost 80% of NSW hospitals had no capital funding made available to them.

In the 2022-23 Budget there was there was $29.2 million in new hospital projects. These new capital funds for hospitals went to only 5% of all public hospitals in 2022-23. However, the funding was not generous. One project Eurobodalla received $11 million and the other 10 hospitals gained an average of $1.5 million each for redevelopments. This would not buy a house in many areas of Sydney, much less provide for complex clinical facilities and medical equipment.

By way of comparison, in 2022-23 the $29.2 million achieved for new hospital projects was less than the annual Public Private Partnership Cyclical Maintenance payments of $31.83 million(NSW Treasurer (M. Kean) 2022). Usually, election years are a time of higher capital allocation for new hospital projects as the intervening years tend to be lean.

Equity

Considering the investment in hospitals to enable future access to appropriate clinical care relative to the number of patients treated and the potential for access to hospital services, ratios of capital investment to patients (2020-21 data) and population were referenced(SCRGS Steering Committee for the Review of Government Service Provision 2023).

The capital allocation for hospitals has fallen to $77.46 per patient in 2022-23 from $ 386.00 in 2016-17(Table 9.4 (Kerr 2019; NSW Treasurer (M. Kean) 2022) . If the allocation is consider per resident of NSW the level of funding has fallen from $ 91.00 in 2016-17 to $18.11 per NSW resident in 2022-23 (Table 9.3(Kerr 2019; NSW Treasurer (M. Kean) 2022). Such low levels of funding will inhibit future access to acute care across the state as hospitals take between 5 and 10 years to build.

The Productivity Commissions most recent estimates of the cost of capital consumed in treating NSW patients was $1,309 per patient weighted separation. This figure is determined with NSW Health and Treasury based on depreciation of assets used in patient care. With 1 891 891 (2020-21)patient

separations the replacement cost for capital consumed would be many billions per annum[1](SCRGS Steering Committee for the Review of Government Service Provision 2023).

It is arguable that the level of investment in public hospitals is below other industry standards of capex to opex. Total investment in NSW public hospitals was $ 1.46 billion in 2022-23[2] while operating costs for hospitals were reported to be $16 billion(NSW Treasurer (M. Kean) 2022)

In a project by project funding method there is limited opportunity for detailed planning, sequential master planning of the site and on-going mechanical and technological development by regions, LHNs, or individual hospitals or services, as capital funding is uncertain and unreliable.

Restricting Capital

Across Australia the prioritised method of distribution of capital for investment in hospitals is knowingly restricting hospitals capacity, hospital bed numbers and hospital based diagnostic services. This is an acknowledged, traditional and widely held health financing tool to restrain the growth in recurrent expenditure on hospitals(Reddy 2022).

Yet capital investment for hospitals encompasses many labour cost saving, quality enhancing elements including information systems, communications technologies, robotics, data centres and digital medical records which the Productivity Commission identified as key to improving hospital efficiency at the microeconomic level (Productivity Commission 2015, 2017, 2023). When microeconomic efficiencies are achieved the cost benefits are replicated across the nearly 2 million patients seen each year and have positive flows to primary health and emergency services. AI is anticipated to have significant benefits for diagnosis and treatment specificity however funding for data collection and equitable health service delivery is not clearly evident in capital funding for hospitals.

Restricting the amount of capital to constrain beds, patient numbers and therefore staff numbers and operating costs has ethical, efficiency, political and efficacy issues(Deeble J. 2002; Kerr 2022; Marmot 2015; Reid 2023; Ahumada-Canale 2023).

Transparency

Reporting on capital for hospitals is not patient centred and is unrelated to clinical standards. Rather capital and investments are regarded as assets, independent of patient care.

Under the same capital funding system as NSW, corruption has also been reported in the distribution and use of capital funds for hospitals across Australia. The absence of transparency and reporting systems for capital has sustained inaccuracy(AIHW 2018; Productivity Commission 2009; Kerr 2015; AIHW 2017) and been tainted by corruption(WA Corruption and Crime Commission 2018;

[1] Using depreciation as an estimate of the capital for hospitals has a number of technical problems.

[2] The value of investment in hospitals was identified by listing each capital funding project in 2022-23 Budget Paper No 3 Infrastructure containing the word ''hospital''. This excluded capital funding for:

digital
drug and alcohol services
worker accommodation
car parks
medical research
pathology only
mental health only.

Independent Commission Against Corruption 2011; Independent Broad-based Anti-corruption Commission 2017)

There is no longer a national system of benchmarking and reporting on capital stocks, capital invested and technologies employed with which to compare the annual investment in NSW hospitals(Kerr 2015) or to evaluate the investment against patient outcomes and community health. Extended waiting lists have implications for economic performance that are not factored into decisions on capital funding for hospitals.

In summary the system of capital allocation is not patient centred, equitable or transparent. Unlike recurrent costs for patient care, capital is not allocated on a per patient-basis but allocated to a relatively small number of institutions each year at a rate below replacement levels.

Efficiency and effectiveness

Three components of efficiency may be relevant to this Inquiry allocative efficiency, technical efficiency and dynamic efficiency.

Of the three aspects of efficiency, allocative or distributive efficiency is the most relevant to capital allocation for acute care. Productive or technical efficiency and dynamic efficiency are dependent on allocative decisions.

Allocative efficiency for operating costs in hospitals has improved by patient-centred ABF funding by diagnosis group. However, not achieving allocative efficiency in capital funding has had negative effects on patient access to appropriate care. This is evidenced by poor patient access measured though surgical waiting lists growing beyond clinical standards, ambulance ramping and overcrowded Emergency Departments less able to meet treatment standards than previously, and ICU patients unable to be moved to hospital beds(AMA 2023; Visontay 2022; NSW Health Bureau of Health Information 2022; Jones 2022; Hannam 2022; Australasian College of Emergency Medicine 2022; AIHW 2022). In turn, this has negative effects on hospital efficiency and staff morale.

A sustainable health financing system manages planned and unplanned patient requirements. Dynamic efficiency examines how well systems for the distribution of capital respond to emerging risks for public hospitals. Clinical and technological change provide uncertainty posing financial risks and opportunities to improve efficiency, patient treatments and quality. Additional uncertainties from policy or funding changes, patient number increases, environmental challenges, epidemiological and population variations such as chronic disease compound the complexity(Duckett 2008a).

Evaluating investment strategies for policy responses to uncertainty, change and innovation encourages dynamic efficiency analysis(Tremblay 2012). Abel considered the role of capital, technological change, growth, uncertainty on efficiency at the national economic level(Abel et al. 1989). Duckett applied the theory specifically to health defining dynamic efficiency as the extent to which the healthcare system adapts to change and innovation (Duckett 2008b).

My research has found that the traditional prioritised project by project method of capital funding for hospitals systematically inhibits the adoption of evidence-based innovation and new technologies. (Ch 9.5.6(Kerr 2019) There was also evidence that not all hospitals benefit from technological improvements equally (Australian Senate Community Affairs and References Committee 2018; NSW Agency for Clinical Innovation 2014).

Conclusion on distribution of funds

Capital funding for healthcare competes with political priority programs, prisons, roads, schools and all other government programs for funding each year. Decisions on capital for hospitals are not made within the context of equitable patient access to appropriate care in efficient and effective hospitals. The method of capital funding does not align with the safe delivery of high quality, timely, equitable and accessible patient-centred care to the people of NSW.

My research identifies that there are significant costs to the people of NSW in poor healthcare access, costs to the state and Commonwealth from economic inefficiency and duplication resulting from the decision- making process for capital for NSW hospitals.

The most significant issue with the prioritised, restricted system of capital funding is that it has more communities who lose than win capital funding. A further consequence of the ''boom and bust'' character of capital funding for hospitals in NSW is that it is not aligned with continuous improvement to sustain contemporary clinical care, retain and provide training places for clinicians, effectively manage patient access or respond to the changing healthcare environment(Costello 2023; Sheperd 2023).

Project by project funding depending on political influence and Treasury priorities means specialised health project workforces are not sustained as developments are sporadic. This results in higher construction costs and longer project and construction times.

Funding future hospitals in NSW

Activity-based funding for the operational costs of hospitals based on the patient, the treatment and the diagnosis group has improved both the allocative and technical efficiency of NSW hospitals. It is arguable that the Commonwealth share of funding should match the funding of NSW on a 50:50 basis. As NSW hospitals and healthcare face major challenges over this decade from clinical and technological change, environmental physical issues, climate change challenges and financial sustainability challenges, the efficiency and effectiveness of health care cannot continue to be restricted by outmoded capital allocation methods.

Transforming healthcare and NSW hospitals will necessitate capital allocation processes to be aligned with clinical care and technological standards for equitable access for all residents of NSW, not just a lucky few. Payment of a per patient activity based capital amount based on clinical standards and clinical pathways offers an equitable way forward.

Shared 50:50 Commonwealth-state funding of a capital payment per diagnosis group will enable well planned continuous improvement of clinical services and capacity and adaptability for every NSW hospital simultaneously.

I recommend consideration of this option to the Special Commission of Inquiry and I would be pleased to answer any questions on capital allocation, capacity, health service planning and the health economics of hospital capital the Commission may have.

Your sincerely

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