New South Wales

# Special Commission of Inquiry into Healthcare Funding

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# Special Commission of Inquiry into Healthcare Funding in NSW

***SUBMISSION***

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***Chair,***
***Yass Hospital Community Consultative Committee.***
[redacted]

**Over the past twenty years the profound changes in rural hospitals throughout NSW and Australia have impacted on the quality, safety and timely delivery of health care to rural Australians.**
**The amazing technological advances in Australian health care have also provided significant improvement to health outcomes for most people, however, these advances are not readily accessible to rural communities.**
**The vast majority of the improved technological resources have been dedicated to Tertiary hospitals in major city locations therefore requiring regional patients to travel for their care. Most importantly, in acute and critical situations local rural hospitals are fundamentally under resourced to be able to treat or even diagnose these acute and chronically ill patients. The situation has been exacerbated by the fact that many regional and rural hospitals have lost key operational capabilities such as operating theatres, many basic diagnostics including medical imaging, birthing, blood transfusions, dedicated resident medical practitioners, mental health services, fracture clinics, oncology, diabetes and dialysis to name but a few.**
**The days of the local hospital being a mini version of a city hospital are well and truly consigned to history. The mythical country hospital as a mini replica of its city cousin is no longer operating - and we as a society need to consider what is an alternative health delivery model because right now, the system is not working.**

**In my local hospital, less than 10% of patients presenting to the Emergency Department are admitted as an inpatient. The remainder of ill patients are transported out of the local area for treatment. My local hospital has more than 2000 emergency department patients present per year (2019 and 2020) who are classified as very ill. (Category 1,2 and 3 combined), but clinical staff are unable to admit the majority because of the lack of resources to safely treat these patients. This is only a portion of the emergency presentations per year. They amount to more than 5500 each year.**

**The imperative challenge for the NSW Government today is to develop a working rural hospital model that will give accessible health delivery to country**

**communities that will ensure "comparable health outcomes and access to health and hospital services to those who live in metropolitan areas."**
**This requires a major review and audit of rural health resources and concomitant delivery which must examine technological advancements such as monitoring equipment, telehealth, key diagnostics to clinically determine health status in situ in order to make informed, safe decisions that are in the best interest of the patient, accompanied by the employment of key clinical, operational staff to manage a new age of health delivery.**

**Much of the fundamental problems are associated with the Australian funding model for hospital and health care in this nation. There is a need to carefully and forensically examine the Activity Based Funding model that seriously disadvantages rural and remote hospitals where inadequate clinical and administrative resources simply do not allow the draconian requirements of justifying payment through the Administrator of the National Health Funding Pool, at the individual patient level. The devil is absolutely in the detail.**

**GOVERNANCE OF ABF:**

- **Activity Based Funding jointly funded under the National Health Reform Agreement of August 2011.**
  **Now ABF scheme revised under the 2020-25 Addendum to National Health Reform Agreement (NHRA).**
- **Components:**
  1) **Independent Hospital Pricing Authority (IHPA) – informs and sets pricing of health care = NWAU. (National Weighted Activity Unit). This is currency for payment of health services across Australia.**
  2) **National Health Funding Body (NHFB)**
  3) **Administrator, National Health Funding Pool.**

  **The Administrator, NHFP, is an independent statutory authority that manages the National Health Funding Pool. NB.** ***In 2019-20 managed a total of $55 billion in funding for health care across Australia. Commonwealth contribution: $23 billion. States/Territories contribution: $32 Billion. The % contribution by the Commonwealth has systematically decreased over the time of the ABF policy and state governments are forced to pay more. At the same time the cost of health care has risen steadily throughout Australia.***

**For further information: See IHPA Annual Reports, Administrator, NHFP Annual Reports. 3 Year Data Plans for both entities. Link:**
**https://www.publichospitalfunding.gov.au/sites/default/files/images/documents/draft_administrators_three_year_data_plan_2022-23_to_2024-25.pdf**

**And https://www.ihacpa.gov.au/sites/default/files/2022-08/IHPA%20Three%20Year%20Data%20Plan%202022-23%20to%202024-25.pdf**

**ADMINISTRATIVE AND CLINICAL OUTCOMES ABF:**

**Cost of Administration – 3 organisations at Commonwealth level – let alone State government oversights. 15 Local Health Districts within NSW – all with a replicated structure regardless of need or size. What is the *full* cost of the program to deliver health care at the individual patient level?**
**Improved Health Outcomes not linked to Funding. The funding program is not specifically linked to any requirement with respect to the Australian Commission on Safety and Quality in Health Care. The Commission leads and co-ordinates national improvements in safety and quality in healthcare across Australia. The Health and Safety protocols run parallel to the funding. Improvement in health outcomes in Australia should be a benchmark for the assessment of Activity Based Funding efficiency. See comment from Jeanette Sheridan below.**
**The NHFP requirement to satisfy payment to any NSW LHD is draconian and severely disadvantages rural and regional hospitals. The requirement involves assessment via a coding regime at the individual patient level. The more comorbidities present etc increase the "value" of the patient for payment. Many rural hospitals work with transient doctors via a "fly in- fly out" system where doctors will provide health care over a period of 24 hours or so, but they are not always aware of their obligations and requirements for ABF. An extremely expensive way to fulfill health care requirements. Further, many regional and rural hospitals do not have the equipment or diagnostics for doctors to fully assess patients who present to hospital. My local hospital does not have a CT scanner, does not have an ultrasound machine, does not have an MRI. Indeed, the local vet has more diagnostic equipment to treat my dog than the local hospital has to treat me.**
**The system in place requires accurate assessment via the coding system for full payment of the service given to the patient. The coding system is based on a system of AR-DRG's (Australian Refined- Diagnosis Related Groups) as a funding tool. Payment currency is rated in terms of NWAU's. Anecdotally I was informed that my LHD could only achieve 0.6 NWAU as the highest because of the lack of equipment and resources allowing little "competition" with city hospitals. The lack of ward clerks, doctors who are aware of the system, coding clerks who can interpret the doctor's notes –**

**that must be concise for payment of services delivered. I note that in 2019 SNSWLHD was 20 million dollars over budget and the NSW Health Ministry downgraded the LHD to Performance level 2. The SNSWLHD Board notes of the 13 June 2019, state "*The CE noted that the under-delivery in the LHD's ABF sites and financial overrun is the reason for the LHD's escalation to level two. Monthly meetings will occur and will focus on strategies to reduce expenses".* The CE resigned shortly after. Therefore, I ask: "Is NSW unable to capture "EFFICIENT" services efficiently? What are the administrative and clinical issues at frontline sites that will enable payment of the maximum Commonwealth rebate from services provided by NSW hospitals? Or is the system not fit for purpose? Why does funding need to be at the individual patient level, so complicated, convoluted and confusing? A system that precious few folk can understand and lacks transparency.**

**"*In summary, using ABF for funding hospital services devolves responsibility to each clinician, in each clinical unit to document all treatment and movement of patients while they are in hospital, so that the full cost of their care is captured." (Jeanette Sheridan Thesis: "Activity Based Funding: The Basis for Australian Health Policy")***

**Hidden costs and individual cost to patients. The lack of tertiary hospitals in rural areas and the consequent need to transport patients to adequate care, sometimes across state borders imposes costs to NSW that are not considered as part of the health budget. Accessibility and transport costs are considerable for the individual as well as the state. The Administrator, National Health Funding Pool calculates the cost of treatment of NSW patients in other states and jurisdictions, most notably the ACT, Queensland, Victoria and South Australia – and pays this amount directly into their accounts. The result is that each year NSW pays other jurisdictions for NSW residents receiving care outside of NSW, due to the lack of adequate services within NSW. In 2021/22 Financial Year NSW paid out to other states and territories, a total balance of $196,460,000 dollars for interstate care for NSW residents. In 2022/23 this figure had increased to $268,252,000 dollars. (Annual Report – Administrator NHFP 2022/23). This money is not part of the NSW Health Ministry Budget. It is payments foregone from the National Funding Pool.**

**Lack of accessibility to adequate health care increases the burden on all people who live remotely from its hospitals in NSW. The cost is considerable both for private individuals, hospital ambulances and chronically ill folk who require constant care. Whilst amazing technological advances have provided significant improvement to health outcomes for most people, these improved technological resources are often located in major city centres thus requiring many regional patients to travel to obtain more targeted care, or for disadvantaged folk to pay for new therapies. The situation has been exacerbated by the fact that many regional**

**and rural hospitals have lost key operational capabilities such as operating theatres, basic diagnostics like medical imaging, birthing, blood transfusions, dedicated resident medical practitioners, mental health services, oncology, diabetes, and dialysis, to name but a few. The hope of Virtual Care modalities to enable better patient care, will need to be managed with the availability of on the ground local resources. Again, compliance with The Australian Commission on Safety and Quality in Healthcare is not ensured because funding is not tied to clinical outcomes. This poses a risk to VC Providers that may indeed negate the local service delivery if resources are unavailable.**

- **The NHRA 2020-25 Addendum states that a goal is to "deliver safe, high quality care in the right place at the right time". How is this noble goal tied to funding under the present system? Is there a specific incentive to improve high quality care throughout NSW?**

**GENERAL COMMENTS:**

**The ABF system is supposedly designed to allow competition between health service providers across Australia to contain prices and therefore "efficiency". It is capped in growth with respect to Commonwealth rebates. Over the life of the ABF policy, the cost of health care has risen steadily throughout Australia. The total growth of Public Hospital payments has increased from $36.9b in 2013/14 to $63.6b in 2022/23, and the total growth of Activity Based Funding has increased from $30.6b to $54.3b. (2022/23 Annual Report: The Administrator, National Health Funding Pool). The original ABF agreement promised Commonwealth funding of 45% from July 2014 increasing to 50% in July 2017. However, this promise from the Commonwealth is yet to be realised with any state or territory. Consequently, the increasing cost of health delivery and its continuing rise has severely impacted states and territories in Australia, particularly, rural Australia.**

**It is my understanding that there has not been a significant review of the ABF system in all that time, to examine cost/outcomes benefits or otherwise. The system Australia-wide is now costing in the vicinity of 65 billion dollars and each state's share of the funding is systematically increasing as we speak. It is beyond time that there is an examination of the status of the NSW Health funding system in terms of the delivery of "safe, high quality care in the right place at the right time" be conducted to seriously examine whether Australian and NSW taxpayers, consumers and patients are benefitting from the current joint funding approach that is confusing, costly, inequitable and wasteful.**

References:
1) Annual reports 2012 to 2023 from The Administrator, National Health Funding Pool.
2) My Healthcare Rights, Australian Commission on Safety and Quality in Health Care. www.safetyandquality.gov.au/rights
3) Three Year data Plan, Administrator National Health Funding Pool 2022-23 to 2024-25
4) Three Year data Plan, Independent Hospital Pricing Authority 2022-23 to 2024-25.
5) "Activity Based Funding: The implications for Australian Health Policy"
6) Master's Thesis Jeanette Sheridan U Syd.
7) "Recent developments in federal government funding for public hospitals: a quick guide" Amanda Biggs, Social Policy section, Parliamentary Library Research Publications.

I have studied in Medical Research for many years and worked at both Westmead Hospital (U Syd )and JCSMR at the ANU. I have since retired and have been involved in volunteer work on the Community Consultative Committee at Yass Hospital, NSW. I have been Chair of the committee for the past 6 years and have researched the ABF system to try and gain an understanding of its functionality and thus its impact on our community.

I would be pleased to appear at a public hearing if deemed useful.

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