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Submission to NSW Special Commission of Inquiry into Healthcare Funding: Issues Paper 3/2024 – Funding Models and the Way NSW Health Funds Health Services in NSW

November 2024

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 32,000 physicians and trainee physicians, across Australia and New Zealand, including over 6,000 physicians and 2,300 trainee physicians in New South Wales. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

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We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the continued opportunity to contribute to the Special Commission of Inquiry into Healthcare Funding's work, including the focus on funding models for health services in New South Wales as outlined in *Issues Paper 3/2024* ('the Issues Paper'). We appreciate the Inquiry's recognition of our initial submission and the valuable input provided by our members, including the joint witness statement and the oral evidence presented by our experts.

The issues outlined in the Issues Paper are of critical importance to both the future of healthcare delivery and the wellbeing of patients across NSW. The RACP remains committed to supporting the development of a robust and equitable healthcare funding system in NSW.

Our College is the sole accredited provider of specialist physician and paediatrician training in Australia and represents over 32,000 physicians across Australasia. As such, we are well positioned to provide expert insight into how current funding models impact both the quality of care delivered by physicians and the sustainability of the healthcare system as a whole.

In this submission, we aim to respond to some of the key issues outlined in the Issues Paper. We emphasise that there is a need to ensure funding reform delivers a more efficient, equitable, and patient-centred approach to healthcare delivery in NSW.

In addition, we refer the Commission to our initial submission[1] to this Inquiry and make reference to it throughout, in addressing key issues outlined in the Issues Paper. We also draw on our comprehensive submission[2] to the Independent Hospitals and Aged Care Pricing Authority (IHACPA) on the Pricing Framework for Australian Public Hospital Services 2024-2025.

These submissions outline specific proposals for what is needed to improve the interface of Federal and NSW jurisdictional planning for improved, more efficient, more cost-effective and timely service provision to patients and we encourage review of these documents.

We look forward to further engaging with the Inquiry and continuing our collaborative efforts to improve healthcare outcomes for the people of NSW.

Responses to Issues Paper 3/2024

1. National funding structures and models for NSW Government receives funding for the delivery of health services from the Commonwealth; and

The RACP recognises that the effective delivery of health services in NSW depends on a collaborative, multi-layered funding system that integrates Commonwealth and state contributions. The current funding structures under the National Health Reform Agreement (NHRA) and other related agreements provide the backbone for healthcare financing in NSW. There is a need to ensure that these structures continue to support the complex care needs of vulnerable populations, such as those with frailty, intellectual disabilities, mental health conditions, and those in regional, rural and remote areas. As the jurisdiction is near the end of the negotiations for the new NHRA, to be completed by mid-2025, all the players need to commit to delivering the goals and principles of the final report to the Mid-term review of the NHRA Addendum 2020-2025, including intersectoral collaboration, optimal blended models of care, financing reform, long-term health reform, workforce and digital health and prioritising underserviced populations.

The RACP submission to the IHACPA identifies specific gaps in the classifications used for the funding jurisdictional hospital and health services, the Australian National Subacute and Non-Acute Patient Classification (AN-SNAP), including components of uncosted time and input, additional costing factors for complexity, the adequacy of Activity Based Funding for service coverage, sustainability and integrated care, as well as reform models indicated.

[1] RACP Submission to NSW Special Commission of Inquiry into Healthcare Funding, November 2023
[2] RACP Submission to the Pricing Framework for Australian Public Hospital Servies 2024-2025

2. Identification of the role and function of the Independent Health and Aged Care Pricing Authority

The RACP recognises the important roles played by bodies such as the IHACPA in shaping and overseeing the allocation of healthcare funding. However, the RACP stresses that for the IHACPA to be effective, it must account for the complex healthcare needs of diverse populations including First Nations people, rural and regional communities, children, people with disabilities and those with chronic and complex conditions.

IHACPA determines the National Efficient Price (NEP) and National Efficient Cost (NEC) for public hospital services. The RACP supports refining these frameworks to consider the additional costs of caring for vulnerable groups, such as those with frailty, intellectual disabilities, mental health issues, and homelessness. IHACPA should also develop better measurement systems to capture the costs of providing care to individuals with high-needs conditions. This is further detailed in our submission to IHACPA.

Additionally, the IHACPA determines the Australian Teaching and Training Classification (ATTC) to provide a nationally consistent approach to how teaching, training and research activities in public hospital services are classified, counted and costed. The RACP strongly supports the Commission considering the application of this classification and the associated national best endeavours data set (NBEDS) when appraising healthcare funding models for NSW, in recognition of the twofold role of public health services as both service providers and as training providers.

3. Identification of the role and function of NSW Government, including Treasury and the New South Wales Ministry of Health, in meeting NSW's obligations under the National Health Reform Agreement

The NSW Government, including the NSW Ministry of Health and NSW Treasury, plays a pivotal role in implementing and meeting the obligations set out in the NHRA. These obligations include ensuring that funding is used effectively to meet health needs across the state, particularly for high-needs populations. However, as set out in our initial submission, the RACP advocates for greater focus on integrated care and innovative care models that promote better integration between primary, secondary and tertiary care systems. In addition, data collection for our NSW hospital system should be standardised across all existing and future categories to inform funding decisions.

Prioritising healthcare funding in rural and regional areas is also critical, as rurality is a cost driver that increases costs per person per hospital admission. For example, it raises costs for ambulance services and public hospital separations compared to metropolitan areas. Additional resources are particularly critical in delivering emergency care and non-admitted care in regional and rural settings for older people, people with mental health conditions, people experiencing homelessness, people with a disability, or people with other complex needs.

Please refer to our initial submission and submission to the IHACPA for further detail, and RACP priorities detailed in the RACP 2023 NSW Election Statement[3].

8. Effectiveness of State Efficient Price in allocating budgets to local health districts and specialty health networks

We consider the advice provided in the RACP submission to IHACPA about the National Efficient Price is applicable to the NSW context. We refer the Commission to pages 5-6 of the RACP submission.

In this submission, the RACP emphasises that the government should ensure that hospital pricing models fully capture the evolving impact of COVID-19 on healthcare delivery. This includes addressing the ongoing if changing costs associated with infection control, extended hospital processes, and the need for specialised resources, such as outreach vaccinations for vulnerable populations. The current NEP includes adjustments for Covid-related expenditures and IHACPA is closely monitoring reporting from hospitals across the country for further developments.

[3] RACP Prioritising Health, 2023 New South Wales Election Statement

Given the significant rise in elective surgery backlogs and the surge in emergency department presentations, particularly in rural and remote areas, the government should prioritise granular data that reflects known cost drivers. For example, it is essential that the unique needs of rural and regional communities—including transportation, travel, accommodation, and additional time requirements—are accurately accounted for in hospital pricing, ensuring equitable resource distribution across all geographical areas.

Hospital pricing models should also include non-clinical healthcare roles—such as public health physicians, clinical pharmacologists, and occupational medicine physicians—whose critical contributions to disease prevention and public health management are not always well captured in traditional Activity-Based Funding frameworks.

Finally, as remote and virtual care models become increasingly integral to healthcare delivery, the government should refine pricing mechanisms to reflect the value of these innovative care models.

Given that some activities in our hospitals are not appropriately costed and do not reflect the 'true' cost of service delivery, including time and resource input, there is a need to adopt a more inclusive and adaptive pricing approach. A key part of this is enhancing the recognition and resourcing of the teaching, training and research functions of health services, which are integral to building and distributing a health workforce that is equipped to meet contemporary healthcare needs. In this way, the government can better support a resilient, effective and equitable healthcare system capable of responding to ongoing and future challenges.

Physicians in non-metropolitan areas often report to the RACP that they are unable to take leave due to concerns about burdening their colleagues and patients, which can lead to professional dissatisfaction and burnout over time. Budget innovation and flexibility is needed to support workforce mobility and enhance patient care.

Another way budget innovation and flexibility could support the reality of workforce challenges and delivery of healthcare is potential use in ensuring physicians and trainee physicians have sufficient (i.e. protected) time to provide / receive supervision, undertake and participate in teaching. Feedback from our physicians identifies a need for:

- funding for more staff to allow for teaching and learning time to be protected
- more support for existing and prospective supervisors to encourage them to take on this role – this includes consideration of the considerable amount of time these supervisors are also often needing to dedicate to non-clinical and other administrative work, and scope for further administrative support for supervisors in their roles
- removal of barriers to supervision
- more encouragement and support from health service leadership in relation to the importance of supervision and attending training
- clear, defined time to be set aside for training
- suitable timing of training so that trainees don't have to routinely attend training outside their normal working hours.

13. a. Effectiveness of existing funding approaches and models in supporting hospital and community health services for adequate patient care

In our initial submission to the Inquiry, we highlighted the challenges posed by the division between primary care (PHNs) and secondary hospital care (LHDs), with their separate funding streams. This division has hindered the delivery of integrated, patient-centred care, especially for individuals with complex health needs who would benefit most from coordinated care involving specialists. To address these challenges, we advocate for the implementation of blended and pooled funding models that foster collaboration between sectors, reduce delays and uncoordinated care, and alleviate pressure on hospital resources by supporting more efficient care in the community. It is critical to note that the recent injections of funds provided by the Australian Government, including those intended for multidisciplinary and integrated care, have been focussed on the primary care sector, necessitating stronger support from jurisdictions such as NSW to improve patient access to specialist services.

We also emphasised the need for multidisciplinary ambulatory care settings, particularly in rural, regional, and remote areas, where access to specialised care—such as diabetes and complex obesity clinics—remains

limited. This approach would enable more holistic care outside of the hospital environment, improving outcomes and reducing potentially preventable hospitalisations. Our initial submission also references initiatives by the RACP aimed at advancing integrated care, outlined on pages 4-5, which further supports the case for a more coordinated and collaborative health system.

A large portion of care provided by public health services is delivered by doctors-in-training, who are undertaking a specialist medical program accredited by the Australian Medical Council, through work-based learning under the supervision of specialist doctors. Expanding the number of doctors-in-training and/or redistributing funded positions for doctors-in-training to meet current and future health service needs must also consider the availability and capacity of specialists to provide appropriate supervision, or risk adverse impacts on training and healthcare experiences and outcomes. Consideration needs to be given to the issues identified above in response to question 8 around the importance of supporting protected supervision and teaching time. Planning and funding models should account for these relationships.

13. b. Effectiveness of existing funding approaches and models in supporting preventative healthcare and out-of-hospital care

Our initial submission to the Inquiry (pages 4-5) emphasised the need for enhanced investment in preventive healthcare and urged the NSW Government to allocate at least 5% of health expenditure over 10 years towards prevention, in line with its commitment under the National Preventive Health Strategy. This commitment should be strengthened further by including a clear-cut outline of the NSW policymakers' approach to allocating funding for preventative health activities in a systematic and considered way. Such dedicated funding should be protected for the purpose of prevention.

We also highlighted the under-investment in primary prevention initiatives, particularly those targeting the root causes of ill health in children and other vulnerable communities. There is a pressing need for greater investment in strategies that focus on preventing disease and injury before they occur by, for example, reducing exposure to health hazards, changing unhealthy behaviours, building system capacity to promote health and increasing resilience to health risks.

To address this, we call for a shift in investment priorities, urging the NSW Government to collaborate with physicians, sectors beyond healthcare, and the private sector to foster a more integrated, health-focused approach to policymaking. This collaboration should address the social determinants of health and reduce the burden of avoidable diseases across the population.

13. c. Effectiveness of existing funding approaches and models in supporting equitable access to health services across NSW including:

i. Rural regional and remote areas

The RACP's initial submission to the Inquiry highlighted the significant disparities in health outcomes between rural, regional, and remote (RRR) areas and their metropolitan counterparts. These areas experience higher levels of chronic illness, greater morbidity, earlier mortality, increased hospitalisation rates, and poorer access to primary healthcare. We also noted the direct correlation between these health outcomes and the underrepresentation of RACP Fellows in RRR areas.

Only 11.4% of our Australian members (Fellows and Trainees) live and work in outer regional, remote, and very remote areas (as defined by the Modified Monash Model 2-7). There are 636 RACP members in the inner regional areas of NSW and 33 members in the outer regional areas of NSW, despite these regions comprising nearly one-third of the state's population. This demonstrates significant specialist underrepresentation and maldistribution across regional, rural and remote areas in NSW.

We reiterate our commitment to engaging with NSW Health on the collaboration proposals outlined on page 12 of our initial submission and are eager to explore solutions that address these ongoing challenges in rural and remote healthcare.

ii. First Nations

In our initial submission, we highlight the growing First Nations population as reflected in the 2021 census and emphasise the significant health disparities faced by Aboriginal and Torres Strait Islander communities. In line with our initial submission, we urge the NSW Government to take the following actions:

- Prioritise and support the leadership and active engagement of Aboriginal and Torres Strait Islander leaders and communities in healthcare decision-making.
- Invest in community-led early childhood services to address health disparities from a young age.
- Ensure Aboriginal and Torres Strait Islander leadership is central to public health programs, promoting culturally appropriate care and community involvement.
- Guarantee equitable access to specialist care for Aboriginal and Torres Strait Islander people, with systems that facilitate regional collaboration to identify and plan for specialist healthcare service needs, including collaboration with Aboriginal Community Controlled Organisations (ACCHOs) to ensure culturally safe and accessible care.
- Accurately quantify the demand for specialist services and ensure that this need is met through targeted planning and resources.
- Promote the use of the RACP's Medical Specialist Access Framework[4] in NSW to develop innovative care models tailored to the unique health needs of Aboriginal and Torres Strait Islander communities.

These actions are critical to addressing the ongoing health inequities and ensuring that Aboriginal and Torres Strait Islander communities receive the care they need.

The RACP advocates for the integration of funded positions for physicians-in-training to work within Aboriginal Community Controlled Health Organisations within NSW physician training networks, along with measures for appropriate supervision. This would create opportunities to redistribute the junior medical workforce to meet First Nations healthcare needs at the same time as building trainee physician capabilities and career pathways. Initiatives in this space should be co-designed with First Nations bodies.

iii. Preventative and community health initiatives including integrated care for chronic and complex conditions"

We refer the Commission to our submission on the Draft National Preventive Health Strategy[5]. Amongst our key recommendations to the Strategy was the need to prioritise target populations beyond the general discussion of equity and inclusion. This may be achieved by setting realistic targets within achievable timeframes for various population groups; these plans will vary in terms of specific approaches and actions required as all Australian governments work towards the end goal of high-quality preventative health care for all. Australians from disadvantaged economic backgrounds, those facing regional and rural barries to access, those with developmental vulnerabilities, people with disability and people with mental health issues all deserve evidence- and population data-based service planning as part of the NSW Government's all funding decisions.

We also bring your attention to the importance of working towards better integration of health care across the health sectors through innovative models of care, with a view to improving preventative and community services throughout NSW. As outlined in the RACP discussion paper Integrated Care – Physicians supporting better patient outcomes[6], appropriate funding and payment models must be used to support models of team-based integrated care. Innovative approaches to funding and payment emphasise managing patient populations and overall health, compared with methods of the past that have been based more on transactions for distinct episodes of care and focused solely on the direct interaction between the patient and clinician.

To be truly coordinated and integrated, these approaches must include all heath care providers, including physicians. In addition, we draw the Commission's attention to the lack of preventive care and community-based initiatives for individuals with substance use disorders in NSW. Our initial submission urges all levels of government to prioritise evidence-based harm reduction, prevention, and treatment strategies that focus on

[4] RACP Medical Access Framework

[5] RACP Submission on the Draft National Preventive Health Strategy April 2021

[6] RACP Integrated Care: Physicians supporting better patient outcomes: Discussion Paper, March 2018; see also RACP Model of Chronic Care Management 2019

improving health outcomes. As representatives of public health and addiction medicine specialists, the RACP again calls on the NSW Government to adopt a health-based approach that allocates funding in line with the growing need for comprehensive services. This includes long-term, sustainable funding to expand the capacity of drug and alcohol services and ensure they are accessible to those in need, as well as systemic efforts to reduce societal disadvantage and health inequities.

We have also identified critical gaps in the care and coordination of older adults and people with intellectual disabilities, which contribute to significant hospital discharge delays and unaccounted activity within IHACPA costing frameworks. We urge the NSW Special Commission to thoroughly review our initial submission, particularly the remedial recommendations outlined on page 8 to address these pressing issues.

13. d. Efficient and economic operation of the health services in NSW including:

i. Value based health care and disinvestment in low value care

As outlined in our initial submission, the RACP has consistently advocated for dedicated efforts in NSW to reduce low-value care, empowering physicians to take leadership roles in transforming clinical behaviour for improved patient outcomes, more effective decision-making, and optimal resource utilisation. This is particularly critical in the context of Activity-Based Funding (ABF), where services are measured by inputs rather than outcomes and some critical care services such as chronic disease management and prevention are not covered by the funding model.

The Evolve program funded and run by the RACP is central to these efforts, aiming to enhance the safety and quality of healthcare by:

- Delivering high-value care based on robust evidence and clinical expertise.
- Supporting physicians to responsibly phase out low-value tests, treatments, and procedures where appropriate.
- Redirecting resources to essential tests, treatments, and procedures, thereby improving the efficiency and effectiveness of care while reducing unnecessary expenditure.
- Contributing to the reduction of the healthcare system's carbon footprint.

Funded, led and governed by the RACP and its Specialty Societies, the Evolve Program involves almost 300 volunteer specialists as part of the Evolve-specific Policy and Advocacy Interest Group, as well as other members who contribute to producing and implementing lists of low-value care practices and educational resources tailored to specialties within the NSW Health system. We once again invite the Special Commission of Inquiry to assess the uptake and broader promotion of the Evolve recommendations as a flagship initiative within NSW Health, including funding for the program itself, which holds the potential to drive significant improvements in healthcare quality and resource management.

13. e. Development of innovative models of care and investment in technology to meet future need

As discussed in our responses above, our initial submission highlights the need for new models of care that integrate LHDs and PHNs, with a focus on expanding ambulatory care services, secondary prevention hubs, and primary prevention services.

We also stress the importance of further investment in telehealth and virtual care outreach to support communities, including video conferencing and telehealth facilities. We refer the Commission to our submission to the Australian National Audit Office's Audit of Expansion of Telehealth Services[7], which outlines feedback from RACP Fellows on how telehealth optimises regional access to care, improves access to specialist care for Aboriginal and Torres Strait Islander communities, ensures equitable access for patients with disabilities, and contributes to reducing the healthcare system's carbon footprint.

14 Adequacy of existing funding models to maintain a sustainable public health system

[7] RACP Submission to the Australian National Audit Office's Audit of Expansion of Telehealth Services, July 2022

The current funding approaches including the reliance on Activity-Based Funding (ABF), have significant limitations that hinder the maintenance of a sustainable public health system and development of a workforce to serve within this. While ABF measures the volume of service delivery, it tends to prioritise inputs over patient and educational outcomes and does not adequately incentivise integrated or long-term care models. For example, hospital funding under ABF does not include many activities that aim to minimise or prevent admitted services, such as critically important preventative and chronic disease care. This creates fragmentation, especially between primary, secondary, and tertiary healthcare services. The lack of cross-sector funding integration between LHDs and PHNs results in uncoordinated care, poorer patient outcomes and satisfaction, delays and inefficiencies, increasing pressure on already overstretched hospital systems.

ABF also fails to address the needs of vulnerable populations particularly in rural and remote areas where access to care is limited. It also overlooks the needs of patients with chronic and complex conditions, who require more intensive, long-term care. A significant concern is the lack of funding for community-based care, such as paediatric outreach clinics. Without adequate support for these services, families are forced onto long waiting lists for private care, exacerbating health inequities. Additionally, ABF does not adequately account for the need to invest in the training and education of the future health workforce, which is critical for ensuring long-term sustainability. As a result, the current approach to funding does not sufficiently account for the evolving healthcare needs of the population, exacerbating existing health disparities, and undermining the sustainability of the public health system.

15 Whether existing funding models optimise health outcomes

The existing funding models in NSW do not adequately incentivise the delivery of services that produce the best health outcomes. Activity-Based Funding (ABF), which is heavily focused on the volume of services delivered, tends to emphasise the quantity rather than the quality of care. This approach can lead to inefficient, low-value care that may not result in the best health outcomes for patients, particularly those with complex, chronic, or long-term conditions. Moreover, it discourages the integration of care across primary, secondary, and tertiary settings, which is critical for managing complex patient needs and promoting preventative care. This fragmented system fails to incentivise health services that focus on prevention, early detection, and coordinated, patient-centred care, which are key to improving long-term health outcomes. In particular, the absence of funding mechanisms that address social determinants of health and equity results in missed opportunities for targeted interventions in high-risk populations, such as those with substance use disorders or those living in rural and remote areas.

16 Alternative approaches to funding that address existing barriers to support high quality patient-centred care

To address the limitations of the current funding approaches, there are several alternative methodologies that could support the delivery of high-quality, equitable, and patient-centred care in NSW. First, moving towards blended or pooled funding models, which combine resources from both LHDs and PHNs, could facilitate more coordinated care across the system, especially for patients with chronic or complex conditions. This would allow for the integration of services and reduce fragmentation, improving access to timely, appropriate care.

Additionally, funding that is based on outcomes rather than volume—such as value-based care models—could incentivise health providers to focus on delivering the most effective care, driving improvements in health outcomes. The growing movement towards value-based health care offers a structured, whole-of-system approach to bring all parts of the healthcare sector together to drive wide-ranging structural reform. The Deeble Institute at the Australian Healthcare and Hospital Association drives some of this important work in the Australian context.

Considerably expanding the use of telehealth and virtual care, particularly in rural and remote areas, is another crucial component of a modernised funding approach. This would ensure more equitable and timely access to specialist care and reduce the burden on physical healthcare facilities. Increasingly AI tools offer potential for improving service delivery and efficiency by saving time for direct patient care, streamlining clinical workflows, enhancing diagnostic and prognostic accuracy, identifying patterns not immediately seen by human observation, optimising treatment selection and personalised care, empowering patient self-management and reducing costs.

Furthermore, increasing funding for preventative services and early intervention programs, with an emphasis on community health and addressing the social determinants of health, could help reduce the long-term cost burden on the healthcare system by preventing the onset or escalation of chronic conditions. Finally, improving workforce incentives and ensuring adequate funding for workforce training, especially in underserved regions, would help address the current workforce shortages and better distribute healthcare professionals across the state, ensuring that all areas have access to safe, timely, and high-quality care.

As an educational institution, the RACP urges the Commission to consider the critical relationships between training and education, workforce development and distribution, and healthcare outcomes. Adequate recognition of training and education in healthcare funding approaches, in alignment with evidence-based workforce development and distribution plans, has great potential to positively affect health care outcomes. The RACP is a strong advocate for networked training models and further investment in establishing networks that are based in rural and/or regional areas and include non-hospital services such as ACCHOs and PHNs, has the potential to reposition the junior medical workforce to better serve NSW's healthcare needs, while building and sustaining pathways into ongoing careers in these areas.

Please refer to our initial submission to the Inquiry and our submission to IHACPA for further details.