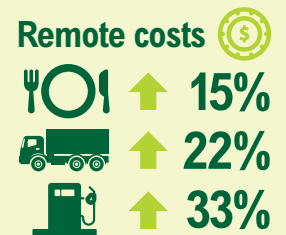




# A fair share for WA health care





# Foreword

Providing health care in a vast, isolated and sparsely populated State such as Western Australia is both challenging and expensive.

Like all Australians, our community deserves to be able to rely on quality care when we are at our most vulnerable, regardless of geography and circumstance. **Western Australia's regions are key contributors to our State and the nation's economic prosperity and deserve the same basic services that the vast majority of Australians take for granted.**

The WA Government knows we also have to deliver a sustainable, world-class health system within our means, because if we don't, future generations will miss out. We acknowledge that we have work to do to make our healthcare system sustainable. That includes looking at the underlying reasons why our cost of delivering hospital services is higher than in other States.

However, there are factors out of our control. **The sheer scale of our State, with sparsely populated areas and communities with stubborn disadvantage are problems unique to but a few regions of this continent.** WA has significantly fewer GPs per head of population than the national average and a lower share of PBS and MBS reimbursements. The State Government is often called on to deliver services because it is the provider of last resort, and sometimes the only provider. For example the State Government provides, and thus pays for, the majority of health services in the North West.

Unique, location-based costs in the delivery of public hospital services are legitimate and unavoidable, particularly in regional and remote areas. These costs are due to hospital type, size and geographical factors that constrain how hospitals can efficiently provide services compared to metropolitan hospitals.

While Western Australia continues to work assiduously to increase efficiencies across the health system, there needs to be recognition of the unavoidable constraints faced by the State. We urgently need the Commonwealth to play their part in the solution.

There are a number of measures where Commonwealth funding does not account for the unique challenges faced by this State. This paper represents the start of a long overdue conversation which will allow Western Australia and the Commonwealth to move forward together to drive **innovation, integration and culture change towards** building a more efficient, fair and **sustainable health system** in this State.



**Hon Roger Cook MLA**  
MINISTER FOR HEALTH

## Recommendations

To ensure that Western Australians receive their fair share from the Commonwealth government, and that our residents receive health care commensurate with both our need and our contribution to the nation's wealth and prosperity, we put forward four simple recommendations. The implementation of these recommendations would go some way towards levelling the playing field and see our State receive **the equivalent of** what other States receive per head of population, for providing health care for their citizens.

While the Commonwealth contribution to WA's Health Budget remains lower than the national average, costs in the Western Australian health system have more than doubled in the past 10 years. WA public hospitals cost around 20 per cent more than the national average. Health expenditure has spiralled to 30 per cent of the State Budget. While we believe the Commonwealth has a pivotal role as the key partner in our health system, we know we also have to do better in constraining the pace of growth while delivering first class healthcare services.

Western Australia is engaged in a comprehensive review of our health system. The **Sustainable Health Review** is being conducted to guide future investment in the WA health system so that we can deliver affordable, integrated services that leverage new technology, new patient pathways and current investment in health care. Consultations have occurred throughout Western Australia to drive the development of a new patient-focussed system which looks beyond bricks and mortar and delivers high quality services regardless of geography and circumstance. We will respond to this report by 2019/20; however, a full and considered response needs a dialogue with the Commonwealth to allow us to plan our commitments together as partners. This will ensure our citizens receive the accessible quality health care that is their right.

The WA Government will drive innovation, integration and cultural change in our health system:

- Innovation will drive different ways of delivering health care, such as Medihotels, Urgent Care Pathways and Innovation Hubs.
- Integration will break down the barriers between GPs, specialists and hospitals.
- Patient opinion will drive a responsive and transparent health system and deliver cultural change.

In the context of building a health system for the State that is innovative, integrated and sustainable, we seek the Commonwealth's commitment to:

1. Halving the disparity in the average amount of overall Commonwealth health funding per person in Western Australia over the forward estimates period and to increasing the funding to the national average level over the next decade.
2. Continue to address the anomalies in the determination of the price paid for healthcare delivery in remote and regional Western Australia, as part of the National Pricing Framework developed by the IHPA, to reflect the true cost of service delivery in these locations, to fairly and equitably meet the needs and circumstances faced by the State.

We also request that the Commonwealth enter into a bilateral agreement to underpin the recommendations and manage a joint response to:

3. Addressing the poor access to primary health care faced by Western Australia, through incentives for GPs, modelled on the successful Southern Inland Health Initiative and/or additional funding to the State to provide supplementary services to disadvantaged populations.
4. Improving access to aged care services in Western Australia, by increasing the number of Commonwealth-funded residential aged care places to the national average over the next decade, with a commitment to halve that gap over the forward estimates; or alternatively provide additional funding to the State to be able to develop its own initiatives in this area to close the gap to the national average.

# Key Points

WA does not receive a fair share of health funding from the Commonwealth measured against:

- PBS per person.
- Medicare per person.
- GPs/100,000 population.
- Aged Care beds per 1,000.

WA faces **unique and legitimate cost challenges** in delivering public hospital services in regional and remote hospital sites in the State.

1. Although some progress has been made for more adequate recognition of disadvantage from 2018-19 WA analysis<sup>1</sup> shows that the current hospital funding model does not adequately recognise provider-based issues, such as hospital location, scale and scope. These issues impact on the ability of WA hospitals to operate at or near to the National Efficient Price (NEP) – the price that determines the amount States get funded.
2. Latest available data shows that Tasmania, which is approximately 20 per cent the size of WA's Kimberley region, attracts an additional 2.7 per cent funding for remoteness under the current national hospital funding model while WA only receives 1.9 per cent additional funding for remoteness, and is vastly more geographically dispersed. While this largely reflects the greater proportion of Tasmania's population that lives outside their major cities, the remoteness loading also fails to recognise that Western Australia's remote towns have higher costs than similarly remote towns in other States.
3. Under the national model, the lowest cost States are the largest populated States, with cost differences explained by population differences, and population relative to geographical size.
4. WA is relatively disadvantaged by the requirement to provide a full range of health services to a comparatively small population, across a considerably larger geographical footprint.
5. WA's isolation from other capital cities means that it must provide a full range of specialist health services often at less than economical volumes, specifically low-volume, highly-complex tertiary and quaternary services. As opposed to other States, where a neighbouring capital city represents a viable option for treatment, Adelaide is smaller than Perth and is over 2500 kilometres away by road.
6. The State has a group of high-cost hospitals in the North West, which service small populations spread over large areas where service provision costs are significant and unavoidably high.
7. The "one-size-fits-all" model results in WA being disadvantaged relative to other jurisdictions.

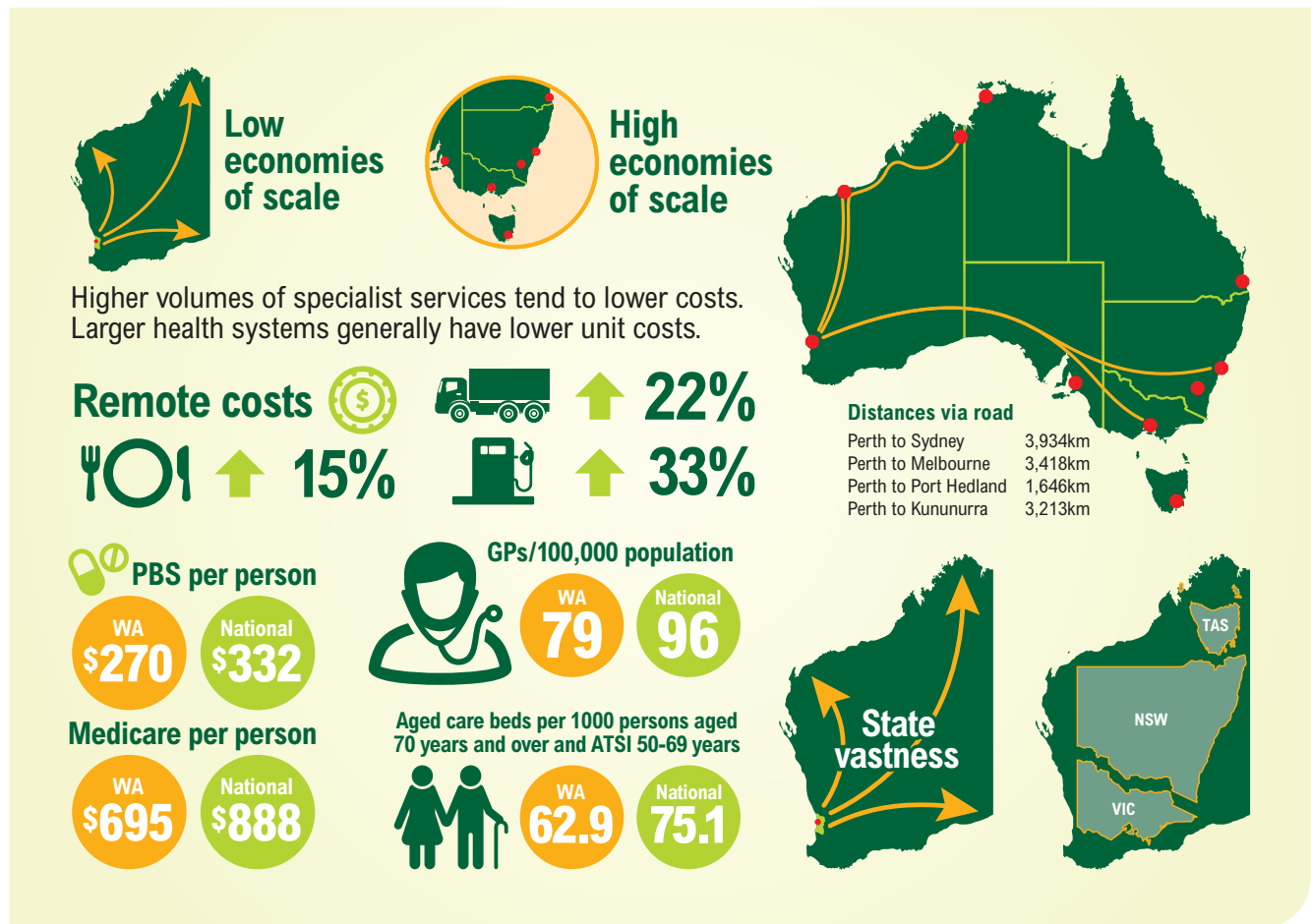
WA's provider-based issues, coupled with historical shortfalls in access for WA residents to GP services and aged care places relative to the national average, places undue pressure on the State Budget.

8. The lower availability of GP services in WA places significant pressure on the health system. The number of GP services in WA (79 GPs compared to 96 per 100,000 population) is significantly below the national average)
9. Significant additional investment has been provided by the State to address issues with doctor shortages and a resulting lack of access to GPs and health services.
10. WA shares a unique burden for investment in primary health care that should be borne by the Commonwealth, in funding GP Services throughout the regions.
11. MBS and PBS Expenditure in WA is below the average for Australia.

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1 Source: Department of Health Analysis of the State Price for Hospital Services

At 30 June 2017, WA had the lowest rate of operational Commonwealth-funded residential aged care (RAC) of any state in Australia at 62.9 places per 1,000 people aged 70 years or over and Aboriginal and Torres Strait Islander people aged 50–69 years, versus a national rate of 75.1<sup>2</sup>. An **all-inclusive** national funding model that gives due consideration to these issues needs to be considered and discussed as part of the continuing commitment to fairly and equitably fund jurisdictions.



## WA's contribution

Despite accounting for just 10.5% of the national population in March 2017, Western Australia accounted for:

- 15.4% of the national economy in 2015–16 (latest available GSP data)
- 45.7% of Australia's merchandise exports in 2016–17
- 18.1% of national business investment in 2016–17, despite recording a 28.7% fall in that year
- 11.2% of the national labour force in the year to September 2017, with the State's participation rate of 67.7% well above the national of 64.8% over that period
- 12.4% of Australia's compensation of employees in 2016–17 (a nominal measure of total wages)
- 17.0% of the total national housing financial commitments for first home buyers in the year to July 2017.

<sup>2</sup> This rate is the lowest ever recorded for WA and the lowest of any Australian jurisdiction aside from the Northern Territory.

# Fixing the anomalies in WA's funding

The WA Government delivers services which would normally be funded by the Commonwealth, especially in rural, remote and very remote parts of the State where the WA government is the provider of only resort. In ensuring Western Australians have access to quality health care, we are subject to substantial additional costs, such as transport, wages and infrastructure. In other States, most of these costs are met by Commonwealth funding, yet in Western Australia, Commonwealth funding is demonstrably inadequate.

The national funding model for 2018/19 is partly addressing the unique challenges to deliver appropriate, targeted Commonwealth funding to WA.

Under the national Activity Based Funding (ABF) model, the lowest cost jurisdictions are the highest population States with jurisdictional cost differences that can be explained by population relative to geographical size. Simply put, the denser your population, the cheaper it is to provide services: residents are concentrated near readily accessible services.

WA is disadvantaged by the requirement to provide a full range of services to a comparatively smaller population across a significantly larger geographical area. WA's isolation from other capital cities also means that it must provide a full range of specialist services, often at less than economical volumes.

Provider factors such as hospital location, scale and scope impact on the capacity of WA hospitals to operate at or around the NEP. These factors are not adequately accounted for in determining the price for service delivery in remote areas: weightings to funding are based around patient profiles, not input costs.

A group of high cost hospitals are located in the North West of the State servicing small populations spread over large areas where input costs are significantly higher and considered unavoidable.

**The national model is purely an average model.** WA has little impact on national averages and therefore the model does not accurately reflect local data or associated issues. WA faces significantly variable conditions compared to other jurisdictions regarding wages and service presence across the largest State in Australia resulting in diseconomies of service delivery scale. Our size and isolation from other tertiary hospital facilities in Australia means that we are less able to move patients across jurisdictions to access specialised services, and must provide them locally.

The current national pricing model does not accurately capture legitimate and unavoidable costs for remote and very remote hospital services in WA. By way of example, the latest available data shows that Tasmania, which is approximately 20 per cent the size of WA's Kimberley region, attracts an additional 2.7 per cent funding for remoteness under the current national hospital funding model while WA only receives 1.9 per cent additional funding for remoteness, and is vastly more geographically dispersed<sup>3</sup>. While this largely reflects the greater proportion of Tasmania's population that lives outside their major cities, the remoteness loading also fails to recognise that Western Australia's remote towns have higher costs than similarly remote towns in other States. This is partially mitigated by revisions to the IHPA funding model from 2018/19, resulting in location-based adjustments being applied to remote and very remote hospitals, which will benefit hospitals in the Northwest of WA.

Activity levels within the more remote ABF funded hospitals are highly variable and when combined with the extreme cost pressures, the result is that these hospitals cost, on average, almost 50 per cent more than the 2015/16 calculated NEP.

## The Pilbara

- Population: 61,435, or 2.4%
- Area: 500,000 km<sup>2</sup>
- Mineral and petroleum sales: **\$82.3bn.**

3 Current IHPA pricing methodology.



Hospital	Distance from Perth (km)	Actual cost per patient (A)	Estimated cost per patient based on the NEP and relevant adjustments* (B)	Per patient cost at National Efficient Price (C) = 45% of B)	WA funded cost per patient (A-C)
Kununurra	3,321	\$7,278	\$4,905	\$2,207	\$5,071
Derby	2,498	\$7,707	\$4,515	\$2,032	\$5,675
Nickol Bay	1,522	\$7,956	\$5,317	\$2,393	\$5,563
Average		\$7,421	\$4,912	\$2,210	\$5,211

\*the national model includes relevant adjustments relating to remoteness and demographics, 2017/18.

WA commissioned a study to understand the factors contributing to the difference between the State's average cost of providing hospital services and national benchmarks. While this study demonstrates the role that we must play in making our health system sustainable, it also highlighted the role the Commonwealth should play in recognising the differences we face through no fault of our own.

Findings of the study indicate that factors unique to WA explain almost half the cost differential.

	% of total difference
<b>Area A – Under Management Control</b>	<b>12.0%</b>
<ul style="list-style-type: none"> <li>Differing models of care</li> <li>Differing length of stay</li> <li>Higher levels of staff, staff mix and resource utilisation</li> <li>DRG coding variances</li> </ul>	0.6% 0.0% 3.7% 7.6%
<b>Area B – Under Government Control</b>	<b>39.8%</b>
<ul style="list-style-type: none"> <li>Higher total compensation for healthcare staff in WA under WA's IR agreements</li> <li>Smaller hospitals with lower operational efficiencies</li> <li>Fewer co-located public and private hospitals</li> <li>Accessibility/Availability of other forms of health care</li> </ul>	30.5% 7.9% 1.3% 0.0%
<b>Area C – WA Unique Factors</b>	<b>48.2%</b>
<ul style="list-style-type: none"> <li>Inadequate recognition of remoteness costs within the national ABF model</li> <li>Hospital efficiency in rural and remote locations</li> <li>More expensive labour market in WA</li> <li>Higher need in WA to cater for high-cost, high-complexity but low-volume services</li> </ul>	15.5% 17.6% 13.2% 1.9%
<b>Total</b>	<b>100%</b>



## Rural and remote loadings are inadequate

As we have outlined, there are unavoidably higher costs in the delivery of health services in regional and remote locations. The Grattan Institute found that “high-cost States share one clear characteristic: they have smaller populations”<sup>4</sup>. This is most evident in the remote and very remote areas of WA where costs are significantly higher, and loadings are entirely inadequate to take into account the amount of investment which is required by the State.

From 2018/19, location-based adjustments will be applied to remote and very remote hospitals which will benefit hospitals in the Northwest of WA. Despite this, there are still cost discrepancies that the Commonwealth will need to address for rural and remote hospitals.

## Royal Flying Doctor (RFDS) funding

Evacuations provided by the RFDS are an integral part of the health service in Western Australia, with developed infrastructure to support it throughout the State. They are underpinned by an investment in capabilities through aircraft, doctors, nurses and pilots to provide standing capacity at all times. Traditionally, the investment in this capacity has been met on a shared basis between the Commonwealth and the State. There has now been a reduction of baseline Commonwealth funding for RFDS to primary evacuation and remote area clinic services from 50 per cent to 25 per cent, again impacting on the capacity of the State to fund services more broadly. Primary evacuations have increased by over 74 per cent in the last decade, or over 600 patients<sup>5</sup>.

## Recommendation

That the Commonwealth:

1. Commit to halving the disparity in the average amount of overall Commonwealth health funding per person in Western Australia over the forward estimates period and to increasing the funding to the national average level over the next decade.
2. Continue to address the anomalies in the determination of the price paid for healthcare delivery in remote and regional Western Australia, as part of the National Pricing Framework developed by the IHPA, to reflect the true cost of service delivery in these locations, to fairly and equitably meet the needs and circumstances faced by the State.

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4 Grattan Institute, *op. cit.*

5 Royal Flying Doctor Service provided figures.

# Sustainable Health Review

The Western Australian Government acknowledges we must work harder to make our health services more efficient. A **Sustainable Health Review** is being conducted to guide future investment in the WA health system so that we can deliver affordable, integrated services which leverage new technology, new patient pathways and current investment in health care.

We have already acted to bring health expenditure under control. The 2017–18 Budget provides expenditure of \$8.9 billion for WA Health, an increase of just 1.4 per cent over 2016–17 and provides an annual average expense growth of 1.0 per cent over the forward estimates. Hospital services expenditure of \$6.4 billion in 2017–18 represents growth of 2.5 per cent and annual average expense growth of 3.3 per cent over the forward estimates. That shows we are delivering hospital services where they are needed, and finding efficiencies while continuing to provide for service growth.

The SHR is being conducted by an experienced Panel of experts that have been appointed by the Government of Western Australia and independently chaired by Ms Robyn Kruk AM. Ms Kruk has more than 30 years of experience in public sector service reform at the State and Commonwealth level, including as Director General of NSW Health, and inaugural CEO of the National Mental Health Commission.

Broad engagement with stakeholders has occurred across Western Australia, including 19 public and clinical forums and over 300 public submissions received.

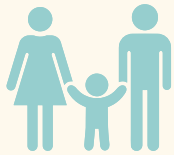
The Sustainable Health Review Panel published its Interim Report on 27 February 2018. The Report presents the Panel's initial observations, preliminary directions, recommendations for immediate action and areas for further work to develop a more sustainable WA health system.

In its Interim Report the Panel has emphasised the importance of pursuing a fair share of funding and greater cooperation between the State and Commonwealth across a range of areas.

Following the release of the Interim Report, the Panel will undertake further engagement with key stakeholders to test its preliminary directions and focus on key issues for its Final Report to Government in November 2018.

# Sustainable Health Review

## WA public health system has grown (last 10 years)



Population  
↑ 29%



ED attendances  
↑ 49%



Hospital admissions  
↑ 39%

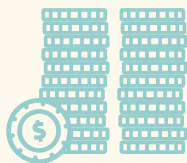


Births (public)  
↑ 36%



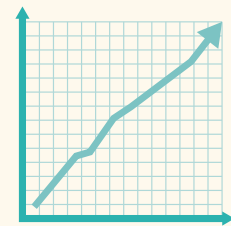
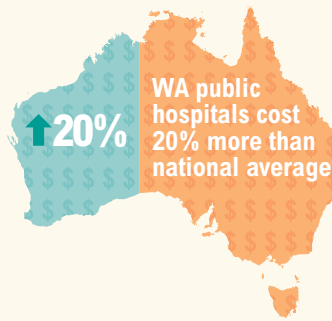
\$7 billion infrastructure investment

## Health costs continue to rise



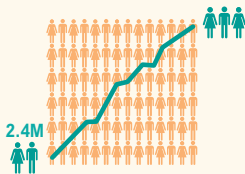
Health spending has more than doubled in 10 years

**\$3.8B** ↑ **\$8.8B**



WA State debt

## The system is under pressure



Growing population (3.2M in 10 years)



Ageing population (50% more people over 65 in 10 years)



Chronic disease cost (\$1B in 10 years)



Fewest GPs per capita of all States

## Key to a sustainable future for health



Patient first



Value for money



Healthy lifestyles



Partnerships across sectors



Technology and innovation

# Access to General Practice

While the State and Territory jurisdictions have primary responsibility for hospital-based care, the Commonwealth has responsibility for ensuring access to primary health services such as GPs.

Schedule E of the *National Health Reform Agreement* ascribes lead responsibility to the Commonwealth for the system management, funding and policy development of GP and primary health care. Availability of GP services in WA is substantially below the national average (79 GPs compared to 96 per 100,000 population respectively), placing significant pressure on the WA health system.

Because of this situation, the emergency departments in State-funded public hospitals become the default provider of last resort for peripheral metropolitan and rural and remote residents in need of primary care, accessing GPs in emergency departments.

It follows that Medicare Benefits Schedule and Pharmaceutical Benefits Scheme expenditure in WA is also well below the national average. Therefore, substantial supplementary State investment is required to redress the lack of access to primary care in WA.

The WA health system invests significantly in the regional and remote public hospital system to address the lack of access to GPs and health services, due to the shortfall in Commonwealth investment in this area. As a result, Western Australia has a very hospital-centric health system, with the State bearing the lion's share of the costs.

An illustrative example of the State Government filling a gap left in Commonwealth responsibility is the Southern Inland Health Initiative (SIHI), which has seen significant investment in the following since 2012:

- Improved incentives to attract and retain GPs in country towns and to take part in emergency department rosters in the SIHI catchment. There are now 37 per cent more GPs available in towns in the SIHI catchment, compared to pre-SIHI levels.
- An Emergency Telehealth Service to provide specialist support to doctors and nurses in small rural hospitals. There are 50 sites in the SIHI catchment benefiting from this service.

This initiative alone costs the Western Australia Government some \$33 million annually in GP incentives. The SIHI GP incentive program has successfully boosted the total number of GPs recruited in the SIHI region. As at October 2015, there were 133 GPs in the SIHI region, 36 more than before the incentive scheme was in place.

More than 67 communities in the SIHI area have benefited from an improved four-year retention rate among GPs, with a 59 per cent retention rate in GP incentive towns versus 30 per cent in towns where GP incentives weren't being paid.

Initiatives like SIHI point the direction to initiatives which could be undertaken in the future to improve the reach of primary health care in Western Australia. While the Commonwealth has stated that it cannot interfere in the commercial decisions of primary health care providers, to not do so is to abrogate responsibility for primary health care for vast swathes of our State. Pharmacy location rules are an example where the Commonwealth actively regulates the provision of healthcare services in Australia.

## Recommendation

3. That the Commonwealth address the poor access to primary health care faced by Western Australia, through incentives for GPs, modelled on the successful Southern Inland Health Initiative and/or additional funding to the State to provide supplementary services to disadvantaged populations.

# Aged Care

Access to affordable, quality aged care throughout the State has increasingly become a challenge in recent years. In turn, this too has applied pressure to State-funded hospital services, with presentations from older Western Australians.

While aged care is a Commonwealth responsibility the State through necessity is increasingly being required to invest in this sector as a consequence of the disparity in the number of Commonwealth funded aged-care places.

At 30 June 2017, WA had the lowest rate of operational Commonwealth-funded residential aged care (RAC) of any state in Australia at 62.9 places per 1,000 people aged 70 years or over and Aboriginal and Torres Strait Islander people aged 50–69 years, versus a national rate of 75.1. This represents a 24.3 per cent decline since 2001, when WA's rate was 83.1 and the national rate was 81.4<sup>6</sup>.

Commonwealth aged-care planning ratios show that WA has a shortfall of approximately 3,400 RAC places in WA. Lower rates of operational RAC result in reduced availability and may increase the time required for individuals to access this type of service. Patients in regional areas often have no other option but hospital care.

For older Western Australians, longer RAC access times may in turn result in:

- Poorer health outcomes and increased rates of emergency presentations as unmet care needs in frail, older people often result in the development or exacerbation of conditions requiring treatment
- Increased pressure on formal and informal community support services
- Increased carer stress for older Western Australians living in the community
- Increased pressure on hospital length-of-stay for those patients who have completed their acute or subacute episode and are awaiting Commonwealth subsidised aged care services, the majority of whom are awaiting RAC.

Changes to the Commonwealth's community aged care environment, particularly the move to a national pool of community places from regional (State-based) allocations have meant that there are increased difficulties for older Western Australians in accessing this type of service, which can contribute to delays in hospital discharge for patients awaiting these services.

The State Government can play a part in improving uptake of aged care licences by improving planning processes and cooperation with agencies at a State level. However, the Commonwealth should look to regional allocations again, or to place-based incentives for aged care providers.

## Recommendation

4. That the Commonwealth improve access to aged care services in Western Australia, by increasing the number of Commonwealth-funded residential aged care places to the national average over the next decade, with a commitment to halve that gap over the forward estimates; or alternatively provide additional funding to the State to be able to develop its own initiatives in this area to close the gap to the national average.

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6 Report on Government Services, 2006 and 2018, Productivity Commission, Tables 12A.11 and 14A.15.

# Conclusion

Health is the most important service government provides, because our wellbeing underpins every aspect of our lives. We deserve to be able to rely on quality care when we are at our most vulnerable, and our citizens expect government to deliver this vital service as a key dividend for their taxes.

At the moment, a disproportionate share of the responsibility for that provision is falling to the State Government.

The issues outlined in this paper are not intractable. What they will require is a new spirit of cooperation and commitment between the State and Federal Government to ensure equity of access to healthcare services for Western Australians.

What we are proposing is just four simple policy measures which would build a stronger partnership for the delivery of quality healthcare services in Western Australia. We will work with the Commonwealth and enlist the support of stakeholders and the community to drive change and deliver a health system which is innovative, integrated, has the patient at its core and is sustainable, so future generations too can rely on quality health care.





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