New South Wales

Special Commission of Inquiry into Healthcare Funding

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Name: Ramsay Health Care Australia

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Ramsay Health Care

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

By email: submissions.hfi@specialcommission.nsw.gov.au

Dear Commissioner,

Ramsay Health Care Australia (RHCA) appreciates the opportunity to provide comment on *the Special Commission of Inquiry into Healthcare Funding*.

First and foremost, RHCA recognises the New South Wales (NSW) Governments efforts to establish the Special Commission to ensure there is appropriate and sustainable healthcare funding to provide the necessary healthcare services required for future generations.

RHCA is willing to engage with the Special Commission in the future to provide our unique perspectives, and in particular the important role the private health system plays in the delivery of healthcare services in Australia.

Ramsay Health Care Australia

At the outset, RHCA commenced with a mental health facility on Sydney's North Shore in 1964, and Paul Ramsay AO led the development of Australia's largest private mental health network. Now, RHCA is Australia's largest private operator, employing ≈34,000 staff, hosting 18,000 doctors and caring for over 1 million patients (including 100,000 public admissions) annually across a network of more than:

- 70 hospitals,
- 100 community-based pharmacies (hospital and retail),
- 15 community-based psychology practices,
- Hospital-in-the-home; and
- Virtual hospital services

contributing ≈$5 billion annually to the Australian economy.

Ramsay Health Care is also a global leader in healthcare, treating 9 million patients across 500+ locations in Australia, Europe, UK and Asia, including day surgeries, primary care clinics, diagnostic & imaging centres, mental health, rehabilitation services, pharmacies, in-home and community care.

Private Hospitals in Australia

The private hospital system is integral to the operation of the healthcare system, delivering two thirds of elective surgery and significant medical sub-acute work, particularly in regional areas. The private hospital system also provides 40% of hospitalisations and significant out-of-hospital presence; and the system is comparative to the size of many individual State health services (*Refer to Table 1 below*).

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Table 1. Overview of Hospitalisations (Australia vs New South Wales)

	New South Wales		National	
	Episodes		Episodes	
PHI Patients in Public Hospitals	295,348	21%	719,695	16%
PHI Patients in Private Hospitals	1,117,278	79%	3,822,406	84%
	1,412,626		4,542,101	
Public Patients in Public Hospitals	1,415,259	96%	5,955,011	95%
Public Patients in Private Hospitals	55,619	4%	303,844	5%
	1,470,878		6,258,855	
ALL Patients Public Hospitals	1,768,912	57%	6,837,095	59%
ALL Patients Private Hospitals	1,359,031	43%	4,756,356	41%
	3,127,943		11,593,451	

NSW Health treats a larger proportion of private health insurance patients than the National average and also utilises less of the private hospital sector's trained workforce and infrastructure to treat public patients than the National average (source data: *AIHW 7-admitted-patient-care-2021-22-tables-costs-and-funding*).

Furthermore, the private hospital system provides a significant number of specific interventions (by ACHI chapter):

- 78% of nervous system procedures;
- 72% of eye procedures and adnexa;
- 60% of musculoskeletal system procedures; and
- 49% of cardiovascular system procedures.

Recommendations:

1. The Special Commission of Inquiry into Healthcare Funding adequately ensures it investigates all sectors (private, public, not-for-profit) across all issues (I.e., funding, workforce, incentives, capital etc) within NSW healthcare industry.

Healthcare Spending

The Intergenerational Report 2023 highlights Australian Government health spending is projected to grow from 4.2 per cent of GDP 2022-23 to 6.2 per cent of GDP in 2062-63. This spending relates to a range of programs and services including the:

- Medicare Benefits Schedule;
- Pharmaceutical Benefits Scheme;
- National Health Reform Agreement;
- Rebates to subsidise the cost of private health insurance; and
- Healthcare services to veterans via White and Gold Care arrangements.

There are also several cost drivers influencing the exponential growth in health spending including:

- Demographic Factors
    - Population growth;
    - Aging and older population; and
    - Clinical epidemiology;
- Non-Demographic Factors
    - Increased demand for health services;
    - Access the highest standards of care; and
    - Funding of new technologies (rapid technological innovation).

Interestingly, the Intergenerational Report anticipates real total health spending for those aged over 65 years is expected to increase around six-fold (accounts for 40 per cent of spending yet only 16 per cent of the population), and for those aged over 85 years, spending is expected to increase nine-fold. It is clear spending will depend on the complexity and acuity of health conditions experienced by the health system and how health system usage may vary over the longer term relative to historical trends.

Similarly, the Future Health Guiding the next decade of care in NSW 2022-2032 Report outlines similar trajectories to the Intergenerational Report as well as specific issues to the NSW healthcare system. It is projected activity across the NSW health system will nearly double by 2031 if today's trends in disease and demand continue. Factors influencing this demand include:

- Increase in demand (beyond population growth);
- Changing demographics (aging population); and
- Growing complexity (multiple chronic conditions).

Unsurprisingly, the Report notes two-thirds of current disease burden in NSW is due to conditions that could be managed outside a hospital setting. In NSW, health is expected to remain the largest category of recurrent State spending, rising at an annual rate of 5.4 per cent on average and growing from 29 per cent of total expenses in 2018-19 to 38 per cent by 2060-61, with currently:

- 85 per cent concentrated in hospitals (outpatient, ambulatory, emergency, inpatient and sub-acute/rehabilitation care);
- 10 per cent for prevention and promotion; and
- 5 per cent for community and other care settings.

Recommendations:

2. The Special Commission of Inquiry into Healthcare Funding considers future public healthcare spending projections and potential opportunities beyond the current health system structures and systems (I.e., consider the role of the private system more broadly).

Funding

RHCA encourages all governments to undertake a more holistic and whole-of-system approach to address healthcare funding, including private health insurance. A comprehensive review of all policy levers and regulations, in addition to lateral and blue-sky thinking, to evaluate the effectiveness of the current frameworks and operationalisation on policy priorities.

From a private healthcare perspective, RHCA warns governments must not prioritise the affordability of private health insurance at the expense of worsening private hospital sustainability. The private hospital sector continues to face sustainability challenges, with profitability dropping from ≈90% of hospital businesses (FY20) to ≈30% (FY22).

	2019-20	2020-21	2021-22
Hospitals (private)	88.9	93.0	30.1
Medical and other health care services (private)	91.9	92.5	90.5
Residential care services (private)	72.4	48.5	43.1
Social assistance services (private)	85.7	75.4	77.8
Total health care and social assistance (private)	90.5	89.1	87.2
Total selected industries	80.3	81.1	79.9

Table 1 Source: ABS (2023) Australian Industry, 2021-22, *Australian Industry by subdivision*, released on 26 May 2023

Like many European countries, private hospitals in Australia have a significant role in the provision of healthcare to all patients (whether funded wholly or partly by Governments) delivering 60% of elective surgery and 40% of all hospital admissions.

Unlike those European countries where the public sector has sophisticated purchasing arrangements across both the private and public hospital sectors, the private hospital sector in Australia is considered more like an adjunct to the public hospital sector and traditionally not contemplated when setting policy.

<u>COVID-19 and the Australian Private Hospital System</u>

At the end of March 2020, the Australian Government made a landmark decision to enlist the support of the private hospital system to ensure the nation's healthcare system had capacity to respond to the COVID-19 pandemic.

The Australian Government requested the private hospital system provide assistant by temporarily integrating into Australia's public healthcare system, which required making infrastructure, essential equipment, supplies, workforce and additional resources available to the Commonwealth, State and Territory Government.

RHCA entered into partnership agreements with the New South Wales, Queensland, Victoria and Western Australia Government's, maintaining full capacity while also making its facilities and resources available.

Example: Between February 2020 and September 2020, RHCA played an active role in Australia's COVID-19 health response including:

- Workforce and Beds – RHCA added more than 30,000 RHCA staff and 9,000 beds to Australia's public health system, with *no RHCA staff stood down;*
- Training – provided free training and resources to external aged care providers in New South Wales and Queensland to equip them with the skills to minimise the risk of COVID-19 outbreaks in their facilities;
- Pharmacy – Ramsay Pharmacy administered almost 17,000 flu vaccinations (400% increase from 2019);
- Public Patients – Almost 87,000 public patients were admitted to RHCA facilities, with more than 28,000 procedures across a range of specialities were performed on these patients;
- Community Services – Ramsay Pharmacy supported the Australian Government's Home Medicines Service, delivering medications to the homes of more than 3,8000 vulnerable people; and
- Local Business – RHCA supported at least 42 struggling Australian businesses during lockdown by purchasing food from restaurants, cafes, suppliers, bakeries for workers.

National Partnership on COVID-19 Response (Viability Agreement)

With an understanding COVID-19 brought with it unprecedented times, it was necessary to establish arrangements, including funding relatively quickly. However, it is paramount National Cabinet (includes the Commonwealth, State and Territory Government's) review such arrangements and processes to ensure these are suitable for future significant health events, most notably the National Partnership on COVID-19 Response (Viability Agreement).

Example: In NSW, RHCA supported NSW Health with the roll out of the mass administration of COVID-19 vaccinations, including enlisting nurses and pharmacists to work in the mass vaccination hubs, special hotel accommodation and public hospitals. This ensured NSW Health facilities remained operational. RHCA deployed approximately 400 staff across the state, including remote areas, such as Dubbo, Broken Hill and Wilcannia.

The Viability Agreement only 'compensated' operators when they were in earnings before interest and taxes (EBIT) loss across a quarter, which had many practical effects including:

- Significant inequity between "Not for Profit" (NFP) and "For Profit" Operators: NFPs were made whole (did not share costs of the response) whereas "For Profit" were significantly financially weakened bearing majority of costs themselves (maintain staff despite significant reduction in activity due to restrictions on elective surgery);
- Significant inequity between Group and Individual Operators: Individual operators were not impacted and could claim any loses, whereas group operators who experienced EBIT losses in one site but continued to make a profit (even reduced) in other sites were penalised (reduce claim across the Group);

- Quarterly by Operator vs Facility by month reconciliation: Private profits covered significant public imposed costs, weakening the very system the Viability Agreements were meant to support (E.g. Quarterly by Operator in QLD, RHCA received $nil);
- Opportunity cost of resources restricted by Public Health Orders: Left idle and not utilised by the public system (waste);
- Instability: The unpredictability of the operating environment meant demand planning and performance optimisation was difficult resulting in inefficient operations, with an inability to make performance improvements;
- Viability of the healthcare system: Continual disruption of private hospital operations and / or de-prioritisation of private patient care to public patients reduces the value proposition of private healthcare, noting the private system complements the public system and reduces the burden on the public hospital system;
- Cost versus Activity: Cost of maintaining staff (and other resources) at historical levels notwithstanding reductions in activity (E.g., % activity reduction x recoverable costs x (1 + EBIT Margin %));
- Lost doctors: Where restrictions impacted some operators (not all) but allowed others to operate (relatively unrestricted), doctors left to operate in hospitals not supporting the governments COVID-19 response (E.g., NSW restricted 20 hospitals (7 were RHCA);
- Social distancing impacts the efficiency and effectiveness of group therapies: Requirements to socially distance and wear face masks, reduced group sizes for rehabilitation and mental health, discouraging patients to seek therapy needed;
- Competition: Private Health Insurers amassed significant profits during the pandemic by paying significantly less claims and are using these funds to vertically integrate to enter the system, placing more pressure on incumbent private hospitals; and
- JobKeeper: These payments were forgone as RHCA did not qualify and were required to continue to pay tax.

Example: Of the $1.7 billion in 2020-2021 to ensure the ongoing viability of private hospitals, nationally, RHCA only received $65 million (3.8%), with $11.5 million in NSW through the various Viability Agreements despite RHCA's market share being ≈25% in Australia.

RHC **emphasises** there is opportunity to enhance this model as part of contingency planning for future significant health events. As mentioned, RHCA is a global operator, and similar viability agreements were in place overseas, with similar lessons to be learnt. Throughout COVID-19, there were discussions to move to "By Group By Quarter" which would result in Government making no contributions to the costs of the response and leaving operators to front all costs.

Post COVID-19 Lessons Learnt

RHC **recommends** governments analyse and understand the lessons learnt from COVID-19. Given RHCA is a global operator, valuable lessons can be learnt from RHCA's overseas operations to support domestic capabilities and planning for future significant health events. RHCA engaged with its hospitals in France, Italy, the UK and the Nordics to share and adopt best practice.

Furthermore, RHCA is **strongly concerned** with budgetary measures being announced by governments throughout Australia to recoup money spent to support businesses and the economy during COVID-19 (I.e., The Victorian Government's 'COVID-19 Debt Levy'). Whether a provider is private, charitable, or publicly owned, COVID-19 proved all operators were part of the Australian healthcare system. Such new budgetary measures are only significantly impacting the private hospital system which stands in stark contrast to the very efforts all operators made as a united response to COVID-19.

Taxes and Levies

As mentioned, private hospitals are facing sustainability challenges, with many cost drivers influencing these challenges. RHCA's cost base is >10% higher than public and not-for-profit hospitals as RHCA offers other 'benefits' to compete with FBT exempt hospitals and pay additional taxes, which meaningfully increase the costs of healthcare as a % of GDP and PHI premiums.

In comparison, private health insurers have strong balance sheets, with profitability increasing from ≈60% (FY20) to ≈94% (FY22), in addition to >$1 billion in COVID-19 deferred claims costs yet to be released and assets covering liabilities twice-over.

It is crucial all governments work to ensure fairer tax treatment is provided to profit operators. On top of existing payroll tax differences for not-for-profits, RHCA faces increasing taxes from state based mental health and COVID-19 levies. In FY22, RHCA paid $272 million in taxes, including $136 million in income tax, $124 million in payroll tax and a further $12 million in new State levies.

These additional taxes and levies impact RHCA's ability to continue to invest in future healthcare infrastructure and workforce for local communities given it is hindered by the unfavourable tax treatment as well as with private health insurers passing on indexation well below costs and their own premium increases.

Furthermore, RHCA does not have a tax exemption status (unlike religious and not-for-profit entities and employees), meaning operating costs are higher than most other operators. As tax concessions are applied inconsistently across the healthcare sector, RHCA employees are not entitled to the $17,000 FBT exemption. There are instances where not-for-profits are also altering their status to a Public Benevolent Institution, increasing their FBT exemption rate from $17,000 to $30,000, placing further cost pressures on profit providers.

The Productivity Commission, *Contribution of the Not-for-Profit Sector, January 2010 asked if FBT exemption placed 'for-profit' organisations at a disadvantage?* noted:

> '... in a small number of areas, notably hospitals, FBT arrangements confer advantage to both not for profits (NFP) and public hospitals. The concession allows them to offer staff, often considerable, FBT benefits that commercial hospitals cannot, despite facing the same funding arrangements. In relation to hospitals, the FBT benefits do impact on competitive neutrality.'

There are also examples of companies whose employees aren't entitled to the FBT exemption creating separate legal entities that are FBT exempt, through which people are then employed to 'work around' this unfair tax on nurses.

All governments recognise the pandemic and subsequent years illustrated the healthcare system works more effectively and efficiently when both the private and public healthcare system coordinate and collaborate, removing unnecessary barriers.

Recommendations:

3. The Special Commission of Inquiry into Healthcare Funding considers the private hospital system in relation to the COVID-19 commercial agreements, including future guidance responding to pandemic or other contingency planning to ensure there is consistency and such agreements better reflect the financial operations of all operators;
4. The Special Commission of Inquiry into Healthcare Funding analyses and understands the lessons learnt, both domestically and internationally to ensure future agreements are fit-for-purpose;
5. The Special Commission of Inquiry into Healthcare Funding investigates and determines whether post COVID-19 budgetary measures significantly impact only a portion of the Australian healthcare system, noting their efforts during COVID-19;
6. The Special Commission of Inquiry into Healthcare Funding considers the tax and levy impacts on the ability for profit operators to provide public healthcare services at a public cost.

Public and Private Collaboration

RHCA **acknowledges** engagement with states and territories will need to remain but notes a national conversation would support progressing local planning and service delivery. However, as a national organisation, RHCA is required to engage with all states and territories it operates in, which can be time consuming and duplicative (with common issues across the board) when it relates to service planning, healthcare delivery and the contracting of service management.

Unlike other private hospital operators, RHCA is a national operator and continues to support states to reduce escalating waitlists through ongoing discussions at the state and local level. Since 2019, RHCA has cared for 651,634 public admissions, mostly in medical, followed by surgical, renal, obstetrics and psychiatry.

Example: In NSW, RHCA provides approximately 7,300 procedures each year, with several public contracts. There is also a signed state-wide agreement with NSW Health, forecast to admit 5,000 public patients in surgical, medical and subacute specialities.

It is clear the private hospital system in Australia makes a significant contribution to the overarching healthcare system by providing a range of services and takes pressure off the public healthcare system, enabling Australians to receive the necessary healthcare to address their healthcare needs.

Service Planning and Delivery

RHCA **urges** governments to consider advising their respective Departments of Health and Local Health Networks to ensure their local private hospital provider are a part of service planning to meet the future healthcare needs of the community. Opportunities remain ongoing to increase private and public partnerships, particularly to reduce elective surgery wait times in the public sector.

RHCA continues to build on its strong relationships with the Australian, State and Territory Departments of Health, and demonstrates the benefits of Australia's model of care, providing a strong standard of healthcare and choice, whilst delivering benefits to Australians. Unfortunately, our partnership with many NSW Local Health Districts to address elective surgery has ceased, following notice and advice that the NSW Budget cannot cover these costs. This will ultimately exacerbate waitlists, as demand for public services continue to exceed historical capacity.

Example: In New South Wales, Ramsay Clinic Thirroul has a 12-month partnership with NSW Health (*agreement being finalised*) to provide services, including 1 inpatient bed over 365 days, and 30 8-week day program admissions. Furthermore, Ramsay Clinic Macarthur has a partnership with South Western Sydney Local Health District to provide services, including on demand general adult mental health beds to provide overflow provision to Campbeltown hospital. There is also a further agreement to provide 3 inpatient beds for youth and eating disorders and DBT, anxiety and eating disorder day programs (DBT 14-16 years, DBT 18-24 years, eating disorders).

Workforce

Preferential employment terms that exclude privately employed nurses (such as scholarships and subsidies to work in the Australian public healthcare system) drains workforce from private hospitals and aged care facilities, which will inevitably increase the unmet demand on public hospitals.

Example: The NSW Government's measure regarding $12,000 study subsidies ($8,000 for students already enrolled) for 2,000 public healthcare workers should be applicable to all healthcare workers (public, private, residential aged care, not-for-profit). This will ensure the system can continue to provide high quality, safe and effective care to all NSW residents, regardless of the setting in which they are being treated.

RHC **recommends** there is an opportunity to plan and coordinate training, recruitment and clinical care delivery collectively, across both the private and public healthcare systems. For example, there is an opportunity to open educational activities which occur in large metropolitan public hospitals to all training doctors in the private sector, further supporting more places for training in the private sector.

Furthermore, better alignment can be created by working collaboratively to address Career Medical Officer (CMO) education, recruitment and rostering. Both sectors face similar issues, with a resultant inconsistent level of middle management care. A dedicated NSW CMO database, with consistent pay schedules across both sectors with a shared education experience may be a solution. This will improve efficiency, safety and effectiveness of the Australian blended public & private healthcare system.

There are also opportunities to further build the NSW public and private medical workforce, by increasing Registrar accredited training positions in the private sector. The private sector provides care to a large proportion of patients, particularly in certain specialities, with Ears, Nose and Throat, Gastroenterology and Ophthalmology being nearly exclusively private. By increasing these numbers, the private sector could support NSW Health train more specialists, thus providing the future medical workforce.

Separetly, governments can seek to increase funding for Intern and PGY2 doctors in the private sector, to match the increase in Registrar positions in the private sector. This will recreate the 'team' approach to private sector medicine, matching the training experience enjoyed in the public sector, for all training doctors.

Example: In NSW, RHCA has approximately 20 Specialist Training Program (STP) funded Registrar training positions. However, RHCA has the capacity to train between 40-50 STP Registrars, just in NSW. Separately, RHCA also trains several unfunded Registrars, that work in the capacity of a Career Medical Officer (CMO) or surgical assists.

Capital

RHC **emphasises** the private system has significantly invested capital (which has latent capacity) and has access to a significant workforce. RHCA encourages governments to partner with the private system to support delivering essential services given the private system has the capital and workforce to address Government dilemmas, such as mental health and elective surgery demands.

As mentioned, opportunities remain ongoing to increase private and public partnerships, particularly to reduce public elective surgery wait lists. With available private hospital capital, unmet public demand for healthcare services can be addressed. There is opportunity for the public healthcare system to utilise existing capital, rather than invest significant funding on in new capital, when health trends are moving away from hospitalisations. For example, the NSW Government has committed $11.9 billion in additional healthcare infrastructure, which does not consider operational costs.

Example: In NSW, Wollongong Private Hospital has a strong partnership with the Illawarra Shoalhaven Local Health District. Pre COVID-19, there were several existing arrangements to support the public healthcare system including urology services. Post COVID-19, an agreement was established to commence cardiac surgery, with more than 250 public patients treated in 2022 who would otherwise have needed to travel to Sydney for this procedure.

Recommendations:

7. The Special Commission of Inquiry into Healthcare Funding determines whether the private hospital system should be a part of service planning to ensure appropriate capital and investment (not duplication) is invested in communities;
8. The Special Commission of Inquiry into Healthcare Funding investigates the benefits of the NSW Government utilising existing private workforce and capital, including incentives to facilitate governments purchasing services off the private system.

Digital Health

RHC **strongly encourages** governments to partner with the private hospital system, noting RHCA has invested in recruitment and education to build Australia's leading private digital and data healthcare workforce. This team is leveraging learnings from within the healthcare industry (locally and internationally) and pivoting digital first and digital native principles from other industries.

RHCA is in a strong position to advise and support all governments on their digital endeavours, including virtual hospital-in-the-home services, electronic medical record of the future and our global digi-physical expertise, as RHCA expedite its significant investment in the development of an Electronic Health Record - the first private healthcare provider to deploy an integrated digital solution at scale in Australia.

All governments (Commonwealth, State and Territory) are investing a significant amount of capital into digital health initiatives. Interestingly, the National Health Reform Agreement (NHRA) incentivises state and territory governments to invest in digital health, whereas the private hospital system is not incentivised by private health insurers.

However, this investment will stifle and will also limit the goal to achieve interoperability across various healthcare systems. As governments would be aware, digital investment is quite significant, with limited returns on investments which will encumber the goal of interoperability and makes it a challenge for private operators to make the necessary investments. Furthermore, it is much harder for small and independent operators to achieve efficiencies in pricing, customisation and implementation compared to a more coordinated approach across the entire healthcare system which would support interoperability, reduce duplication and waste.

RHC **recommends** governments consider incentives to support the uptake of digitisation within the private healthcare system, such as tax incentives or budgetary measures to support investment. There is opportunity to improve sharing of clinical data between public and private systems, which will assist in both education and training of clinicians as well as to treat public patients in private hospitals (or vice versa). There is no reason as to why governments should only invest in specific components of the healthcare system, when the private hospital system continues to manage two-thirds of elective surgery and has strong relationships with the primary care system.

Recommendations:

9. The Special Commission of Inquiry into Healthcare Funding investigates whether current Digital Health Strategies and Plans consider the private health sector;
10. The Special Commission of Inquiry into Healthcare Funding considers whether it is appropriate to establish separate funding for private hospitals to digitise.

The Future of Private Healthcare in Australia

Given the ongoing challenges with the Australian healthcare system, RHCA **strongly recommends** governments consider alternate models of funding which can be applicable to all sectors within the healthcare system (public, private, not-for-profit). RHCA's patient profile has started to shift in terms of types of admissions, with 77 per cent private, 12 per cent public, 5 percent self-funded and 4 per cent Defence/DVA and 2 per cent other. This shift in patient admissions suggests alternate models of funding must be considered, like other models being implemented overseas.

Virtual Care Services – Ramsay Connect

Ramsay Connect is a provider of multi-disciplinary community, in-home (home-based) and remote healthcare services for patients transitioning home after hospital or require additional support after treatment. These services provide consumers with an integrated, accessible, and flexible healthcare experience through patient-first, innovative and financially sustainable healthcare models which are clinically safe, effective and often socially desirable alternatives to hospital-based care. Ramsay Connect co-design and deliver services with both the public and private healthcare systems. Offers include:

- Hospital Substitution Programs – such as Hospital Care at Home, Reconditioning at Home and Rehabilitation Care at Home which allows patients to transition out of hospital much sooner and receive individualised care in the comfort and safety of their own home;
- Survivorship Programs – supports patients after active cancer treatment through a clinician-led, personalised program through coaching, psychosocial support and managing co-morbidities; and
- Virtual Home Health Service – supports patients with chronic disease through a nurse-led disease management service using advanced technology to avoid and/or reduce rates of hospitalisation.

Ramsay Connect has been significantly involved with the public healthcare system, focusing on:

- Reducing rates of potentially preventable hospitalisations;
- Co-designing service solutions to meet local healthcare needs;
- Managing the demand on the public healthcare system; and
- Identifying private patients in public facilities who can access non-admitted private services.

Example: In South Australia, Ramsay Connect has co-designed a virtual care model with Central Adelaide Local Health District for people with chronic respiratory conditions. This virtually enabled service supports people manage their conditions at home through a nurse-led model of care utilising remote monitoring technology. Importantly, the service integrates with the tertiary sector's specialist clinics and the consumers general practitioner.

This example highlights excellent collaboration between the public and private system, utilising expert clinical input, human-centred design capabilities and the ability for the private system to invest in the requisite technology and operational capabilities. It also identified the types of outcomes-based funding mechanisms that would support such a service to deliver value for consumers, clinicians and the tertiary and primary healthcare systems.

> Example: In Victoria, Ramsay Connect in partnership with Ramsay Health Care and the Victorian Department of Health and Human Services are working on the implementation of comprehensive care pathways to reduce the state's elective surgery waitlists. The services encompass post-surgical care in the consumer's home, ensuring optimal recovery and reducing the burden on the state's ambulatory and outpatient services post-operatively.

The collaboration identified the public and private system working together can improve access to specialist clinicians in areas with significant issues relating to equity of access to healthcare, whilst enabling a model to be delivered outside the traditional ABF mechanism that perversely disincentivises public providers to innovate efficiently in this space.

However, this collaboration at a local level between the public and private system can be hindered by bureaucratic processes, limiting new and innovative models of care to be provided to Australians to treat their healthcare needs. The following is an example of the public and private system working together to manage a problem for regional communities yet was stymied by a centralised decision of the state health department.

> Example: In Queensland, Ramsay Connect has worked with the Wide Bay Hospital and Health Service (HHS) on a virtual care solution to improve support for people in their regional catchment to manage chronic conditions. The design considered integration with existing Hospital-in-the-Home services to reduce emergency department utilisation for care escalation needs, as well as improving equity of access to specialist-level care in an area with shortages of such services. The Wide Bay HHS was ready to deploy funding under the Connected Care Pathways funding mechanism until Queensland Health determined all 'virtual-type' services be placed on hold due to a state-wide review and strategic planning initiative.

RHCA and its subsidiaries continue to be advised that they are leading healthcare operators regarding the design and implementation of technology-enabled models of care which improves equity of access and reduces rates of preventable hospitalisations. It is clear the public and private systems must work effectively together to address some of the problems the Australian healthcare system faces – greater flexibility in funding, work collaboratively across tertiary and primary care to support patient care.

<u>Alternatives to Private Health Insurance</u>

Example 1: My Hospital Benefit

Given the ongoing challenges with the Australian healthcare system, RHCA **strongly recommends** the Australian Government considers alternate models of funding which can be applicable to all sectors within the healthcare system (public, private, not-for-profit).

RHCA **notes** the Australian Government may wish to commission the Department of Health and Aged Care to consider future options to fund private healthcare in Australia (beyond the Private Health Insurance Act). The role of private hospitals in addressing public sector elective surgery backlogs suggests alternate models of funding must be considered, similar to other models being implemented overseas, such as the United Kingdom's Patient Choices Legislation.

This provides patients the genuine option to be treated in a public or private hospital. Australia could introduce a more structured and nationally consistent policy approach to the role of private hospitals in providing care to public patients where a patient exceeds the national waitlist time period for their treatment in the public sector.

This kind of approach could also serve as the foundations for the establishment of a 'my hospital benefit' which all Australians would be entitled to (being a consolidation of funding across a number of initiatives, such as the private health insurance rebate) with patients choosing to either fund any difference between the 'my hospital benefit' and the hospital charges or purchasing an insurance product to cover the difference.

Example 2: Financial Services Products (Non-PHI)

Financial Services Products (Non-PHI) play a significant role in the funding of care in Australia, particularly early access to superannuation on compassionate grounds for the treatment of several chronic conditions.

This is an example of how the contribution to the production of commercial value through the treatment of a chronic condition has been deemed a policy priority for Government and accordingly non-traditional financial services products are permitted to contribute to that person's healthcare costs.

Similarly, other countries have taken this broader policy approach to the private funding of healthcare through the regulatory framework which supports: health savings accounts, employer contribution schemes, medical expenses tax offsets and single-payor consolidated into a Government entity.

Example 3: Overarching private health policy body

RHCA **recommends** the Australian Government establish a national body to review all the main current funding models and identify their alignment with the overarching strategy of the healthcare system.

It is evident there is no current national body, including the National Health Reform Agreement (NHRA) to provide strategic oversight and ensure funding mechanisms are aligned and support the overarching strategy of the healthcare system, to ensure it remains sustainable to deliver the healthcare needs of Australians. Various funding mechanisms remain disjointed, and it is important all interested parties discuss all mechanisms including the NHRA, activity-based funding, private health insurance, Medical Benefits Schedule and Pharmaceutical Benefits Scheme.

Example 4: National Health Reform Agreement (NHRA) / Government health resourcing

RHC **believes** the NHRA health funding, planning and governance architecture is not fit-for-purpose, given the private hospital system is an important component of the overarching Australian healthcare system to support emerging priorities for better integrated care, and more seamless interfaces between different health system.

This is why RHCA **strongly believes** the private hospital system should be a part of the NHRA, to ensure greater public and private collaboration and coordination occurs, leading to an increase in efficiency and allocation of resources, including the provision of healthcare services to all Australians.

Example: Interestingly, state governments continue to outsource approximately 20% of elective surgeries to the private hospital system.

RHCA **emphasises** the NHRA is an agreement committed to improving the health outcomes of all Australians and to ensure the sustainability of the Australian healthcare system. It is acknowledged the NHRA was originally established as a mechanism to fund public healthcare services between the Commonwealth and State and Territory Governments. However, overtime, the scope of the NHRA has broadened through the addition of addendums which address non-financial matters, including integration between different health systems and chronic health conditions.

RHCA **encourages** the Australian Government to amend the NHRA to include the private hospital system as part of the partnership with Commonwealth, State and Territory Governments, to address private hospitals treating public funded patients, incentives for the public system to partner with the private system, and a fit-for-purpose funding model.

Despite the NHRA mainly being an agreement regarding funding arrangements between the Commonwealth, States and Territory Governments, RHCA **reminds** all Governments COVID-19 demonstrated both the private healthcare system and public healthcare system provide significant contributions, and both systems are complementary to each other.

RHC **emphasises** the private healthcare system can contribute and provide services to support Australians with chronic health diseases, noting significant investment in out-of-hospital and community-based services. The addition of *Schedule C – Long-term Health Reform Principles* which includes chronic health has increased the priority of handling such health issues, particularly in partnership with primary care.

Example: In New South Wales, Ramsay Connect has collaborated with Western New South Wales Local Health District on the development of a virtual healthcare service to support people with chronic conditions in regional, rural and remote NSW, which will reduce the pressure on emergency departments and can be scaled nationally. A pre-budget submission was lodged to the Australian Government (with support from the local Federal Member of Parliament) to fund an integrated model under an outcomes-based funding mechanism.

Currently, the NHRA provides little opportunity for the private hospital system to engage with public policy levers. Interestingly, the NHRA specifically mentions interfaces between health and primary care, mental health, aged care and disability services (Refer to *Schedule F – Interfaces between Health, Disability and Aged Care Systems*) but is silent on the private hospital system. Concerningly, the NHRA mentions private health insurance (the payors of healthcare services) more so than private hospital operators (the provider of healthcare services) (Refer to *Schedule A – Sustainability of Funding for Public Hospital Services* and *Schedule G – Business Rules*).

RHCA **notes** the private hospital system is essential to National Cabinet achieving its NHRA Long-term Health Reforms (Schedule C), given the private hospital system nationally cares for more people than any individual State's hospital system and traditionally delivers a significant volume of services to public funded patients, which peaked during the COVID-19 pandemic.

It is important the governments consider future funding models which better reflects the make-up of the Australian healthcare system, such as a fit-for-purpose funding model which state and territory governments can use to contract with private operators. This funding model could be an adaptation of the National Weighted Activity Unit approach, to reflect the operational differences of private hospital operators. For example, specific funding for capital, taxation and education, as well as 3rd party contracted clinical services (such as visiting medical doctors vs salaried doctors).

RHC also **reminds** governments the private hospital system must be a part of the solutions to ensure patients receive integrated and seamless care, particularly with primary care and digital health. By including the private hospital system in these national conversations, the entire Australian healthcare system will have visibility, interaction and an understanding as to the current priorities and initiatives to ensure health outcomes continue to improve and the system remains sustainable.

Recommendations:

11. The Special Commission of Inquiry into Healthcare Funding investigates whether it would be beneficial for the private hospital sector to form part of policy mechanisms (I.e., amend the NHRA to include the private hospital sector as part of the partnership with Commonwealth, State and Territory Governments);
12. The Special Commission of Inquiry into Healthcare Funding considers whether amending the NHRA can support a role for private hospitals to treat publicly funded patients, such as:
    a. Incentives for the public healthcare system to partner with the private hospital system to deliver essential services to Australians;
    b. Co-developing with the private hospital system a fit-for-purpose funding model which state and territory governments can use to contract with private operators;
    c. National Commercial Framework which provides consistent terms to support national healthcare operators partner with the public healthcare system;
13. The Special Commission of Inquiry into Healthcare Funding considers whether future options to fund private healthcare in Australia (beyond the Private Health Insurance Act) be considered by governments.

Conclusion

RHCA continues to be a willing participant alongside all governments in response to COVID-19 and always assisted with staffing, aged care and capacity, where required and beard most costs incurred in redirecting RHCA's resources to support the COVID-19 response.

RHCA hopes the Special Commission will consider the role of the private hospital sector to support delivering healthcare services for all Australians, including NSW residents, regardless of the setting.

Please do not hesitate to contact me on [redacted] should you require any further information.

Thank you for the opportunity to provide a submission.

Kind Regards,

Dean Breckenridge
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31 October 2023