Health Services Union – NSW/ACT/QLD – 2023

Submission to the Special Commission of Inquiry into Healthcare Funding (NSW)

HSU thanks NSW health workers for their commitment to providing exceptional care to those in need. The dedication and expertise of this unique cohort of workers frequently leads to positive and transformative health outcomes for patients and communities. However, the COVID-19 pandemic has exposed weaknesses in the underlying structures of our health system, not just in NSW but right across Australia. Our current system is plagued by inequalities and inefficiencies. It is a system marked by conflicting and misaligned priorities, split along the dividing lines of politics, geography, and wealth. For too many Australians, healthcare is out of reach and unaffordable. Yet despite these challenges, we have a rare opportunity right now to re-engineer and critically reform our health system for the benefit of current and future generations. We submit the following recommendations:

RECOMMENDATIONS

1. Expand telehealth GP services and improve access to urgent primary care in after-hours settings to reduce pressure on NSW emergency departments and paramedics.
2. Remove rebates for specialists who charge more than double the Medicare schedule fee for consultations.
3. Ensure that Australians on low incomes and First Nations people can access primary care at no or minimal cost to address health inequity.
4. Extend the duration of certain Pharmaceutical Benefits Scheme prescriptions to reduce prescription co-payments; ensure metropolitan and regional Australians have access to appropriate after-hours Pharmacy services; and maintain new settings regarding the 60-day dispensing of prescriptions.
5. Support the Commonwealth Government's scope of practice review, 'Unleashing the potential of the Health Workforce', paying particular attention to allied and community health, and paramedicine.
6. Reduce out-of-pocket costs for allied health, diagnostic and radiotherapy services to encourage integrated care.
7. Support an expansion of Salaried Medical Officers (staff and senior staff specialists) positions in NSW public hospitals to ensure timely and equitable access for public patients.
8. Increase education and monitoring of Medicare billing practices to protect against fraud and non-compliance within the taxpayer-funded Medicare Benefits Schedule.

COMBINED HSU AND REFORM CRITICAL RECOMMENDATIONS

9. Establish a new independent body to provide guidance on best practice models of care, scope of practice, and funding of new drugs and medical procedures.
10. Increase spending on prevention to five per cent of total health expenditure.
11. Develop a new funding mechanism for healthcare that shifts away from fee-for-service towards outcome or capitation-based payments.
12. Remove private health subsidies for private health insurance, and instead directly support the use of private healthcare through a new hospital benefit payment.
13. Undertake a national review of the pay and conditions in the healthcare workforce to underpin the future supply of workers.

14. **Re-establish the National Health Workforce Agency to coordinate health workforce planning across states and territories.**
15. **Strengthen national governance frameworks and look to further the role of local networks in healthcare delivery to overcome the fragmentation between levels of government.**

INTRODUCTION – WHO WE ARE

16. HSU thanks the Special Commission of Inquiry into Healthcare Funding (NSW) for inviting us to make a submission to this Inquiry – we do so on behalf of nearly 48,000 union members.

17. Our members work in public and private health, ambulance, aboriginal health, aged care, disability and mental health sectors across NSW.[1] They are pathologists, paramedics, aged care workers, physiotherapists, cooks, radiographers, clinical psychologists, cleaners, administrators, laundry staff, dental assistants, junior doctors, medical hospitalists, disability support workers, health education and promotion officers, theatre technicians, ward clerks, occupational therapists, security officers, alcohol and other drug workers and approximately 100 additional unique health occupations.

18. HSU members work in big cities and small remote towns. They are most often the first on the scene and the last to be seen. Without them, there is no health system in NSW. Our members are uniquely proud of the work they perform in the communities they serve. Without their dedication and professionalism, we would not have a health system in New South Wales.

19. A defining aspect of our mission as a union is to continuously advocate to ensure citizens and residents have access to high-quality, timely, equitable, and affordable patient-centred health services in New South Wales. We note that access to appropriate healthcare is, and should always be, a protected right afforded to all in a modern liberal democratic society. Furthermore, we note that best practice health care is predicated on a workforce that is properly supported and equipped to meet increasing levels of complexity and expanding demand for services.

SUBMISSION BACKGROUND AND PURPOSE

20. It is with reference to this unique history and diverse work culture that we make a submission to this Inquiry. Our members are central to the performance of the NSW public health system – a system whose costs amount to nearly one-third of the NSW State Budget ($33 billion in 2022-23). It is a system marked by rising costs and inflationary pressure, workforce shortages, fragmentation, underinvestment in preventative and community-based care and increasing inequity. It is a system that does not guarantee high-quality, timely, affordable, and accessible healthcare for all. It is a system at breaking point and in urgent need of structural reform.

21. HSU commends the NSW Government for having the foresight to set up this Inquiry. Australia has held only one review at a Royal Commission or Special Commission level examining the health system as a whole: the Commonwealth 'Royal Commission into Health' (1926). This 1926 review aimed to improve

[1] HSU also represents health workers in the Australian Capital Territory and Queensland.

governance practices and focused on preventative care and coordination between health authorities in response to the crises of the Great War, the Spanish Flu Pandemic, and venereal disease outbreaks.

22. The current COVID-19 crisis has similarly exposed failures and flaws in the design and operation of a system struggling to adequately manage evolving health needs in an unpredictable global health supply chain and tight labour market. Nevertheless, in the face of crisis an opportunity to embark upon a significant and lasting program of 'reform and renovation' has emerged.[2] HSU argues that now is the time for serious policymakers and politicians to take on the challenge of creating a sustainable and equitable health system in NSW and across Australia.

23. Our submission is based on extensive feedback from HSU members gathered through quantitative and qualitative surveys - and direct interviews. The report provides a snapshot of evidence and experiences from clinicians and staff on the ground. HSU members are stationed at every major link of the health chain; they see the health system in its entirety and are uniquely positioned to give an account of its strengths and weaknesses.

24. We locate this submission within the extensive domains of health and labour economics research. We argue that singular approaches to health reform seldom yield sustainable outcomes but rather reinforce prevailing inefficiencies and commonly compound undesired externalities. Relying solely or predominantly on the opinions and evidence of entrenched institutional actors in the health sector will lead to familiar and simplistic prescriptions that have failed to deliver lasting structural reform: 'more money, more doctors, more nurses'.

25. HSU attaches 'Reform Critical: A Fragmented System at Breaking Point' *(Reform Critical)* - a joint research project conducted with *Impact Economics* and authored by leading Australian health economist Dr Angela Jackson[3]- as an addendum to this submission. Published in February 2023, this seminal report represents the views of HSU and is based on feedback from more than 4,500 health workers across NSW. It constitutes the broadest survey of NSW health workers undertaken in recent years and serves as a catalyst to initiate serious discussions on reform priorities.

26. *Reform Critical* highlights the principal themes being investigated by this Inquiry and pays particular attention to a health system that is at breaking point. The report references five areas in which the health system is in crisis: patient care, healthy populations, efficient health care, sustainable workforce, and equity in access. It reveals that despite the dozens of major reviews commissioned at both commonwealth and state levels over the previous 40 years the reform agenda remains ad-hoc and '…does not incentivise outcomes, rather it incentivises the provision of more health services'.[4]

27. We note that allocating taxpayer dollars in the health sector is a highly contested political subject. In investigating healthcare funding and expenditure, this Inquiry would benefit from focusing on the integrated nature of high-performing health systems. At present, we have a fragmented system cutting

[2] Bowtell, B. (2021). *New Variant, Old Politics*, https://www.fabians.org.au/afr2_bill_bowtell.

[3] Dr Angela Jackson is the Executive Director at Impact Economics and has recently been appointed to the Commonwealth Government's National Covid-19 Inquiry.

[4] Jackson, A. (2023). *Reform Critical: A Fragmented Health System at Breaking Point.* Impact Economics and HSU. p. 4.

across Commonwealth and State/Territory lines – and public and private divides. This unique by-product of Australian federalism creates bureaucratic duplication and policy confusion. It fails to adequately promote cost-effective community and multi-disciplinary models of care.

28. For this Inquiry to be effective it should avoid adopting an overly legalistic footing where practicable and instead foster community participation and engagement. As an instructive guide, the Special Commission into Acute Care Services in NSW Public Hospitals, the Special Commission into the Drug Ice, and the Royal Commission into the Victorian Royal Commission into Mental Health all facilitated the opportunity for a diverse array of communities and experts to be heard.[5] We emphasise that '**accessibility**' is a key theme of this Inquiry.

29. HSU understands that the Australian Medical Association's NSW chapter (AMA) opposes this Inquiry and labelled it a 'HSU power grab'.[6] We are unsure how calling for reform to create a sustainable, affordable, and equitable health system for all citizens and residents now and into the future constitutes a 'power grab'. Nevertheless, we note the statements of the Australian Salaried Medical Officers' Federation (NSW) and Royal College of General Practitioners (NSW) who have both welcomed the construction of this process and noted its importance.[7]

30. In making this submission, HSU pays particular attention to Terms of Reference A, B, C, D, F, G, H and J. We have sought the views of health workers (further to *Reform Critical*) as to how a more equitable, accessible, and cost-effective health system can be created for current and future generations. We have also captured data from our members highlighting the real challenges they face in accessing and affording the healthcare they need. That a large cohort of health workers cannot afford the healthcare they need is emblematic of a system in crisis.

31. To be clear, this submission does not and cannot address all structural deficiencies and reform priorities listed in the Terms of Reference – this vital and significant undertaking is the responsibility of the Commissioner of this Inquiry, and the expected reform agenda is ultimately the responsibility of the Cabinet of NSW, and the Commonwealth Government. Indeed, HSU notes that the questions raised by this Inquiry can only be answered through a collective approach, one which incorporates expertise, experience, and innovation from across the health and public policy sectors. HSU will make supplementary submissions on matters that emerge throughout this proceeding – including, but not limited to, a detailed analysis of workforce shortages in the first half of 2024.

32. Our arguments are straightforward: the NSW health system is at a breaking point, it has failed to manage escalating workforce shortages, is marked by underinvestment in community and preventative care, is fragmented and is confronting substantial problems with waste and Medicare non-compliance. To address these critical issues, a whole-of-system approach to the funding and delivery of health services which is patient-centred is required. It should be based on evidence-based frameworks of care and be

[5] HSU notes the 'Garling Inquiry' visited 61 hospitals and took more than 1200 submissions. During this Inquiry, HSU is committed to actively assisting in making representatives available and furnishing information pertinent to anticipated public hearings.

[6] Payne, H. & Grayson, H. (2023, 23 August). NSW spending inquiry is an HSU power grab: AMA. *Medical Republic*. https://www.medicalrepublic.com.au/nsw-spending-inquiry-is-an-hsu-power-grab-ama/97489

[7] See public comments of the RACGP and ASMOF. RACGP - https://www.medicalrepublic.com.au/nsw-spending-inquiry-is-an-hsu-power-grab-ama/97489. ASMOF - https://www.asmofnsw.org.au/Website/Media_Release_Articles/ASMOF_NSW_Welcomes_Healthcare_Funding_Inquiry.aspx.

guided by understanding the interconnectedness of health practice. It must have at its core an adequately equipped and supported professional workforce. Only this approach will produce high-quality, timely, accessible, equitable, and cost-effective care for the people of NSW.

A HEALTH SYSTEM AT BREAKING POINT - THE DATA

33. Term of Reference 'A' investigates how health funding can 'most effectively' support the delivery of '…**timely, equitable and accessible**' health services '…now and into the future'.[8] To commence, we examine these terms and determine if NSW meets such standards.

34. Australia is often singled out as delivering strong health outcomes based on specific metrics. However, there are clear indications that our system is 'pushing the stress performance curve into the red'.[9] As confirmed in this section, the benchmarks of hospital and ambulance activity are seldom being met; Local Health Districts (LHDs) in NSW seem unable to meet existing demand despite funding injections from the Commonwealth Government; and the 'grey literature' attests to the human impact of worsening health figures.

35. Leading NSW health experts Professor Clare Jackson and Professor Diana O'Halloran comment, '…patients deteriorate waiting for specialist assessment, and junior doctors find themselves trapped in increasingly overstretched, dysfunctional work environments'.[10] As one HSU member remarked in a direct interview: '…the system is so stretched we see patients deteriorate before our very eyes, and we can do little within current structures to help them'.

36. In October 2023, HSU conducted an extensive survey (HSU Survey) and direct qualitative interviews of more than 800 members in response to this Inquiry. The insight and evidence provided by these NSW health workers, combined with contemporaneous health economics and population data, clearly demonstrate that the NSW health system is currently incapable of meeting existing state-set benchmarks.

37. As *Reform Critical* states, despite the collective sacrifices of the people of NSW during the COVID-19 pandemic, '…our system is in crisis, struggling under the weight of additional demand and years of failure to undertake the structural, governance and funding reforms needed to build a strong health system that is fit for purpose'.[11]

TIMELY CARE?

38. The term 'timeliness' in healthcare can be understood as a system's 'capacity to provide care quickly after a need is recognised' and is one of the key indicators of the efficiency and performance of a health

[8] New South Wales. (2023). Terms of Reference, Special Commission of Inquiry into Healthcare Funding. See pp. 1-3.

[9] Jackson, CL & O'Halloran, D. (2021). Reforming our healthcare system: time to rip off the band-aid? *Medical Journal of Australia*, 215 (7). pp.301-303. doi: 10.5694/mja2.51261.

[10] Ibid. pp. 301-303.

[11] Jackson, A. *Reform Critical*. p.12.

system.[12] Dr Carla Saunders and Dr David J Carter, experts in health management and law respectively, contend that timely healthcare access implies '…an adequate supply and **right of entry to necessary services** and is recognised as a central aim of healthcare quality and a fundamental feature of patient-centred care'.[13] The U.S. National Institute for Medicine argues that '21st-century' health care should be 'timely - reducing waits and sometimes harmful delays for both those who receive and those who give care.'[14]

39. Providing timely care effectively reduces mortality and morbidity for chronic conditions and has a strong net positive economic correlation.[15] The NSW Government states that 'prolonged waits…may reduce patients' quality of life, their productivity at work, and the likelihood of achieving good health outcomes'. It further notes that 'long-term disability or risk of death from acute conditions are influenced by the timeliness of treatment'.[16]

THE LONG WAIT: SURGERY, AMBULANCE AND EMERGENCY DEPARTMENTS

40. It is common for patients in the NSW public hospital system to wait months or even years for essential surgeries. In response, the recently elected NSW Labor Government established the Surgical Care Taskforce (SCT) in May 2023 with the aim of stabilising and improving surgery wait times. This SCT's sensible same-day patient discharge focus has demonstrated that safe and innovative reforms can deliver early positive results.[17] Nevertheless, the system is still facing extreme pressure to meet patient demand.

41. The experience of those with private health insurance is fundamentally different from those who rely on the public system. Private hospital coverage enables individuals to bypass long public hospital waiting lists thus affording patients additional autonomy over their personal health needs. [18] It allows choice, as National Health Insurer HBF poignantly and correctly promotes in its marketing material reminding consumers that private coverage is especially useful if '…you have an upcoming holiday to plan around, or if you need to get back to work quickly'. [19]

42. An analysis of medium-term surgery wait times in NSW shows a significant decline in the capacity of the health system to meet clinical care benchmarks.

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[12] *Healthy People 2020. Access to Health Services.* U.S. Department of Health and Human Services. Office of Disease Prevention. Accessed on 13/10/2023 at http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services.

[13] Saunders, C & Carter, DJ. (2021) Right time, right place, right time: Improving the timeliness of health care in New South Wales through a public-private partnership. *Australian Health Review*, 41(5). pp. 511. doi.org/10.1071/AH16075.

[14] U.S. Institute of Medicine. (2001) *Crossing the Quality Chasm: A New Health System for the 21st Century*. The National Academies Press. p. 6. Doi.org/10.17226/10027.

[15] Smart, NA & Titus, TT. (2011). Outcomes of early versus late nephrology referral in chronic kidney disease: a systematic review. American Journal of Medicine, 124 (11). pp. 1072-82. Accessed on 20/10/2023 at http://www.scinecedirect.com/science/articel/pii/S0002934311004128.

[15] https://www.hbf.com.au/blog/the-difference-between-a-public-and-private-patient

[16] Bureau of Health Information. (2012). *Healthcare in focus: access and timeliness.* BHI, December. P.33. Accessed on 23/10/2023 at https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0005/177206/APR_HealthcareInFocus2012_access-timeliness.pdf

[17] NSW Labor Govt Slashes Overdue Surgery List. https://www.miragenews.com/nsw-labor-govt-slashes-overdue-surgery-list-by-1110937/.

[18] Jackson, A. *Reform Critical.* p.28.

[19] HBF. (2018, 9 November) Public and Private – What's the Difference? Accessed on 26/10/2023 at https://www.hbf.com.au/blog/the-difference-between-a-public-and-private-patient.

Bureau of Health Information (BHI) April to June 2023 Elective Surgery data:[20]

- 94,238 patients were on the NSW waiting list (up from 77,954 in April-June 2018).
- 9,142 patients waited longer than the recommended period for surgery (up from 517 in 2018 – a near 18-fold increase).
- **34.6% of patients categorised as requiring 'semi-urgent' surgery were not treated within the clinically recommended timelines** (a 10-fold increase from April-June 2018).
- 10% of patients requiring non-urgent surgery waited longer than 488 days.
- The percentage number of patients waiting more than 365 days for surgery is double that in Victoria and more than three times higher than in Queensland.[21]

43. Ambulance waiting times continue their upward trend with a set regression from the benchmark standards achieved in the pre-pandemic reporting period. NSW paramedics are under more pressure than at any point in the history of the service with the number of critically unwell patients needing ambulance transport and expert paramedic treatment growing. So stretched in the service that veteran paramedic Mick Grayson observed in *Reform Critical* that '…it's not uncommon to be greeted [upon ED arrival] with, oh, we have no beds, **we're going to 'ramp you'** and you're like, would you like know what's wrong with the patient first?'.[22]

    BHI April to June 2023 Ambulance data:[23]

    - 357,491 total callouts (highest on record).
    - 177,594 emergency callouts (highest on record).
    - **13,525 'highest priority – P1A responses for patients with a life-threatening condition (highest on record).**
    - The percentage of P1A responses within the 10-minute benchmark was 64.3% (down from 72.7% in April-June 2018).
    - The percentage of P1-Emergency responses within the 15-minute benchmark was 44.7% (down from 62.3% in April-June 2018).

44. Emergency Physician and President of the Australasian College of Emergency Medicine Dr. Clare Skinner recently remarked that the NSW health system is in 'dire straits' noting that **'the pressures on emergency departments just keep building, it's just not sustainable'**.[24] HSU members have also attested to the system being overwhelmed with one junior doctor lamenting the rise of triage 1 and triage 2 patients is 'completely unsustainable, the level of demand makes it impossible to see less critically acute patients also in need of care in a timely manner'.[25]

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[20] Bureau of Health Information. (2023) *Healthcare Quarterly, April to June 2023*. BHI. pp.1-32. https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0006/900276/BHI_HQ53_APR-JUN_2023_REPORT.pdf.

[21] Jackson, A. *Reform Critical*. p.29.

[22] Ibid., p. 14.

[23] Bureau of Health Information. (2023) *Healthcare Quarterly, April to June 2023*. pp.1-32.

[24] Cited in Aubusson, K. (2023, 1 March). Critically ill overwhelm NSW Emergency Departments in Record Numbers. *The Sydney Morning Herald*. https://www.smh.com.au/national/nsw/critically-ill-overwhelm-nsw-emergency-departments-in-record-numbers-20230228-p5co35.html.

[25] HSU direct interview – 22/10/2023.

BHI April to June 2023 Emergency Department data[26]:

- 770,654 ED attendances (marginally down from the same quarter in 2022).
- 65.8% of patients had their treatment start on time (second lowest on record).
- **56.7% of all patients spent less than four hours in ED** (lowest on record).
- **6,385 Triage 1 presentations** (highest on record).
- 117,949 Triage 2 presentations (highest on record).

ACCESSIBLE, EQUITABLE…UNIVERSAL?

45. Term of Reference 'J' states that this Inquiry should have regard to '…existing reviews, reports and recommendations…and other national settings insofar as they impact on the delivery of high quality, timely, equitable and sustainable public hospital and community health services in NSW, in particular co-payments.'[27] Term of Reference 'G: v.' invites examination of the 'barriers' to '…accessibility and **affordability of specialist clinical services**'[28].

46. Upon the introduction of Medicare in 1984, then Prime Minister Bob Hawke delivered a speech in Sydney to the 'Health and Research Employees' Federation' (HEF - precursor to the HSU) declaring that '**no Australian need now fear that treatment of sickness will have crippling financial consequences**'.[29]

47. In October 2023, a health worker described their experience of healthcare in NSW thus:

> '…**I can't afford the healthcare I need**. Private specialist fees are exorbitant. My GP is great but doesn't bulk bill and charges a gap so I'm out of pocket $50 for every visit. He said I needed surgery to fix an ongoing chronic issue, which is affecting my capacity to work. But what do I do? I simply can't afford the hundreds of dollars out of pocket to go private…**I live paycheck to paycheck and have two little mouths to feed. It's thoroughly depressing, I guess I'll wait 9-12 months to see a public specialist, I don't have a choice**'.

48. Australia's national public health insurance scheme was constructed to '…guarantee all Australians, as a basic right, protection against financial impact of essential medical and hospital treatment'.[30] Medicare was designed to make healthcare available to all irrespective of a person's socioeconomic status and capacity to pay. And while the NSW health system provides highly professional care to those in need, and where there is the capacity to do so, high 'co-payments' (otherwise referred to as gap or out-pocket payments) are making healthcare inaccessible for a large proportion of the population.

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[26] BHI. Healthcare Quarterly. pp.1-33.

[27] New South Wales. (2023). *Terms of Reference*, Special Commission of Inquiry into Healthcare Funding. p. 3.

[28] Ibid., p.3.

[29] Hawke, B. (1984). *Speech by the Australian Prime Minister, Health and Research Employees' Federation, Sydney, 5 March 1984*. p. 3. https://pmtranscripts.pmc.gov.au/sites/default/files/original/00006332.pdf.

[30] Ibid., p.3.

49. In Australia, individuals directly pay for 17% of all healthcare expenditure ($29.8 billion nationally in the 2019-20 period).[31] This is one of the highest proportions of any OECD nation and is double the amount contributed by private health insurers.[32] Our system relies heavily on individual contributions and out-of-pocket payments to fund core healthcare requirements.

NSW HEALTH WORKERS - CAN YOU AFFORD HEALTHCARE?

50. To prepare for this submission, the 'HSU survey' invited nearly 8,000 NSW public and allied health workers to provide detailed information to inform our submission. The survey received 782 complete responses. More than 65 per cent of the respondents had worked in healthcare for at least 11 years - with 34 per cent having worked for more than 20 years. Greater than two-thirds of respondents were women. Quantitative questions have been designed to limit speculation and open-ended responses. The information provided by our members is not available through either government or non-government workforce analyses.

51. HSU asked these health workers: *Can you afford necessary medical care, including specialist care for you and your family?*

52. HSU received the following results[33]:

- 779 health workers responded.
- **47.1 per cent answered – 'No'.**
- 34.4 per cent answered – 'Yes'.
- 18.1 per cent answered – 'Prefer not to say'.

53. HSU is deeply concerned that almost half of those surveyed indicated that they cannot afford the necessary medical care they need. This represents a system in crisis struggling to meet essential patient demand.

54. In their words, NSW health workers offered the following reflections:

- 'I needed to see a cardiologist. A three-minute consultation and scan cost $800.00. Had I known the cost prior to the appointment I wouldn't have taken it. **Needed to use a credit card to pay**'. *Patient Services Manager*.

- 'I avoid specialist appointments that cost upwards of $200. The costs of healthcare are rising, and **it is very hard to get specialist appointments as the wait times are usually many months long**'. *Hospital Scientist*.

[31] This includes medication payments listed under the Pharmaceutical Benefits Scheme (PBS). See Babbage, S & Hutchins, D. (2019). Australia's Out-of-Pocket Healthcare Problem. *Health Matters, PWC*. Pp.11-18. Accessed on 22/10/2023 at https://www.pwc.com.au/health/health-matters/out-of-pocket-healthcare.html.

[32] See Duckett, S., Stobart, A. & Lin, L. (2022) Not so universal: How to reduce out-of-pocket healthcare payments. *Grattan Institute*. Pp. 4-7. Accessed on 27/10/2023 at https://grattan.edu.au/wp-content/uploads/2022/03/Not-so-universal-how-to-reduce-out-of-pocket-healthcare-payments-Grattan-Report.pdf.

[33] HSU Survey, October 2023.

- ‘I have a chronic health condition. I have waited too long for specialist appointments which **caused an extension of ill-health**’. *Volunteers Manager*.

- ‘I don't see how anyone with a mortgage and family commitments could pay for private health coverage. Remembering that **private health cover helps bypass queues for specialist care**. *Speech Pathologist*.

- ‘I’ve been waiting on surgery for over 12 months and can’t afford private [insurance]. I also have to go to Sydney to get the care I need’. *Aboriginal Health Worker*.

- ‘I’m on a range of medications, and while I get a rebated price on most, some I don’t. For people who require medication for life, the costs are often prohibitive, and I frequently find myself choosing between essential groceries and my meds’. *Dental Assistant*.

- ‘In the recent past yes, I frequently bypassed essential medical care, especially dental care because it is just so unaffordable in Australia. I am fortunate that now I can afford private health insurance – but this was not always the case. What does it say about Medicare and universal health, **it’s not universal – the system is unfair**’. *Clinical Psychologist*.

55. HSU members demonstrate that access to ‘timely, equitable and affordable patient-centred care’ is now out of reach for many NSW health workers. What is also evident is that those with chronic health conditions or co-morbidities are further disadvantaged because of the inequitable structure and operation of Australia’s health system.

56. Health policy expert Professor Stephen Duckett, together with economists Annika Stobart and Linda Lin point out in their 2022 report ‘Not So Universal’ that ‘**the people who need the most healthcare – the poor and the chronically ill – miss out on care most. This is bad for those individuals, but also bad for taxpayers and the economy. It makes people sicker, widens inequities, and puts further strain on the health system down the track**’.[34]

OUT-OF-POCKET PAYMENTS FUEL INEQUITY… AND SYSTEM COSTS

57. Term of Reference ‘G: v’ invites comment on how barriers to workforce expansion ‘…can be addressed to meet the **supply, accessibility and affordability of specialist clinical services**…’[35]

58. High out-of-pocket payments and costs are barriers to affordable healthcare access across NSW. Established population health research indicates that the burden of high healthcare costs is disproportionately felt by women, young people, First Nations people and those with chronic health conditions.

59. It’s a discernible trend that people in the lowest socioeconomic quintile are far more likely to skip specialist appointments than those in the highest earning quintile – and they also spend a great

[34] Ibid., P.4

[35] New South Wales. (2023). *Terms of Reference*, Special Commission of Inquiry into Healthcare Funding. p. 3.

proportion of their disposable income on accessing services. High healthcare costs also drive some people into poverty, with a 2019 study revealing that one in three low-income households are spending more than 10 per cent of their income on healthcare – defined in the health literature as '**catastrophic expenditure**'.[36]

60. The level of out-of-pocket fees ignites vigorous policy, political and academic debate in Australia. When addressing HEF members in 1984, Prime Minister Hawke noted the historic challenge of constructing a national public health insurance scheme stating that 'the AMA has been happy to obtain concessions from the government, but then has been unable to respond with binding commitments from the medical profession'.[37] Any agreement, he remarked, '**requires two to tango**'.[38]

61. Today, many historically entrenched barriers to access and affordability remain. There is no real limit to what specialists can charge patients; many specialists charge more than double the Medicare schedule fee, some speciality areas are particularly expensive (in part due to personnel shortages) and there are few options outside of the public hospital system for patients to see specialists free of charge.

62. It should also be highlighted that market power in healthcare resides with those who have the capacity to set prices; and with those who can meet these price settings through the facility of private health insurance and medium-high earnings or inherited wealth. This leads to a statistically large number of citizens and residents, including NSW health workers and HSU members, foregoing necessary medical care because they simply can't afford it.

63. To this point, HSU notes the cyclical economic relationship that exists between skipped treatment and future health system costs. A 2019 Australian study estimated that the cost of non-adherence to a prescribed medication schedule, overseen by medical professionals, for those with hypertension, elevated cholesterol, and depression is $10.4 billion annually. It concluded that improving adherence to medication plans could save $1.9 billion per annum.[39]

UNDERINVESTMENT IN COMMUNITY AND PREVENTATIVE CARE

64. Term of Reference 'C' examines the allocation of NSW Health funds and the extent to which this allocation of resources '…**supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes**'.[40]

65. Chronic diseases cause the vast bulk of illness in Australia, accounting for 85 per cent of the disease burden. Almost half of all Australians live with at least one preventable chronic health condition – such as cardiovascular disease, cancer, asthma, diabetes, chronic kidney disease, and mental health

[36] Callandar, E. (2023) Out-of-pocket fees for health care in Australia: implications for equity. *Medical Journal of Australia*. doi: 10.5694/mja2.51895.
[37] Hawke, B. (1984). *Speech by the Australian Prime Minister*. p.9
[38] Ibid., p.9.
[39] Cutler, RL., Torres-Robles, A., Wiecek, E., Drake B., Van der Linden, N, Benrimoj SIC., & Garcia-Cardenas, V. (2019). Pharmacist-led medication non-adherence intervention: reducing the economic burden placed on the Australian health care system. *Patient Prefer Adherence*. 23.13. pp. 853-862. doi: 10.2147/PPA.S191482. PMID: 31213779; PMCID: PMC6537038.
[40] New South Wales. (2023). *Terms of Reference*, Special Commission of Inquiry into Healthcare Funding. p. 1.

conditions – while approximately half of all people older than 65 have two or more chronic health conditions.[41]

66. The problem is also becoming more acute with the disease burden rising by 38 per cent over the past three decades. Risk factors such as obesity, unhealthy diets, alcohol, and vaping are not being adequately addressed to achieve optimal outcomes.[42]

67. At present, the increasing incidence of chronic conditions coupled with the inability of our health system to effectively address their underlying causes is resulting in a rise in preventable hospital admissions. The Australian health system **spends $38 billion annually providing healthcare to those with a chronic condition – including $2 billion on preventative hospitalisations**.[43]

68. Data captured in *Reform Critical* estimates that **in the 2017-18 year, there were 217,865 preventable hospital admissions in NSW**, an increase of 25 per cent since 2012-13. These are counted as additional bed days and reflect substantial additional costs imposed upon the NSW health system. Each admission is estimated to cost on average $5,200 which equates to **more than $1.1 billion in avoidable expenses per year to the NSW health system**.[44]

69. People who develop chronic conditions are at higher risk of leaving the workforce and falling into poverty due to decreased income and high medical expenses. It is also the case that those with chronic conditions who lose employment find it harder to re-enter the workforce. This cyclical loop of poor health repeats itself at an exponential rate: poor health worsens socio-economic disadvantage, and disadvantage results in poorer health outcomes and higher rates of chronic disease.[45]

70. OECD analysis reveals that Australia is falling behind other nations when it comes to spending on prevention measures and is also failing to live up to the commitments made by our own government. **Australia currently spends less than 2% of total healthcare budgets** across the Commonwealth and State levels on prevention, which is significantly lower than the average among OECD countries. In fact, our spending is half of what the UK invests and only a third of what Canada spends on prevention.[46]

71. Canadian health management economist Dr Olivier Jacques and political scientist Dr Alain Noël theorise that 'Preventive care is particularly unlikely to be prioritised by governments since it is a public good that requires the allocation of scarce resources in the present to generate diffuse benefits that unfold only in

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[41] Australian Bureau of Statistics (2022) *Health conditions prevalence*. https://www.abs.gov.au/statistics/health/health-conditions-and-risks/health-conditions-prevalence/latest-release.

[42] Breadon, P. (2023, 3 May). Cuts to preventative health are a false economy. *Pearls and Irritations*. https://grattan.edu.au/news/cuts-to-preventive-health-are-a-false-economy/.

[43] Jackson, A. *Reform Critical*. p.48.

[44] Ibid., p. 49.

[45] Burdorf, A. & Schuring, M. (2015). Poor Health as Cause and Consequence of Prolonged Unemployment: Mechanisms, Interventions, and Policy Recommendations - in Vuori J., Blonk R., Price R. (eds) *Sustainable Working Lives. Aligning Perspectives on Health, Safety and Well-Being*. https://doi.org/10.1007/978-94-017-9798-6_12.

[46] OECD (2020). *OECD Health Statistics 2021*. Organisation for Economic Co-operation and Development. Accessed on 23/10/2023 at https://www.oecd.org/health/health-data.htm.

the long-term'. In this respect, it constitutes a quiet era of public policy – not supported by powerful interest groups or strong public opinion.[47]

FLAWED AND FRAGMENTED FUNDING ARRANGEMENTS

72. Term of Reference 'J' invites examination of '…**national structures or settings, including the National public hospital funding model and/or National Health Reform Agreement**'.

73. In addition to the identified underinvestment in community and preventative care in NSW and across Australia, the current funding arrangements for chronic disease prevention, intervention and management are structurally flawed, hindering efforts to realign the focus towards integrated health.

74. As the CSIRO explains: 'Many people with complex and chronic diseases require long-term, proactive, and systemic care approaches; however, current models of care and funding systems are still largely designed to be responsive to episodic care for issues such as infectious disease and trauma. Furthermore, the overlapping role and responsibility of ambulatory and inpatient care services, separate funding streams and models of care, as well as activity-based funding for acute care, can create barriers to integrated care'.[48]

75. Complex and fragmented funding arrangements 'encourage activity and efficiency over integrated care'. According to the Productivity Commission's report '*Innovations in Care for Chronic Health Conditions*' (2019), general practice doctors are paid for 'activity rather than outcomes', which means they have 'less incentive to spend more time with people and ensure they have provided the care that meets their needs'.[49]

76. *Innovations in Care* further notes that the economics of treating chronic conditions are misaligned and thus generate obdurate incentives within the existing national primary care funding framework: 'People with chronic conditions are particularly disadvantaged as their needs are often complex and they may require longer consultations, which tend to offer lower remuneration than an equivalent time spent on shorter consultations.'[50]

77. Undermining community and integrated preventative care is the funding split between Commonwealth and State/Territory jurisdictions. Primary and secondary prevention activity occurs in the Primary Health Network funded through the MBS. In contrast, the operational benefits of investing in prevention - namely limiting healthcare costs associated with treating chronic conditions – are evident in acute care settings managed by the States and Territories.

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[47] Jacques, O & Noël, A. (2022). The politics of public health investments. *Social Science and Medicine*. 309. https://doi.org/10.1016/j.socscimed.2022.115272.

[48] CSIRO (Commonwealth Scientific and Industrial Research Organisation) (2019), *HealthLinks Chronic Care Evaluation — Summary of Implementation and Outcomes for 2016-17*. Report for the Victorian Department of Health and Human Services, p. 4. https://www.health.vic.gov.au/publications/healthlinks-chronic-care-evaluation-summary-of-implementation-and-outcomes-for-2016-17.

[49] Productivity Commission. (2021). *Innovations in Care for Chronic Health Conditions*. Productivity Reform Case Study. p. 145. https://www.pc.gov.au/research/completed/chronic-care-innovations/chronic-care-innovations.pdf.

[50] Ibid., p.145.

78. What multiple reviews and reports in recent years have identified, including *Reform Critical*, is that there is a strong economic disincentive to create and foster integrated health services between the Commonwealth and the States/Territories. The embedded fragmentation and complexity in the design of national funding settings means governments are reluctant to adequately adopt best-practice integrated health policies because of the fixed medium and long-term return on investment timeline. Conversely, States/Territories have constrained capacity and a lower incentive to invest in large-scale community and preventative care programs when uncertainty exists in changing political environments.

79. Preventative healthcare is a crucial aspect of any high-performing health system. Its effectiveness in addressing chronic diseases is well-established, yet community-based and primary health prevention programs remain underfunded due to flawed economic decision-making frequently adopted by politicians and policymakers. This is evident in the stagnant funding of preventative care in Commonwealth and NSW State budgets since 2012, indicating a widespread reliance on false economic assumptions in health policy. **Investing in preventative healthcare not only improves health outcomes but also generates significant returns, making it a sound and wise investment for any government**.

RELIEVING THE BURDEN ON GPs – UTILISING THE ENTIRE HEALTH WORKFORCE

80. HSU calls attention to Terms of Reference 'F: ix-x' which invites comment on 'opportunities for **expanded scope of practice for paramedics, community, allied health workers**, and nurses and/or midwives'; and the 'role of **multi-disciplinary community health services in…reducing pressure on the hospital system**'.[51]

81. Health policy experts uniformly agree that there is an enormous opportunity to better utilise the health workforce to achieve cost-effective and positive patient outcomes by increasing access to coordinated, multi-disciplinary community-based healthcare in NSW and across Australia.

82. *Reform Critical* notes that 'internationally pharmacists perform tasks such as writing and re-issuing prescriptions, ordering tests, conducting basic screening, implementing chronic disease management plans, managing minor illnesses, and providing prenatal and palliative care. Paramedics are involved with running injury and illness clinics, conducting home visits, implementing care plans, and providing health screening and prevention services'.[52]

83. However, this is not occurring extensively in NSW or across Australia where the Primary Health System overwhelmingly relies on GPs who account for nearly 75 per cent of clinical staff in general practice. For every 10 GPs in Australia, there are less than three nurses or allied health clinicians to support them.[53] By comparison, for every 10 GPs in the United Kingdom, there are approximately 10 non-GP supporting clinicians. In the United States of America, physician assistants provide around 11 per cent of medical services delivered outside of hospitals, whereas in Australia that figure would be near zero.[54]

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[51] New South Wales. (2023). *Terms of Reference*, Special Commission of Inquiry into Healthcare Funding. p. 2.

[52] Jackson, A. *Reform Critical*. p.54.

[53] Breadon, P., Romanes, D., Fox, L., Bolton, J., and Richardson, L. (2022). *A new Medicare: Strengthening general practice*. Grattan Institute. p. 27.

[54] Hooker, R. S. and Everett, C. M. (2012). The contributions of physician assistants in primary care systems. Health and social care in the community. 20. 1. pp. 20–31. https://pubmed.ncbi.nlm.nih.gov/21851446/.

84. A cursory look at the research and outcomes from international jurisdictions demonstrates that multi-disciplinary and integrated models of care are becoming standard practice. Evidence confirms that a diverse and highly skilled group of non-GP clinicians and allied health staff can share parts of a GPs role with equivalent safety, quality of care and health outcomes.[55]

SUPPORTING OR OBSTRUCTING CARE?

85. According to the majority of respondents to the HSU Survey, NSW Health's relatively small allocation of resources to community and preventative care **obstructs access rather than supports it**.

86. In their words, NSW health workers offered the following reflections:

- 'Health is not addressing the obesity pandemic. We spend excessive amounts of clinical time on this complex client group with minimal outcomes. We need to re-frame the medical and allied health model to prioritise…both prevention and management'. *Community Education Officer*.

- 'Access to community mental health care is limited only to people who are very acute…**many people can't afford to see a psychiatrist** and there's no accessible community-based support'. *Mental Health Worker*.

- 'The existing NSW Health system operates predominantly on a 'sickness model', focusing primarily on treating the ill. Once a patient is discharged, they often lack access to essential community support services such as healthy lifestyle and nutrition programs, harm reduction initiatives, and early disease screening. **This gap in post-discharge support can result in a recurring cycle of illness, compelling many patients to seek hospital care again**'. *Doctor - Medical Hospitalist*.

- 'The care delivered by NSW is very reactive, and this seems to worsen as the demand for healthcare increases. **Money is spent on increasing medical capacity to deliver acute care services with… very little focus on increasing the allied health workforce to meet increased demand**. Rather than appropriately funding programs that have been shown to reduce hospital admissions, reduce the length of hospital stay, and improve quality of life – funding is spent on increasing emergency department beds or paying for surge beds. This is cyclical and it will only get worse with time'. *Patient Support Officer*.

- 'Health promotion gets a tiny percentage of the budget and evidence shows money spent on **prevention saves many times the amount later spent on acute hospital care**'. *Health Education Officer*.

[55] Breadon, P. et.al. *A new Medicare*. p. 27.

- ‘There’s such a narrow focus placed on integrated and preventative care in the NSW Hospital system. We are not set up to follow patients properly after discharge, so they end up back in the hospital. Half of the people should not be walking through our doors in the first place if they had better community care. The system is completely flawed in its design, it’s back to front. **What’s the point of gastric surgery when we don’t promote healthy diets and exercise – have I missed something?**’. *Dietician*.

87. HSU also draws upon the evidence provided by members in preparation for a submission made to the ‘Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales’.[56] The most prevalent response from the nearly 100 mental health practitioners who responded to qualitative questions was to bring attention to the ‘missing’ mental health services - community models and structures of care. One respondent noted the severe shortage of available community-based mental health appointments results in ‘services becoming more and more focused on acute care, short-term care, and prioritising [off-boarding] statistics’ and stated that ‘mental health care is now predominantly a ‘patch up’ care service’. Dozens of respondents implored the government to appropriately fund and staff community-based mental health services as this constitutes ‘the most pressing gap in the system’.

ACCOUNTABILITY, NON-COMPLIANCE, OVERSERVICING AND WASTE

88. Term of Reference ‘D’ invites comment on ‘Strategies available to NSW Health to address escalating costs, **limit wastage, minimise overservicing…and proposed recommendations to enhance accountability**’.[57]

MEDICARE NON-COMPLIANCE AND FRAUD

89. As previously mentioned, Australia's Medicare system operates on a fee-for-service model. The current payment system for medical practitioners is based on the number of services provided, rather than the quality of care delivered to patients. This flawed design sends ineffective market signals and economic incentives that contribute to significant levels of Medicare billing fraud and non-compliance.

90. Research first published in 2021 by Dr Margaret Faux - a lawyer, registered nurse, and health compliance expert - pointed to a system in which fraud and non-compliance amount to nearly 30 per cent of Medicare's annual budget, approximately $8-10 billion nationally.[58] If correct, this estimate would place the cost of inaccurate medical billing to NSW taxpayers at more than a tenth of the NSW’s annual health budget.[59]

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[56] See HSU. (2023) *Submission to the Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales*. https://www.parliament.nsw.gov.au/lcdocs/submissions/81929/0134%20Health%20Services%20Union%20-%20NSW%20ACT%20QLD%20(HSU).pdf

[57] New South Wales. (2023). *Terms of Reference*, Special Commission of Inquiry into Healthcare Funding. p. 2.

[58] See Philip, P. (2023). *Independent Review of Medicare Integrity and Compliance*. https://www.health.gov.au/resources/publications/independent-review-of-medicare-integrity-and-compliance?language=en.

[59] HSU approximates a conservative figure based on population spread estimated average MBS allocations per person.

91. Popular media outlets were quick to broadcast details of Dr Faux's research and communicate how 'rogue' doctors were 'putting patients at risk, billing dead people and falsifying patient records, all to boost profits'.[60] Examples of 'pack and stack' billing practices and Medicare 'cheat sheets' were reported by Fairfax mastheads and through Adele Ferguson and the Australian Broadcasting Commission's flagship '7.30' program.[61] Such focus generated wide interest partly because of the long-held trust the community has placed in the advice and guidance of doctors and their associated professional and lobby bodies.

92. In response to Dr Faux's research, the Commonwealth Government commissioned an independent review into the integrity of Medicare and its compliance mechanism. Lead investigator, economist Dr Pradeep Philip, a former Secretary of the Victorian Department of Health and Human Services, described a system with higher than previously understood levels of fraud and non-compliance.

93. On the quantum of fraud annually, Dr Philip concluded 'that on a conservative definition of compliance and fraud, it is entirely feasible the value of non-compliance could exist in the range of $1.5 billion to $3 billion'.[62] He went on to state this analysis comes with the '**significant caveat, in that there is real potential for the problem to scale to the order of magnitude in Dr Faux's analysis should effective controls, systems and education not be put in place.**'[63]

94. It is important to note that Dr Faux's research confirmed that the *primary* cause of medical fraud was ignorance as many doctors 'do not understand' the complex billing system and often had no idea they were not complying with regulations.[64]

95. Dr Philip's report made the final blunt assessment: 'Legislation, governance, systems, processes, and tools are currently not fit for purpose and, without significant attention, will result in significant levels of fraud'.[65]

96. In raising the incidence of negligent or unethical Medicare billing practices, it is not the intent of HSU to suggest that it is a standard practice adopted by hard-working and diligent medical professionals and specialists. Our members work alongside talented medical professionals daily and observe the tremendous care they provide to Australians. However, the amount of fraud reported highlights a system that patently lacks appropriate governance and oversight. We further note that the MBS places disproportionate power and trust into the hands of a select cohort of workers – a privilege not afforded to most health workers – and one in which accuracy is paramount.

OVERSERVICING AND WASTE

[60] Ferguson, A & Gillett, C. (2022, 17 October). Experts estimate that $8 billion dollars a year lost to Medicare fraud and waste. *Australian Broadcasting Corporation*. https://www.abc.net.au/news/2022-10-17/medicare-leakage-fraud-waste/101537016

[61] https://www.smh.com.au/politics/federal/little-frauds-debated-on-doctors-only-facebook-groups-20221111-p5bxku.html

[62] Philip, P. (2023). *Independent Review of Medicare Integrity and Compliance*. p. 4.

[63] Ibid., p. 4.

[64] Faux, M. (2021). *Claiming and Compliance under the Medicare Benefits Schedule: A Critical Examination of Medical Practitioner Experiences, Perceptions, Attitudes and Knowledge*. [Unpublished thesis, PhD]. University of Technology, Sydney. pp. i-ii.

[65] Philip, P. (2023). *Independent Review of Medicare Integrity and Compliance*. p. 4.

97. *Reform Critical* notes that 'while estimating rates of fraud are relatively straightforward, estimating rates of overservicing are problematic'.[66] Healthcare professionals often face complex situations that require expertise and nuanced decision-making. These scenarios fall in the 'grey zone' where professional judgement and opinion are required. However, it's clear that even a slight overuse of certain elective surgeries can cost taxpayers hundreds of millions of dollars annually and can result in lower-quality health outcomes – particularly in post-surgery complications.

98. The Grattan Institute's report, 'Questionable Care - Avoiding Ineffective Treatment', published in 2015, highlighted that five elective surgeries were frequently performed on patients even when the evidence clearly suggested that they were unnecessary or ineffective. The report confirmed a large number of people **received treatments that they didn't require**, which led to unnecessary expenses and additional health risks.[67]

99. The analysis focused on five specific treatments: vertebroplasty, arthroscopic debridement for osteoarthritis of the knee, laparoscopic uterine nerve ablation for chronic pelvic pain, removal of healthy ovaries during a hysterectomy, and hyperbaric oxygen therapy for various conditions.[68] The report found that these treatments were either unnecessary or should only be used in rare cases that meet specific clinical criteria. This demonstrates that the system is not following the best-practice clinical guidelines in certain areas.

100. The analysis indicated that various hospitals in Australia and NSW have been performing the listed surgeries excessively. In a particularly stark case study, arthroscopic debridement for the knee (inserting a tube to remove tissue) is found to be no more effective than a placebo for osteoarthritis. Despite the lack of scientific evidence to support its effectiveness, **more than 10,000 knee arthroscopies were performed on individuals aged 50 years or older in NSW each year between 2004 and 2016**.[69] In the 2016-17 financial year, approximately 43,000 MBS-funded arthroscopic knee surgeries were performed **costing the taxpayer more than $22 million**.[70]

101. *Reform Critical* cites the high levels of caesarean sections performed in Australia, noting that in 2020, 38.6 per cent of live births were caesarean sections well above the 10-15 per cent accepted by the World Health Organisation as being associated with reduced rates of maternal and neonatal mortality. A reduction in the rates of caesarean births in Australia to 15 per cent 'could save the health system $378 million a year given the lower costs on average of vaginal births, but importantly would lead to improved health outcomes for women and babies'.[71]

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[66] Jackson, A. *Reform Critical*. p. 20.

[67] Duckett, S., Breadon, P., Romanes., D. Fennessy, P., Nolan, J. (2015) Questionable care: Stopping ineffective treatments, Grattan Institute. https://grattan.edu.au/wp-content/uploads/2015/08/828-Questionable-Care3.pdf.

[68] Ibid., pp. 3-15.

[69] Chen, H.Y., Harris, I.A., & Sutherland, K. et al. (2018). A controlled before-after study to evaluate the effect of a clinician-led policy to reduce knee arthroscopy in NSW. BMC Musculoskeletal Disorders. 19, 148. https://doi.org/10.1186/s12891-018-2043-5.

[70] RACP, *Doctors warn against unnecessary arthroscopic knee surgery*. https://www.racp.edu.au/news-and-events/media-releases/doctors-warn-against-unnecessary-arthroscopic-knee-surgery.
https://www.racp.edu.au/news-and-events/media-releases/doctors-warn-against-unnecessary-arthroscopic-knee-surgery

[71] Jackson, A. *Reform Critical*. p. 21.

VIEWS OF MEMBERS

102. In examining waste in the NSW health system, HSU asked health workers the following survey question: *Do you think NSW Health wastes money?*

103. HSU received the following results:

- 782 health workers responded.
- **79.16 per cent answered – 'Yes'.**
- 3.58 per cent answered – 'No'.
- 17.26 per cent answered – 'Unsure'.

104. The HSU survey asked participants to share examples of waste in the health system through individual case studies. From 582 responses received, three areas of concern were identified by survey participants that require attention and action from both the NSW Government and this Inquiry:

- Excessive use and over-reliance on Visiting Medical Officers in the NSW hospitals.
- The widespread engagement of consultants.
- Over-ordering of diagnostics tests in relation to medical imagining – radiography.

VISITING MEDICAL OFFICERS – A NSW PHENOMENON

105. Term of reference 'F' invites examination into the 'use of locums, **Visiting Medical Officers, agency staff and other temporary staff arrangements**' within NSW Health.

106. The medical industry in NSW has received considerable criticism in light of the comparably high use of temporary doctors and Visiting Medical Officers (VMOs) to cover for permanent shortages. This has raised concern about the huge cost to taxpayers and the sub-optimal impact it might have on patient care.

107. The NSW State Government employs doctors through part-time and full-time permanent roles and through casual arrangements – including the use of Visiting Medical Officers (VMOs) and Locums.

108. *Reform Critical* highlights that high doctor salaries contribute to rising healthcare costs in Australia compared to other systems internationally. In NSW, some casual arrangements allow doctors to charge **more than $4,500 a day and nearly $25,000 a week**, often for fly-in and fly-out positions.[72]

109. The NSW public hospital system is defined by two categories of specialists: Salaried Medical Officers (SMOs) are directly employed; while VMOs are contracted and renumerated through sessional services and fee-for-service arrangements. Both treat public patients and private patients in public hospital settings.

[72] Woodburn, J., Craig.,& Reading. (2022, 9 August) Locum doctor fee rises lead charity to withdraw financial support in five NSW towns. *ABC*. https://www.abc.net.au/news/2022-08-09/nsw-towns-at-risk-no-gp-services-locum-doctor-costs/101311848#.

110. ‘AdvanceMed’ a human resources company specialising in the recruitment of Australian-based VMOs describes how there is a considerable disincentive for specialists in NSW to take salaried roles: ‘A VMO surgeon working 40 hours per week for 48 weeks a year would earn $540,096 for 48 weeks a year (as of March 2023) – or about $80,000 more than an SMO’ in the NSW public hospital network.[73]

111. The use of VMOs in hospital settings in NSW shows that the state is charting a divergent and expensive health management model compared to Victoria and Queensland. Analysis by *Reform Critical* calculated that in 2022 the cost of VMOs to the NSW health system exceeded $1 billion.[74] In the decade from 2012 to 2022, **the costs of VMOs increased by 54 per cent**. Further, NSW spent four times more than Victoria and ten times more than Queensland on VMOs in 2020-21.[75]

112. *Reform Critical* further notes that the high reliance upon VMOs right across the NSW public hospital system is costly and undermines standard continuity of care principles – a central element driving strong patient outcomes. Many doctors have shown hesitation in adopting new, affordable, community-based healthcare models.

113. HSU members in NSW are concerned about the high usage of Visiting Medical Officers (VMOs) as confirmed by the evidence below:[76]

- ‘Visiting Medical Officers have been noted to occasionally bill for services that were not provided, including claiming to manage patients of whom they had no prior knowledge. Additionally, VMOs occasionally charge for services without being required or asked to. **This kind of over-servicing is not just financially concerning but can also be medically disruptive**. For example, a VMO might offer a management plan for a patient not under their direct care. This happens even when there's an existing plan from the primary consultant, and the VMO's input wasn't sought. These unsolicited plans from VMOs can contradict the original plan, leading to confusion among patients, nurses, and junior medical staff. The result? Unnecessary tests, conflicting medical advice, and an increased workload for nurses and junior doctors’. *Doctor – Medical Hospitalist.*

- ‘…**there’s a heavy reliance on VMOs and external contractors as the system is not investing in core services properly** then subsequently paying overtime and/or increasing bed days for patients’. *Physiotherapist.*

- ‘VMOs and the complete lack of negotiation with contracts are outrageously expensive’. *Senior Patient Manager.*

- ‘We have VMO doctors reporting on obstetric ultrasounds for two mornings per week. Today the VMO reported three scans and read the paper. Ridiculous waste of money. Our full-time doctors used to report obstetric morphology scans but now ‘don't want to’. **All the**

[73] See https://advancemed.com.au/salary-of-australian-doctors-surgeons/.

[74] Jackson, A. *Reform Critical*. p. 22.

[75] Ibid., p. 22.

[76] HSU Survey, October 2023.

public patients are being referred to their private practices for the scans, where they may or may not report the scan'. *Sonographer*.

OVERUSE OF PATHOLOGY AND MEDICAL IMAGING TESTS

114. HSU also cites the extreme concern held by dozens of pathology and medical imaging professionals who specifically reported to this survey – including those who conducted direct interviews with HSU to explain their concerns[77].

- 'I perform examinations that will not provide additional information or alter patient management but am forced to by referrers. These examinations are ***not only costly, but they take time to complete, creating a backlog of imaging procedures***. I have discovered…ED doctors have [frequently] not even seen a particular patient before ordering imaging leading to the patient being re-presented for further imaging when the referrer sees them'. *Radiographer*.

- 'Nobody oversees the ***over-ordering tests by VMOs***'. *Pathologist*.

- 'Far too much imaging is being ordered across all modalities in ***contrary to clinical guidelines. These tests are invariably useless and highly expensive*** – they clog up the system and take from other patients in need'. *Medical Imaging Specialist*.

- '…referring unnecessary x-rays, US, CT & MRI - ***clogging up the system with unnecessary exams***…makes it hard to get to the sick people who actually in need our help. If referring doctors weren't paid for reading the results of everything they ordered, a lot less [tests] would be ordered. Also paying locum and private radiology companies crazy money (over $90,000/month) instead of paying our radiology experts decent money is a joke - that's just my hospital. *Radiographer.*

- '…incomplete assessment of patients leading to ***over-ordering and inappropriate ordering of imaging examinations*** - further leads to a drain on resources, unnecessary increases in radiation exposure, delays in reporting, and extended wait times in emergency'. *Radiographer*.

115. A senior clinician and academic fellow at a major public hospital in NSW has provided evidence to HSU that the overuse of imaging services has become a common practice in the state, which contradicts both national clinical standards and international research. The clinician highlighted the **excessive use of computed tomography and emphasised the negative impact on patient outcomes**. The views expressed by HSU members align with accepted health research, which warns against the waste and potential risks associated with overusing certain diagnostic and imaging tests.[78]

[77] Ibid.

[78] Youens, D., Doust, J., Ha, T. N., O'Leary, P., Slavotinek, J., Wright, C., & Moorin, R. (2022). Association of regulatory body actions and subsequent media coverage with use of services in a fee-for-service system: a longitudinal cohort study of CT scanning in Australia. *BMJ Open*, 12. 4. https://doi.org/10.1136/bmjopen-2021-057424.

USE OF CONSULTANTS

116. HSU further draws attention to our organisation's July 2023 submission to the NSW Parliament's inquiry into the government's use and management of consulting services. During the investigation, HSU presented evidence showing the extent to which NSW Health relied on ineffective and often ideologically biased advice from consulting firms. This practice is not only a complete waste of taxpayer money but also harmful to the public health system of NSW.

117. Data obtained during the 'Use of Consultants' inquiry revealed significant spending on health-related consultants from 2011 to 2022.

- NSW Ministry of Health - $235.3 million.[79]
- LHDs - $125.2 million.
- Four LHDs spent more than $10 million.[80]

118. Figures analysed by HSU revealed that the collective LHD spend on consultants for the two consecutive six-year intervals dating 2011-2016 and 2017-2022 inclusive rose by at least 50 per cent.[81] The amount of spending raises concerns about the leadership and governance structures responsible for overseeing LHDs.

119. Term of Reference 'B. i' of this Inquiry scrutinizes the **'balance between central oversight and locally devolved decision-making** (including the current operating model of Local Health Districts)'.[82] We argue that the use of consultants in NSW Health highlights a possible instance of 'soft corruption' within LHDs, due to issues with utility, function, and transparency. As heard in the 'Use of Consultants' Inquiry, there is and has been a strong link between the so-called 'Big Four' management consultancies and LHD board appointments. Indeed, evidence furnished during the Inquiry suggested at the time that 660 Price Waterhouse Coopers aligned consultants were sitting on up to 900 public boards across the country.[83]

120. A thorough analysis of the relevant literature fails to adequately describe and quantify the economic, social, cultural, and health benefits resulting from the decentralised structure of Local Health Districts (LHDs). On the other hand, replicating governance structures may lead to unfavourable consequences such as a reduction in board competencies, considering the multitude of LHD board appointments, and the difficulty in attracting, training, and retaining highly skilled and innovative members.

121. In 2011, the NSW health system was reconfigured, and Local Health Districts (LHDs) were established. At the time the NSW Department of Health sought advice from several consulting firms to guide the restructuring of public health services. It is worth noting that this advice is considered cabinet-in-confidence and has not been disclosed to the public.[84]

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[79] This figure represents the inclusive total of spending across the NSW public health system.

[80] See data supplied to Inquiry Chair, Abigail Boyd MLC, and published on the Inquiry page of Public Accountability and Works Committee website.

[81] Ibid.

[82] New South Wales. (2023). *Terms of Reference*, Special Commission of Inquiry into Healthcare Funding. p. 1.

[83] See data supplied to Inquiry Chair, Abigail Boyd MLC, and published on the Inquiry page of Public Accountability and Works Committee website.

[84] HSU. (2023). *Submission to the Inquiry into the NSW Government's Use and Management of Consulting Services*. p.9. 'https://www.parliament.nsw.gov.au/lcdocs/submissions/80286/0017%20Health%20Services%20Union.pdf

122. HSU Survey respondent for this Special Commission Inquiry also provided extensive feedback regarding waste and the use of consultants in NSW Health.[85]

- ‘The money paid to consultants is extraordinary when this **all could be performed at the management level, just as it was 30 years ago**’. *Finance Director*.

- ‘Government contractors often then have a **monopoly on price**. We have consultants come in and they barely have an impact on the improvement of services. They just want the money’. *Community Health Manager*.

- ‘MNCLHD has paid Organisational Design Consultants four times over the last six years…to investigate a new organisational model to service the ICT Digital Health needs of the MNCLHD. Four times to review and agree on an operating mode’. *Senior Systems Manager*.

- ‘Our LHD’s management has spent more than a million dollars in recent years in securing the advice of **external consultants who for the most advise us to sack staff and appoint external contractors to take these roles** – overseen of course by a management consulting firm. Is this not the absolute definition of snouts in the trough type corruption’. *Executive Administration Officer*.

123. The 'Use of Consultant' Inquiry found that NSW and LHDs spent over $250 million on consultants with little to no discernible efficiencies or improvements. In our submission to this Special Commission Inquiry, we re-iterate this previous research and contend that the ‘NSW Government’s excessive use of consultants represents flawed and increasingly redundant management practice, creates real problems regarding transparency in the utilisation of taxpayer money, and obstructs the development and capacity of current and future staff’.[86]

CONCLUSION

124. In our submission to this Inquiry, HSU has in plain terms, highlighted that the NSW health system is at breaking point and desperately in need of whole-of-system reform. The COVID-19 pandemic accelerated our current crisis and tragically revealed the challenge of caring for an aging population in a labour market that consistently undervalues the skills and capabilities of healthcare workers.

125. We have paid particular attention to the opinions expressed by our members, those positioned at every point of the NSW public health system and who see how rapidly health fortunes can change. They have told us that the demography of illness is shifting, no longer acute and episodic, but now defined by chronic conditions and complexity. They have also reminded us of the sober reality of a health system

[85] HSU Survey, October 2023.

[86] HSU. (2023). *Submission to the Inquiry into the NSW Government's Use and Management of Consulting Services*. p.9. ‘https://www.parliament.nsw.gov.au/lcdocs/submissions/80286/0017%20Health%20Services%20Union.pdf

consisting of haves and have-nots, in which socioeconomic status is a central determinant of positive health outcomes, and in which too many are unable to access and afford the care they need.

126. To conclude, HSU looks to the NSW Government to exhibit the necessary leadership required to take on the challenge of sustainable and intergenerational health reform. This cannot be achieved by way of sound bites, press releases, or superficial enquiry that facilitates a handful of savings but does little to address underlying structural issues at hand. Instead, we call on governments at all levels, as well as workers and key stakeholders, to re-engineer a health system built upon sustainable, integrated and community-based models of care. To find budget savings and efficiencies, we must comprehend that the most substantive structural savings will materialise by arresting chronic illness through preventative care. Reform is Critical – safe, timely, equitable and accessible healthcare is the reasonable expectation of the people of NSW - and of committed, passionate, and highly skilled health workers.

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