Submission No 22

INQUIRY INTO IMPACT OF AMBULANCE RAMPING AND ACCESS BLOCK ON THE OPERATION OF HOSPITAL EMERGENCY DEPARTMENTS IN NEW SOUTH WALES

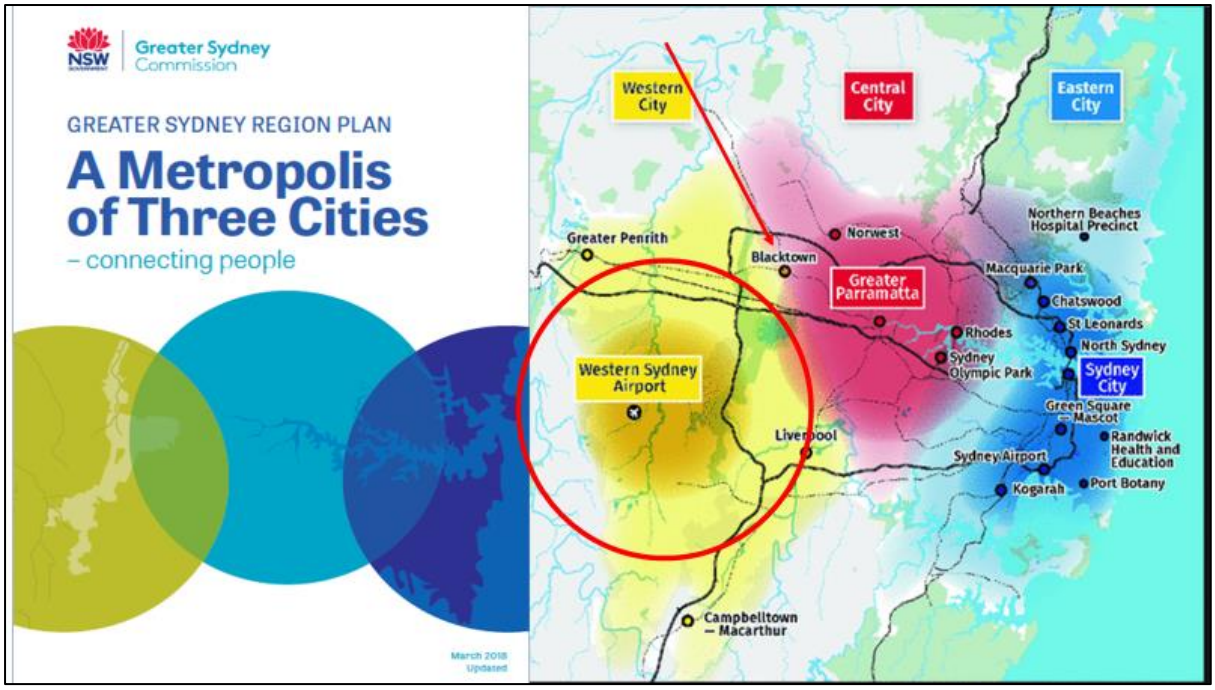
Name: Professor Graham Reece

Date Received: 11 September 2022

A View From the Bedside : Interactions with NSW Health - highly engaged, responsive and demonstrating balanced leadership

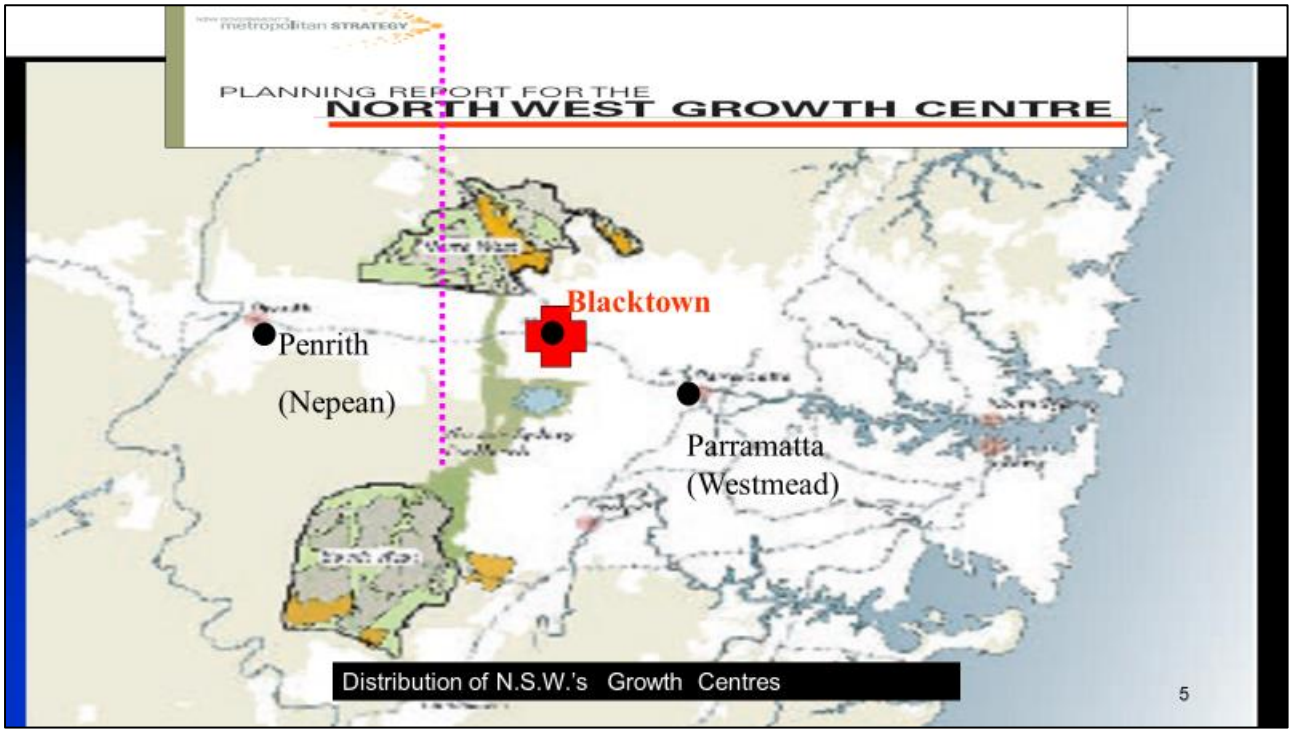
1. Introduction

As a senior doctor, one feels *grateful* and *privileged* to be invited to work at Blacktown Mt Druitt hospital - a two campus hospital serving the people of Western Sydney.

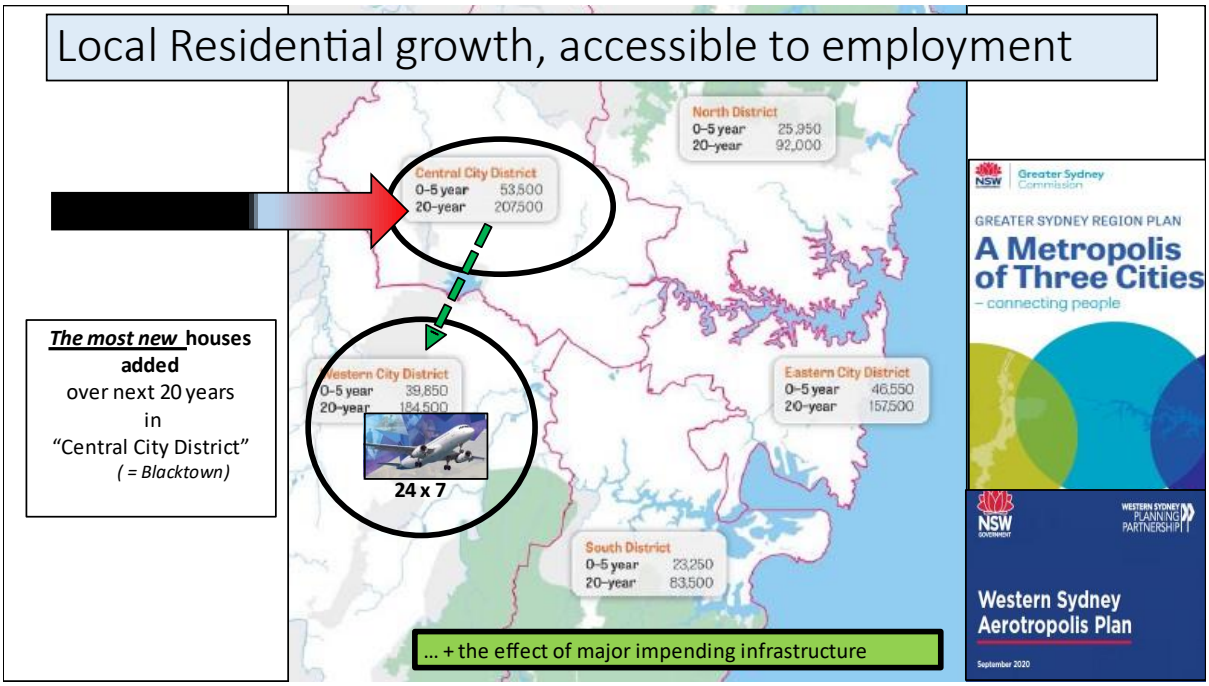


2. Demographics

Population growth over the past 15 years has been driven by the development of the Norwest Sector, with major transport linkages to Blacktown.



Residential expansion and proximity to the Western Sydney International Airport - be operational 24 x7 (due to open Christmas 2026), will stimulate ongoing demand.



When viewed at a national level, two of the fastest growing Statistical Areas, are close to Blacktown campus.

Australian Bureau of Statistics

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Key statistics

Capital cities

Regions

New South Wales

Latest release

Data download

Regional population

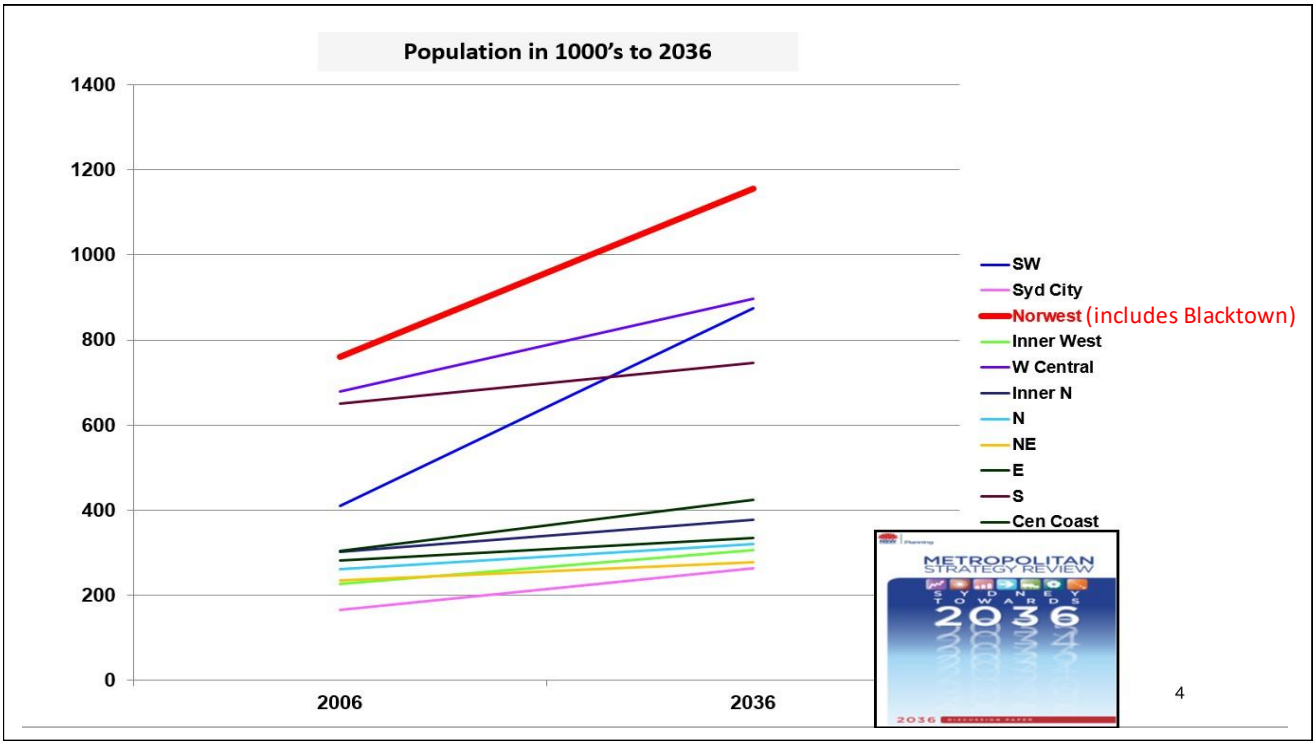
Statistics about the population and components of change (births, deaths, migration) for Australia's capital cities and regions

Reference period 2020-21 financial year

Areas with the largest growth

SA2	SA4	ERP at 30 June 2021	2020-21 (no.)
Riverstone - Marsden Park	Sydney - Blacktown	48,063	7,360
Cobbitty - Leppington	Sydney - South West	42,386	5,352
Cranbourne East	Melbourne - South East	60,489	5,027
Rouse Hill - Beaumont Hills	Sydney - Baulkham Hills and Hawkesbury	40,333	4,260
Mickleham - Yuroke	Melbourne - North West	19,029	4,127

The growth in Sydney's north west , which includes Blacktown, is forecast to remain relatively high at least until 2036.



Although Blacktown is already comparatively populous, significant growth is anticipated.

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Growth at BT till 2036 is large, by comparison

SYDNEY'S FORECAST "HIGH GROWTH" COUNCILS, 2006-2036

LGA NAME	LGA CODE	2006	2036	Inc 2006-36	% inc
Blacktown	750	280,612	481,267	200,655	71.5%
Camden	1450	50,940	249,771	198,831	390.3%
Liverpool	4900	170,915	324,438	153,523	89.8%
Sydney	7200	165,596	264,807	99,211	59.9%
Baulkham Hills	500	165,143	258,840	93,697	56.7%
Campbelltown	1500	147,440	233,757	86,317	58.5%
Wyong	8550	142,686	228,237	85,551	60.0%
Penrith	6350	177,152	234,308	57,156	32.3%
Bankstown	350	176,857	225,100	48,243	27.3%
Parramatta	6250	153,891	201,431	47,540	30.9%
Auburn	200	68,231	115,557	47,326	69.4%
TOTAL		2,712,771	4,172,743	1,459,942	53.8%
% OF GMA		52.0%	58.1%	74.0%	
TOTAL GMA		5,214,203	7,187,137	1,972,934	37.8%

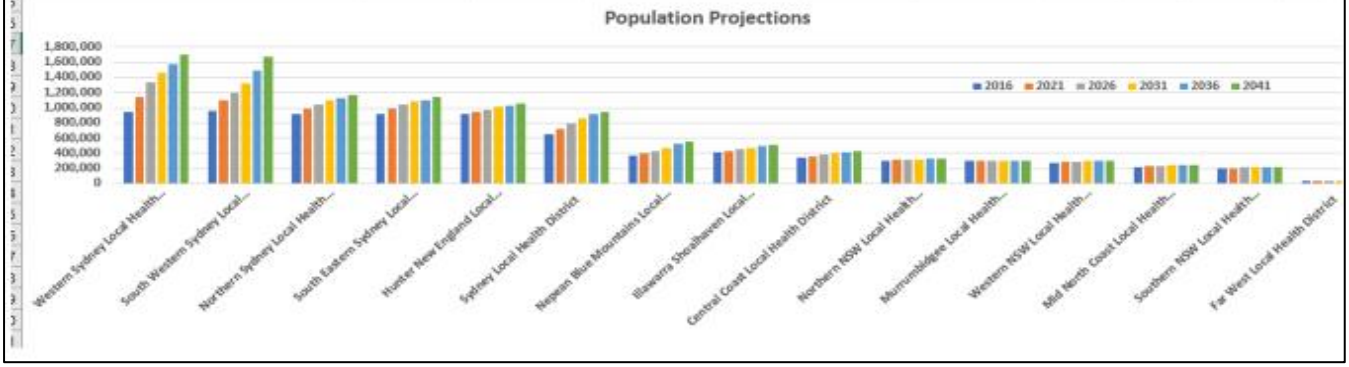
Source: based on Bureau of Transport Statistics data, released May 2010

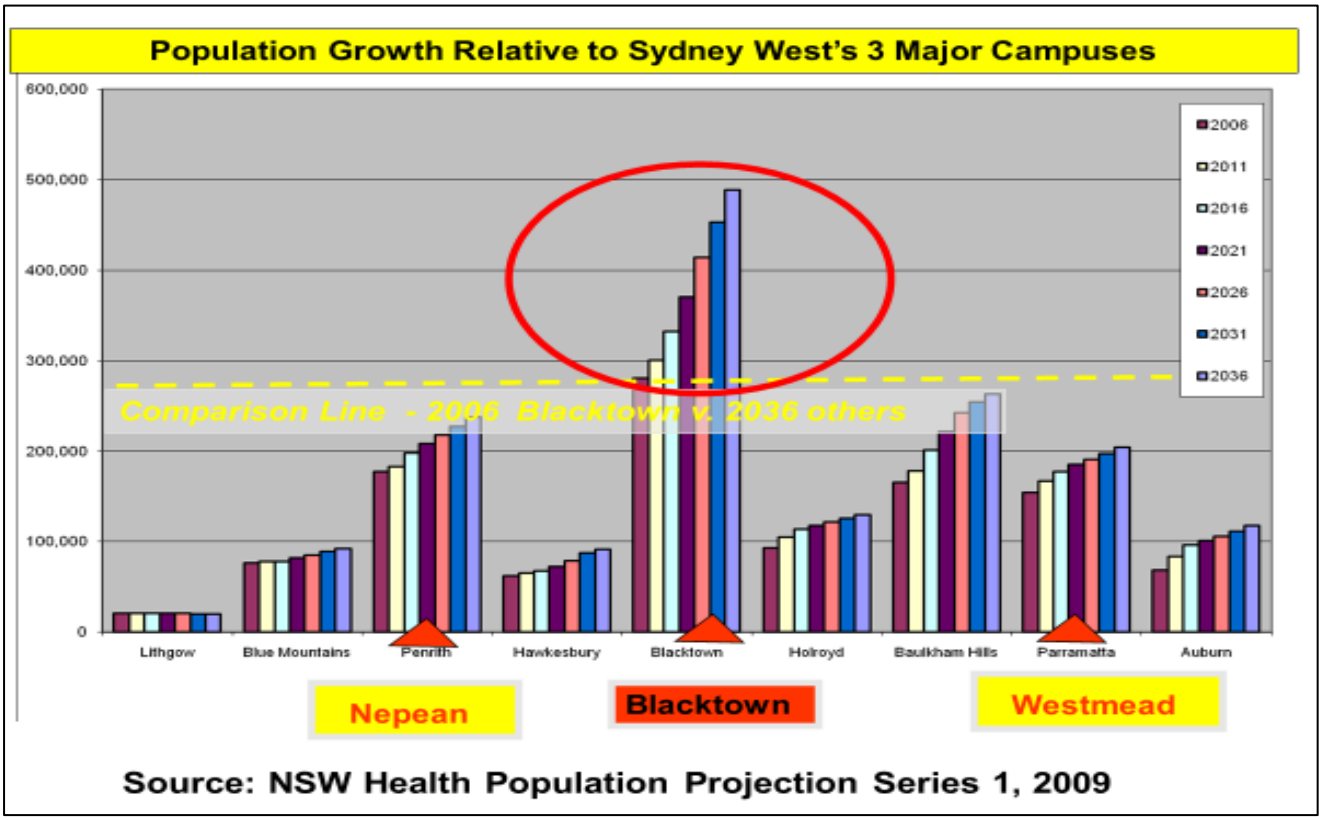
GMA: Greater Metropolitan Area (includes the Hunter and Illawarra)

In terms of Health Services, since 2021, **WS LHD** has become the most populous.

Source: NSW Health, CaSPA

LHD_NAME	2016	2021	2026	2031	2036	2041	Change 2021 - 2031 Number	Change 2021 - 2031 %	Change 2031 - 2041 Number	Change 2031 - 2041 %
Western Sydney Local Health District	948,377	1,144,280	1,330,409	1,467,610	1,580,416	1,699,605	323,330	28%	231,995	16%
South Western Sydney Local Health District	964,099	1,095,111	1,202,184	1,321,396	1,484,916	1,676,087	226,286	21%	354,691	27%
Northern Sydney Local Health District	911,536	985,708	1,045,542	1,091,346	1,131,620	1,164,226	105,638	11%	72,880	7%
South Eastern Sydney Local Health District	911,886	979,370	1,036,936	1,080,291	1,096,538	1,135,239	100,920	10%	54,949	5%
Hunter New England Local Health District	910,401	947,737	978,978	1,009,898	1,031,377	1,053,664	62,161	7%	43,767	4%
Sydney Local Health District	655,111	722,492	785,790	855,351	911,446	946,556	132,859	18%	91,205	11%
Nepean Blue Mountains Local Health District	368,179	397,544	418,533	468,777	529,367	553,338	71,233	18%	84,562	18%
Illawarra Shoalhaven Local Health District	404,873	428,938	450,853	470,979	489,170	505,691	42,041	10%	34,712	7%
Central Coast Local Health District	336,611	357,974	380,955	397,370	417,500	431,864	39,396	11%	34,494	9%
Northern NSW Local Health District	298,691	309,726	316,482	320,155	321,701	321,175	10,428	3%	1,020	0%
Murrumbidgee Local Health District	294,519	299,093	302,650	304,066	303,895	302,277	4,973	2%	-1,789	-1%
Western NSW Local Health District	276,954	283,481	288,958	293,033	295,894	297,545	9,552	3%	4,513	2%
Mid North Coast Local Health District	216,762	226,422	233,978	241,184	246,078	249,610	14,761	7%	8,426	3%
Southern NSW Local Health District	204,808	207,863	210,361	211,512	211,379	210,131	3,650	2%	-1,382	-1%
Far West Local Health District	30,051	29,231	28,405	27,594	26,672	25,702	-1,638	-6%	-1,892	-7%
Total	7,732,858	8,414,969	9,011,013	9,560,559	10,077,967	10,572,710	1,145,590	14%	1,012,151	11%

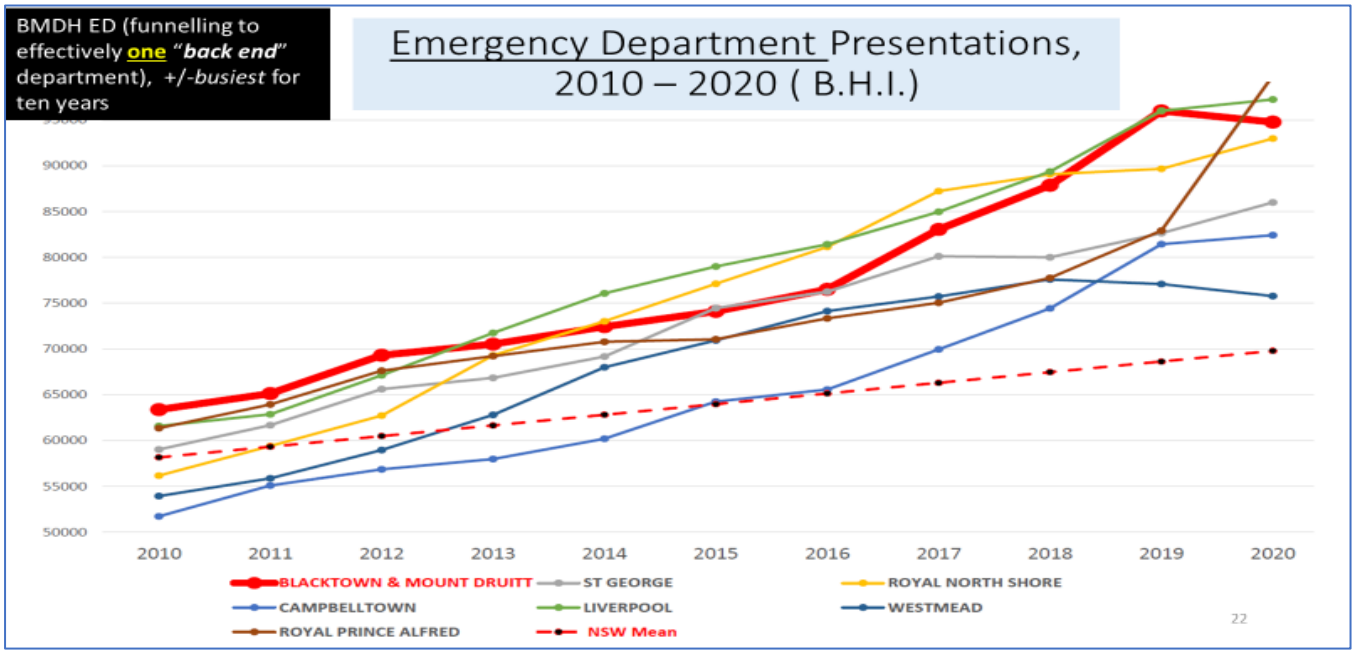




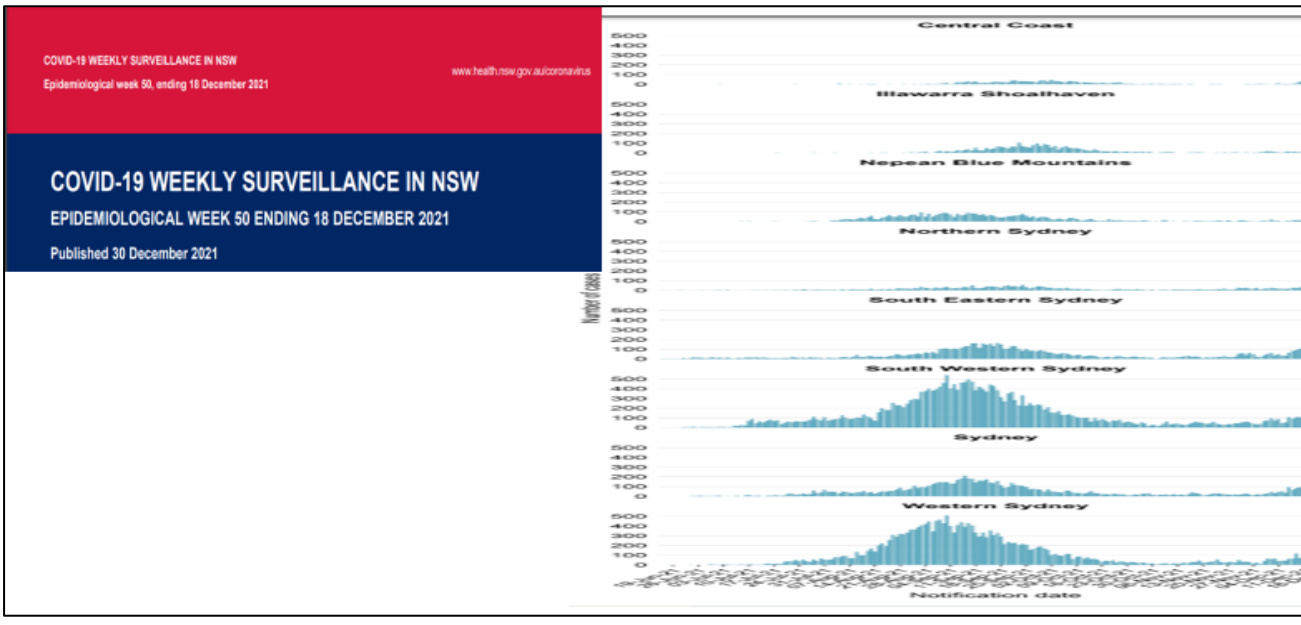
3. Emergency Department Pressures

3.1 Pressures from ED presentations / growth within the L.G.A. :

To avoid resource wasteful duplication of clinical services with a subcritical mass, enhance clinical outcomes and optimise workforce retention, the clinical departments of obstetrics, palliative care, high acuity medicine, lower acuity surgery, rehabilitation and Intensive Care, are located at *one, or the other*, campus. Therefore the campus of destination for any patient, having presented to the E.D. on either Blacktown or Mt Druitt campus, is dependent on the speciality they require. BMDH E.D. receives a *high number* of presentations. With NSW Health, the LHD and *Resilience Funding* , recent strategies to streamline patient care include moving to establish Rapid Access Clinics and the appointment of senior clinical (medical and nursing) staff, to expanding services.



3.2 COVID (and its *ongoing variable* economic effects across the socioeconomic spectrum) have not been equally distributed across all LHD's.



3.3 Burden of Chronic Disease

Blacktown L.G.A. has a *disproportionate burden of chronic disease*, not purely related to its population size. The relevance of this fact to the hospital system, is that in this patient group, a minor clinical deterioration is more likely to exceed the threshold requiring hospitalisation.

A2 — Smoking attributable hospitalisations by Local Government Area, NSW 2016-18

Local Government Areas	Spatially Adjusted Number of Separatio	Spatially Adjusted Rate per	Significantly higher or lower
Blacktown	2,719	764.9	++
Camden	500	579.2	--
Campbelltown	1,159	704	++
Canada Bay	422	453.6	--
Canterbury-Bankstown	2,148	584.4	--
Central Coast	2,784	819.5	++
Cumberland	1,424	623.4	--
Griffith	225	854.2	++
Liverpool	1,331	610.1	--
North Sydney	291	397.9	--
Northern Beaches	1,311	490.8	--
Parramatta	1,324	535.6	--
Penrith	1,252	609.3	--
Sutherland Shire	1,278	560.5	--
Sydney	1,232	539.6	--
The Hills Shire	981	585.5	--
Wollongong	1,574	738.6	++

2 — Circulatory disease deaths by Local Government Area, NSW 2016 to 2017

Local Government Areas	Spatially Adjusted	Spatially Adjusted Rate per 10	Significantly higher or lower than State
Blacktown	592	168.5	++
Camden	107	128.3	0
Campbelltown	287	175.9	++
Canterbury-Bankstown	485	133	--
Central Coast	495	146.7	++
Liverpool	291	135.2	0
Mid-Coast	156	168.8	++
Newcastle	286	176.3	++
North Sydney	61	83.4	--
Northern Beaches	317	118.7	--
Parramatta	278	115.4	--
Penrith	346	170	++
Port Macquarie-Hastings	104	129.9	0
Randwick	191	127.7	-
Sutherland Shire	265	116.6	--
Sydney	237	104.6	--
The Hills Shire	179	108.6	--
Tweed	144	152.7	0
Wollongong	300	141.2	0

3.4 Inpatient Demand – Increased competition for inpatient beds

The group of inpatients categorised by the NSW Bureau of Health Information as "acute overnight" and "unplanned", are the highest acuity group, requiring - often in a time sensitive window - more complex interventions. Despite its classification only as a major metropolitan hospital, BMDH ranks *within the top ten* hospitals, for managing this complex patient cohort.

Appendix table 2: Hospital admission activity measures by peer group

NSW admitted patient activity by hospital and peer group, January to March 2021

Activity and performance

"Back End"

	All episodes				Acute episodes		
	Total episodes	Planned	Unplanned / other	Same-day	Overnight	Total acute bed days	Average length of stay (days)
New South Wales	**476,600**	**215,509**	**261,091**	**218,235**	**231,746**	**1,277,065**	**2.8**
A1 peer group: Principal referral							
Bankstown-Lidcombe Hospital	12,214	6,532	5,682	6,226	5,437	29,610	2.5
Concord Repatriation General Hospital	13,753	8,485	5,268	8,006	4,810	32,953	2.6
Gosford Hospital	13,853	4,863	8,990	4,966	8,324	43,920	3.3
John Hunter Hospital	19,938	9,428	10,510	8,758	10,844	65,691	3.4
Liverpool Hospital	22,882	10,475	12,407	11,363	10,812	71,027	3.2
Nepean Hospital	15,793	6,644	9,149	6,504	8,444	48,270	3.2
Prince of Wales Hospital	12,969	6,232	6,737	7,045	5,280	33,673	2.7
Royal North Shore Hospital	18,561	7,398	11,163	8,120	9,704	57,828	3.2
Royal Prince Alfred Hospital	20,354	9,079	11,275	9,928	9,811	62,078	3.1
St George Hospital	16,495	7,201	9,294	7,124	8,495	49,393	3.2
St Vincent's Hospital Sydney	10,755	5,934	4,821	6,241	3,898	31,122	3.1
Westmead Hospital	27,118	15,271	11,847	15,745	10,827	73,714	2.8
Wollongong Hospital	12,919	4,578	8,341	4,631	7,831	45,278	3.6
Total A1 peer group	**218,066**	**102,577**	**115,489**	**104,766**	**104,870**	**645,988**	**3.1**
B peer group: Major							
Blacktown Hospital	10,819	2,245	8,574	2,913	7,341	36,809	3.6
Mount Druitt Hospital	2,752	1,451	1,301	1,393	1,042	3,457	1.4
BMDH	13,571	3,696	9,875	4,306	8,383	40,266	
Campbelltown Hospital	16,787	6,279	10,508	7,153	8,952	38,754	2.4

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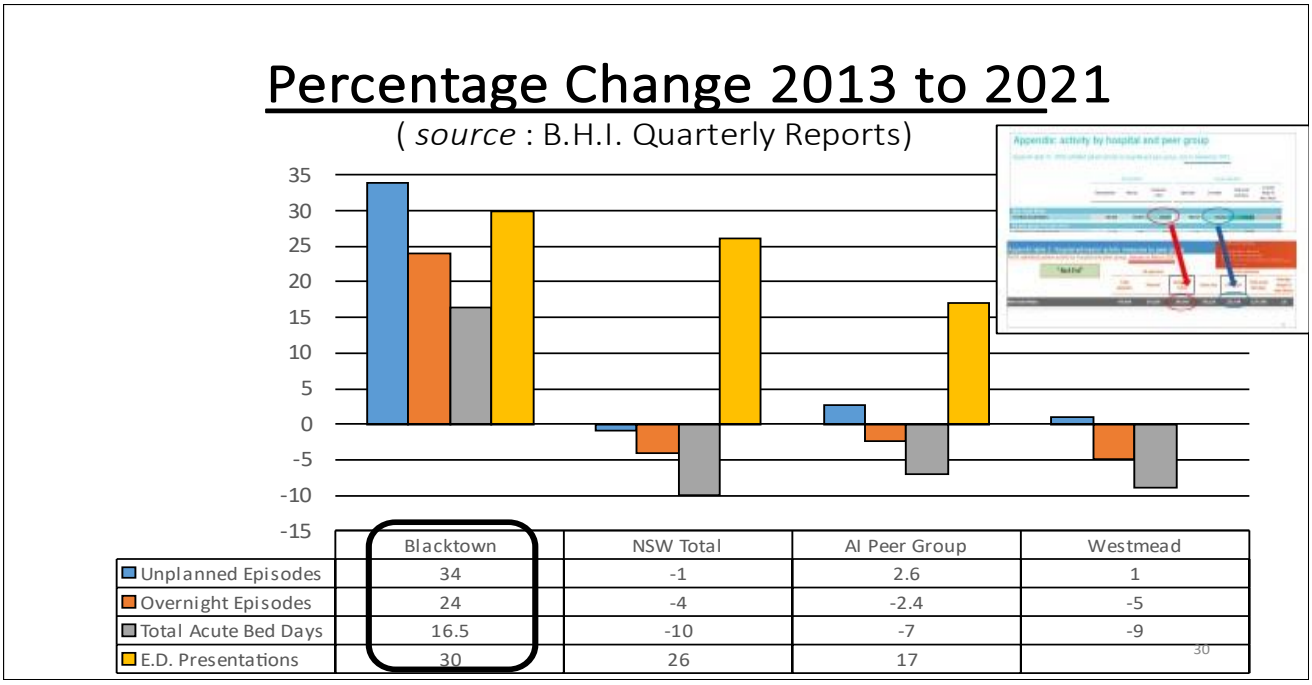
According to BHI data, the demand imposed by these more complex type admissions over recent years at Blacktown, has been *contrary* to trends across most of N.S.W.



	Blacktown	NSW Total	Al Peer Group	Westmead
Unplanned Episodes	34	-1	2.6	1
Overnight Episodes	24	-4	-2.4	-5
Total Acute Bed Days	16.5	-10	-7	-9
E.D. Presentations	30	26	17	

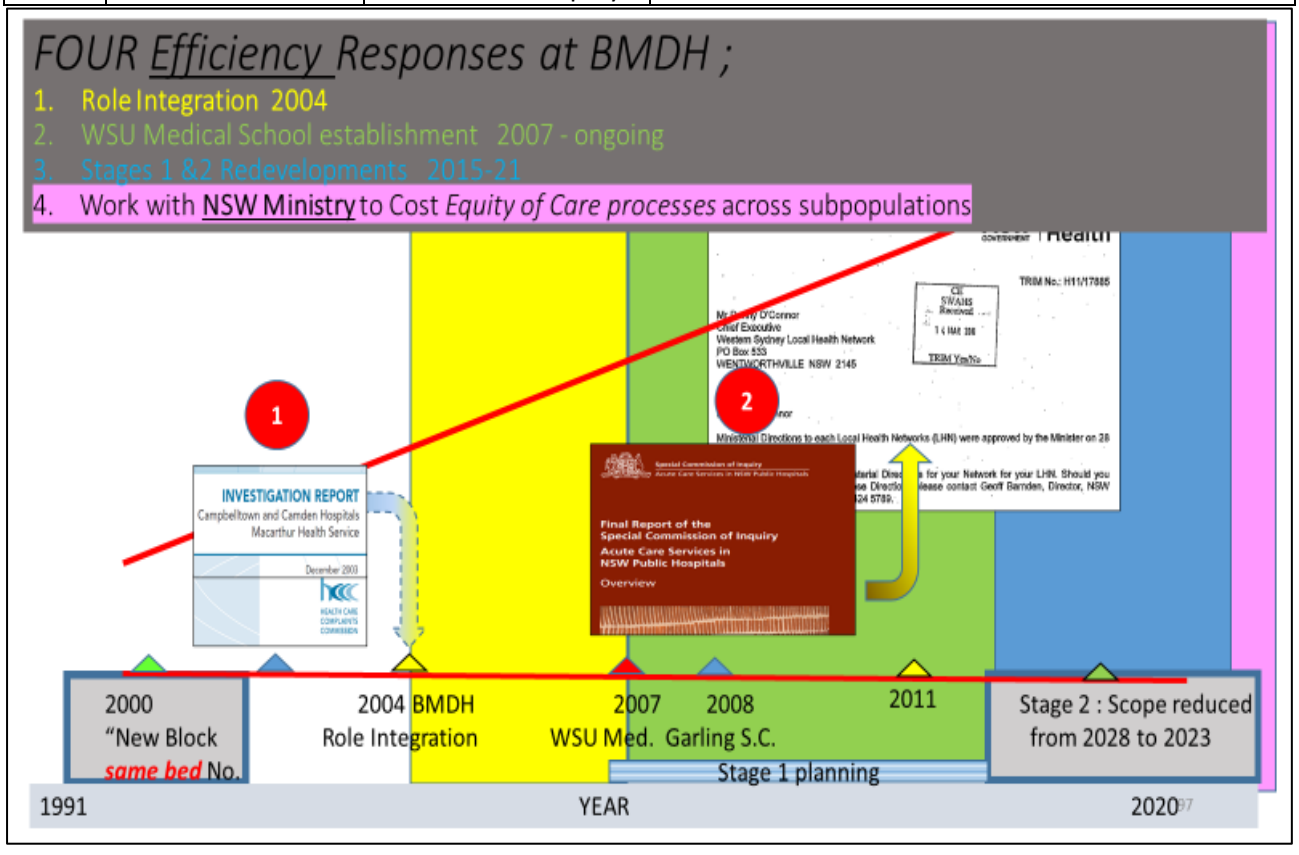
4. Response to Growth

4.1 BMDH

BMDH , with guidance from the LHD and strong support from NSW Health, over the last twenty years has undergone major internal clinical reconfiguration and restructures, in order to position itself to deliver patient care most effectively, efficiently and robustly.

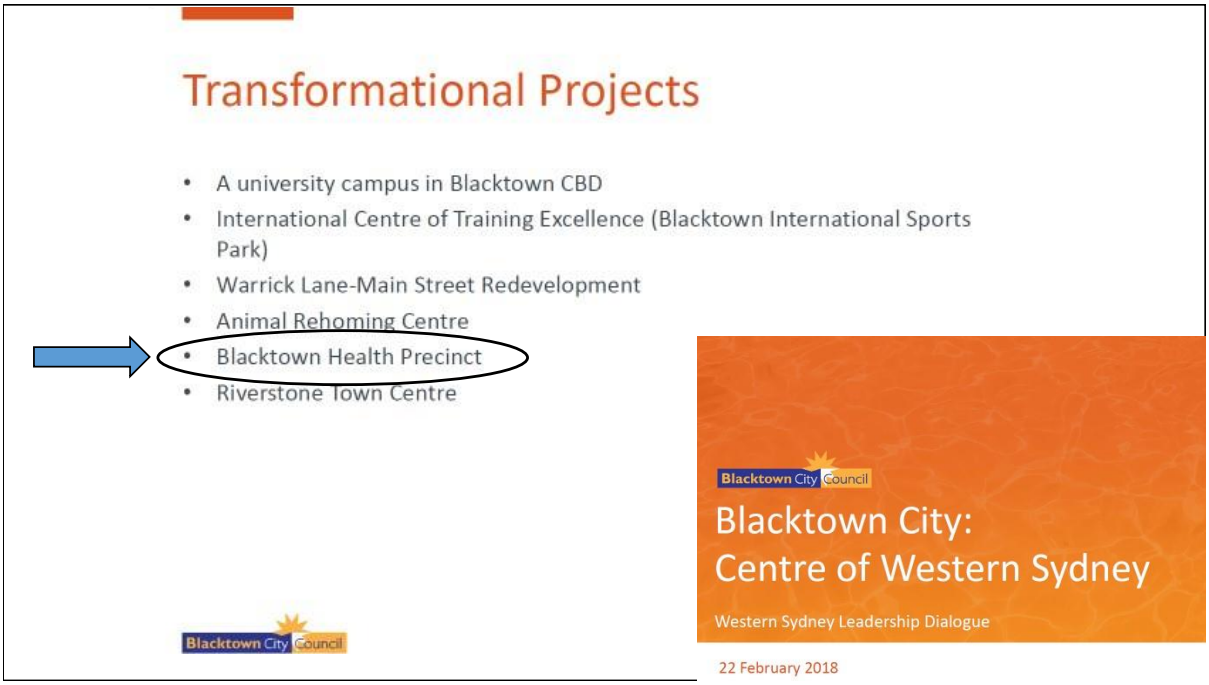
Secondly, health services, in order to be effective, must not just be physically accessible – they must be *financially accessible,* according to the means of the local population.

Stage	Years	Efficiency Initiative	Effect
1	1. 2000 2. 2005-2015 3. 2008	1. Macarthur Report 2.Role Delineation 3.Garling Report	Clinical *Centres of Excellence* established for improved outcomes, critical mass and optimal workforce retention.
2	2007	**Western Sydney University Medical School** commissioned On site	Local Med school to support local population
3	2011	Ministerial Directive	Funding review – BMDH fully compliant
4	2015-20	**Rebuild**	Stages 1 and 2 BMDH Redevelopment
5	2020-2022	**Consultation with NSW Health** : Cost of Production/Access and Outcome Equity	1. Equity Funding 2. Resilience Funding 3. NSWHealth -> I.H.P.A. review

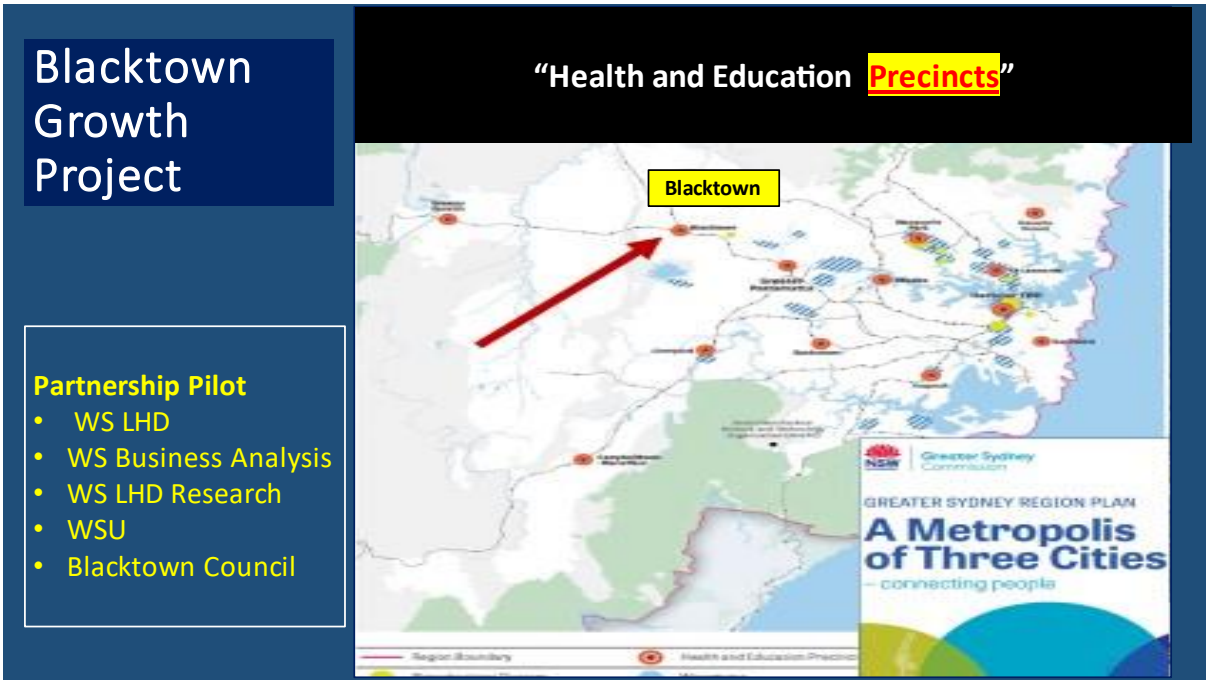


4.2 State, Commonwealth and Local Government, Coordinated Support

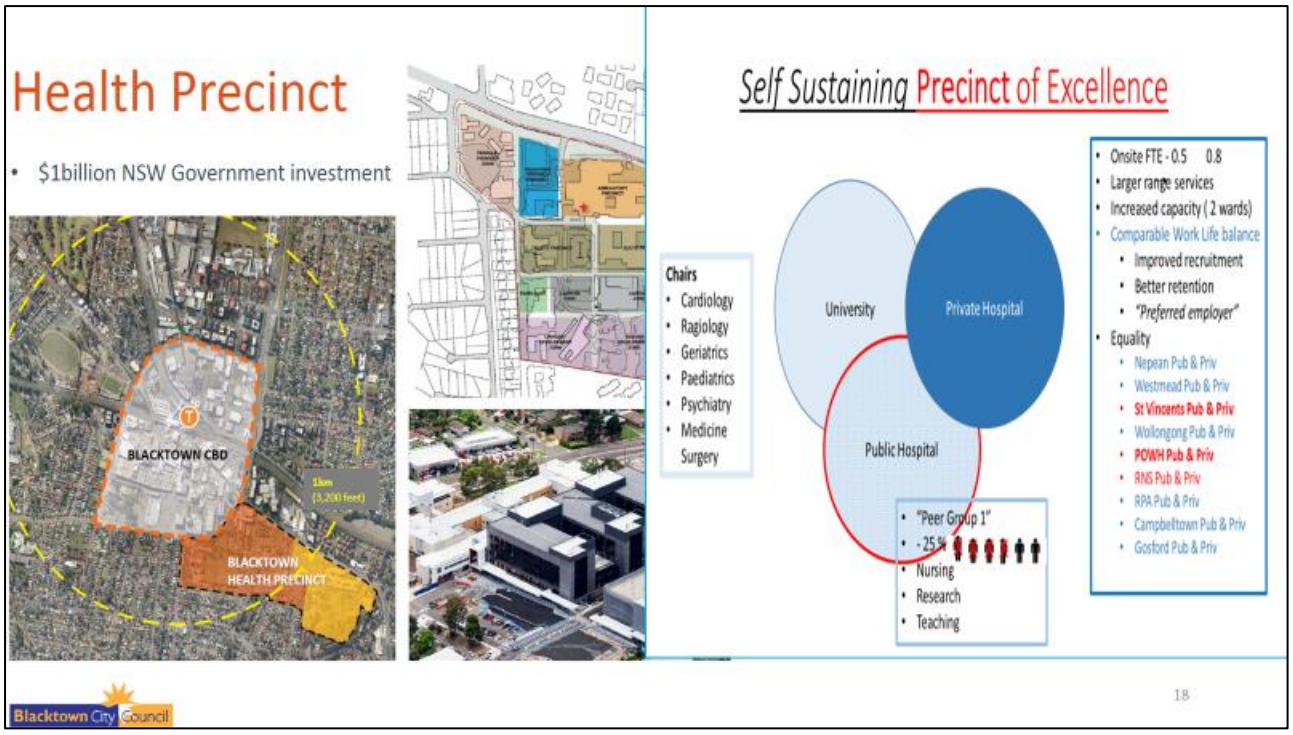
Blacktown Council has listed the development of the Blacktown Health Precinct, as one of its flagship *transformational* projects



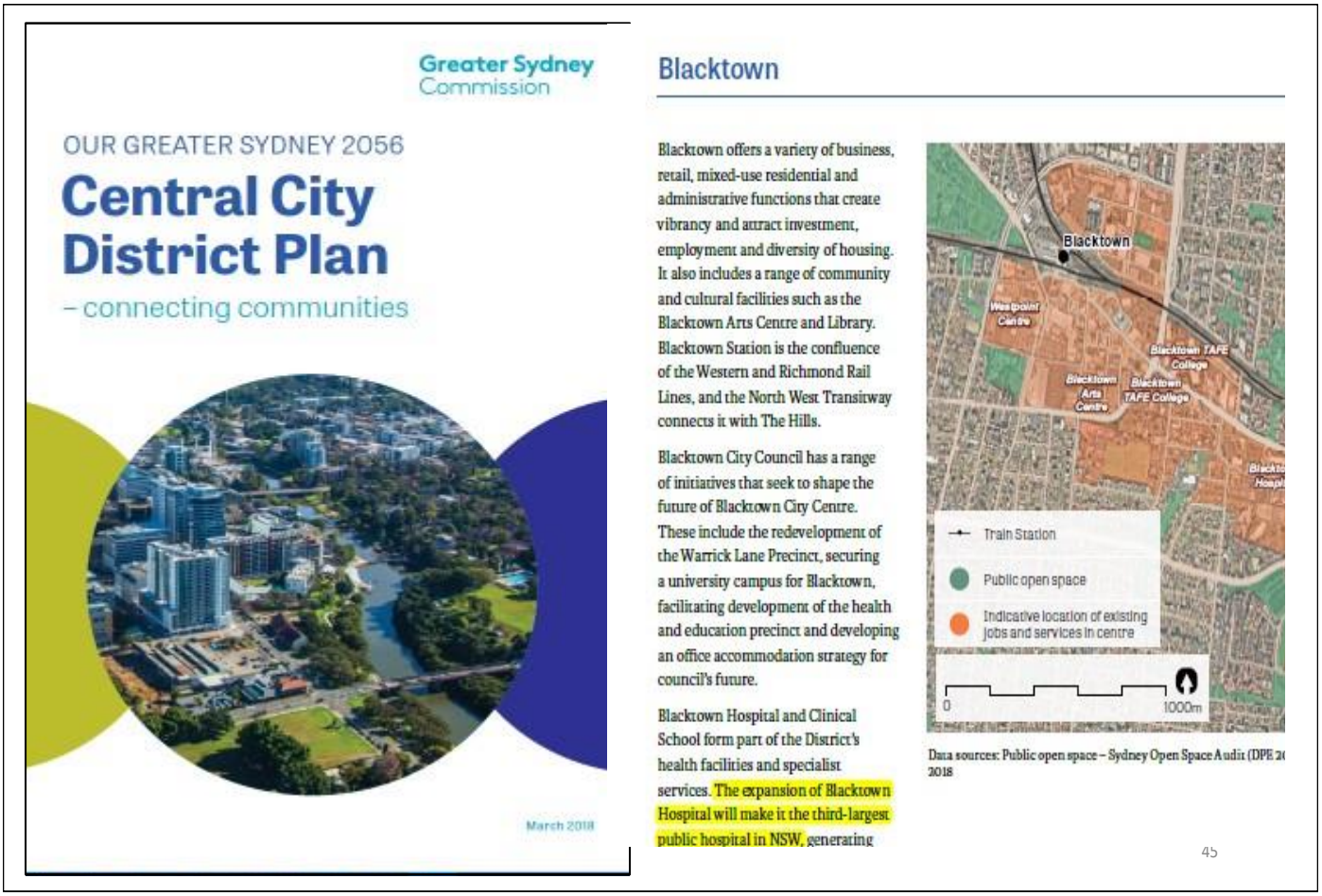
The Health Precinct is evolving with input from major strategic and academic partners.



The D.A. has recently been lodged for the expanded Blacktown *Health Precinct*

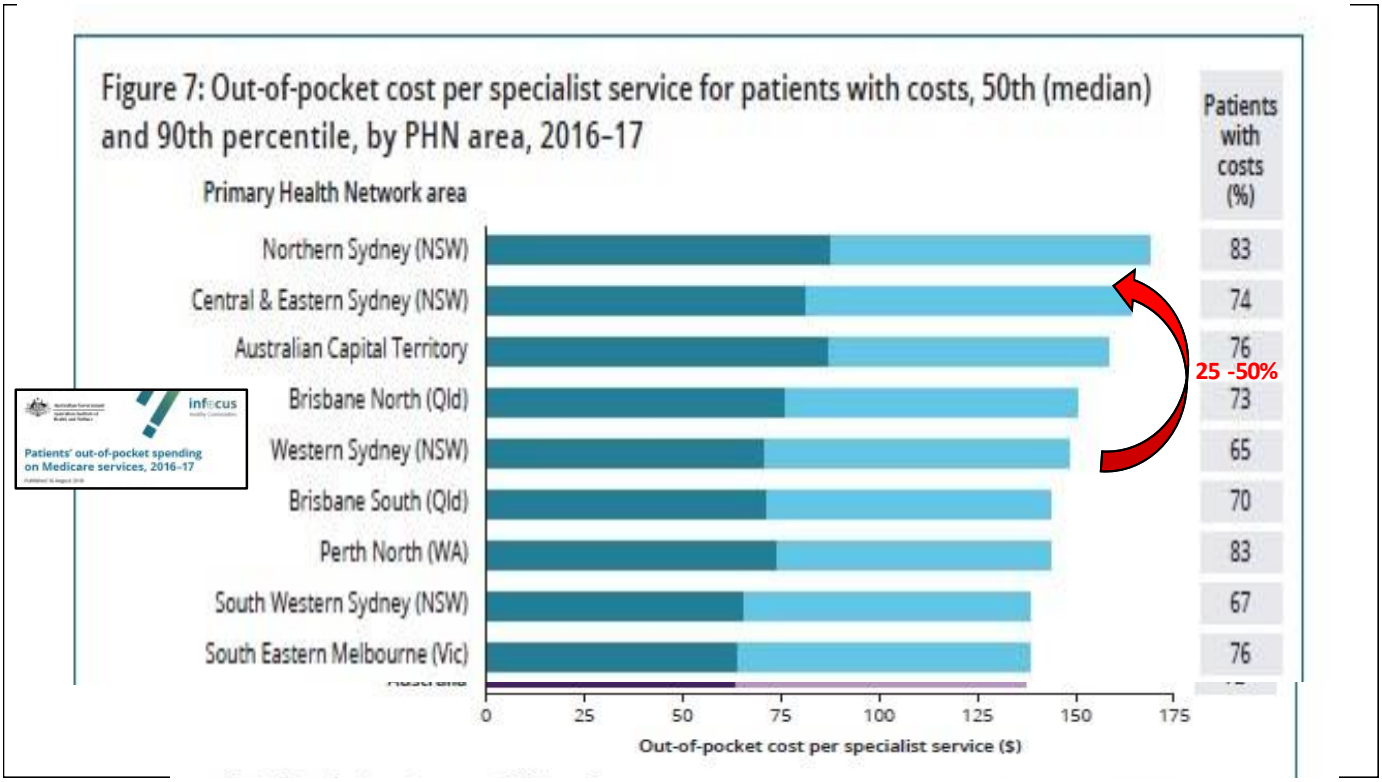


It is acknowledged that the hospital will require to continue to mature to efficiently cater for local demands.



5. Challenges

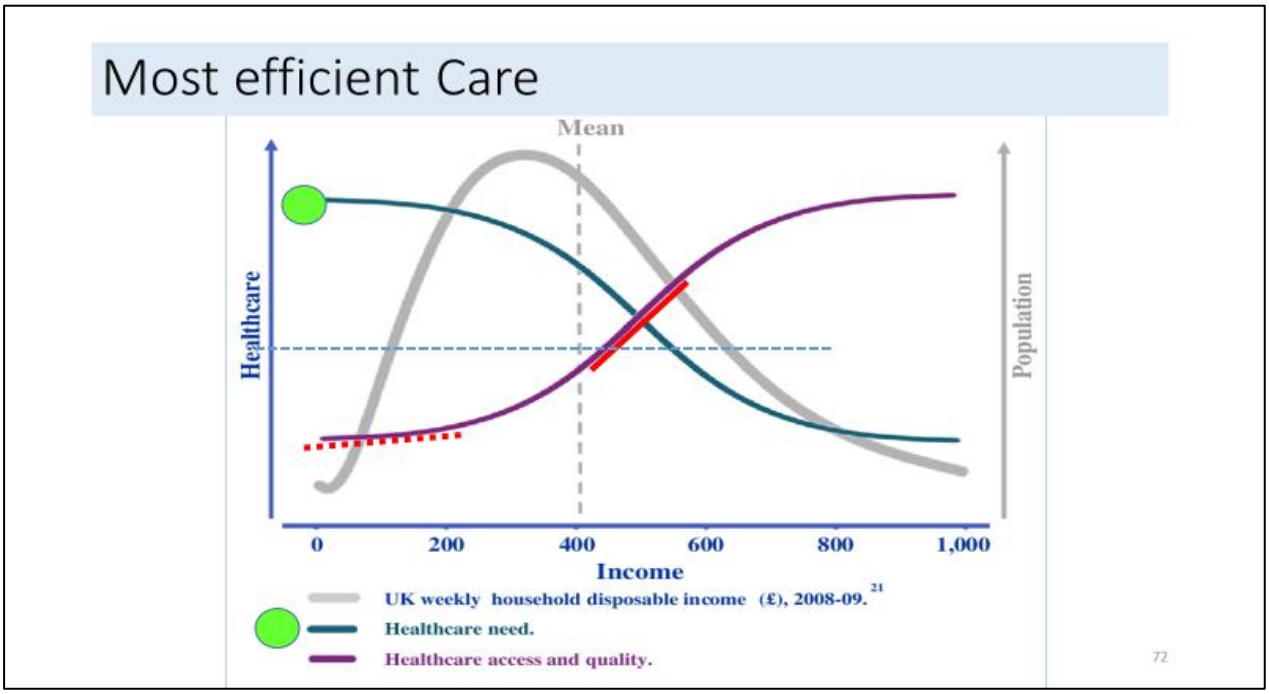
5.1 Economic



5.2 Funding

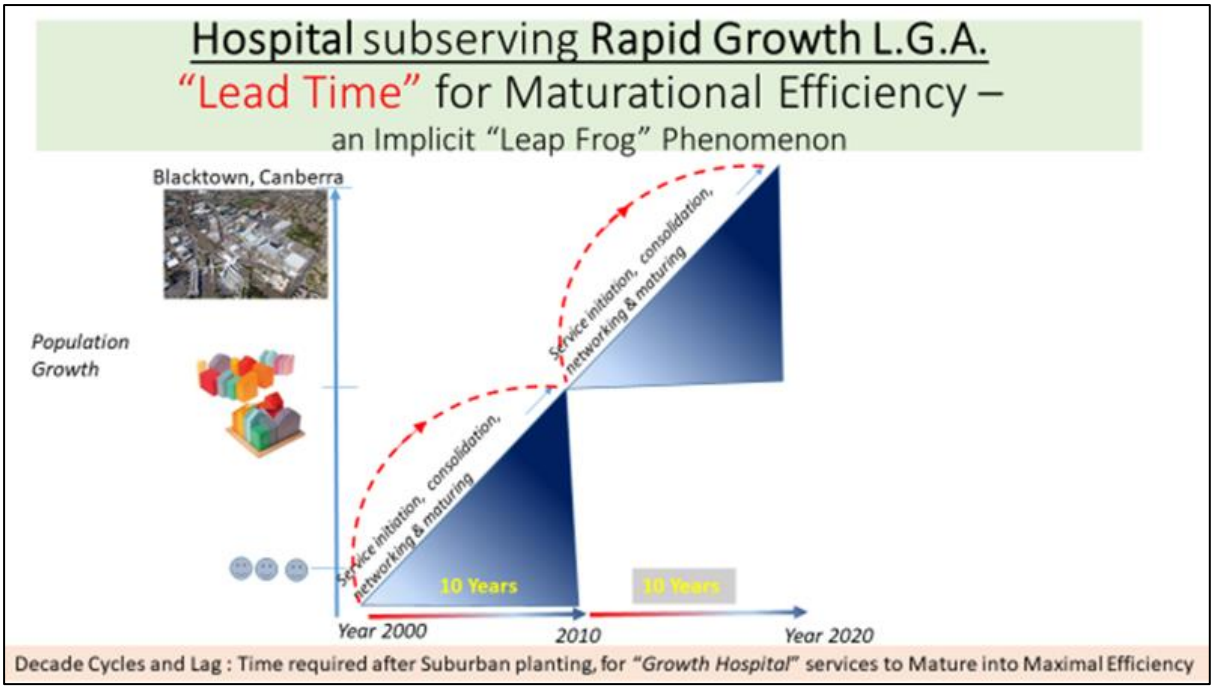
In recent years, increases in the monetary value of the N.W.A.U. have not been matched by changes in medicare rebates. It therefore seems to have been perceived by some patients to be preferable to attend the one stop E.D., where the majority of high end services are conveniently collocated.

Addressing the Relative Value Index will optimise system efficiency and resilience.

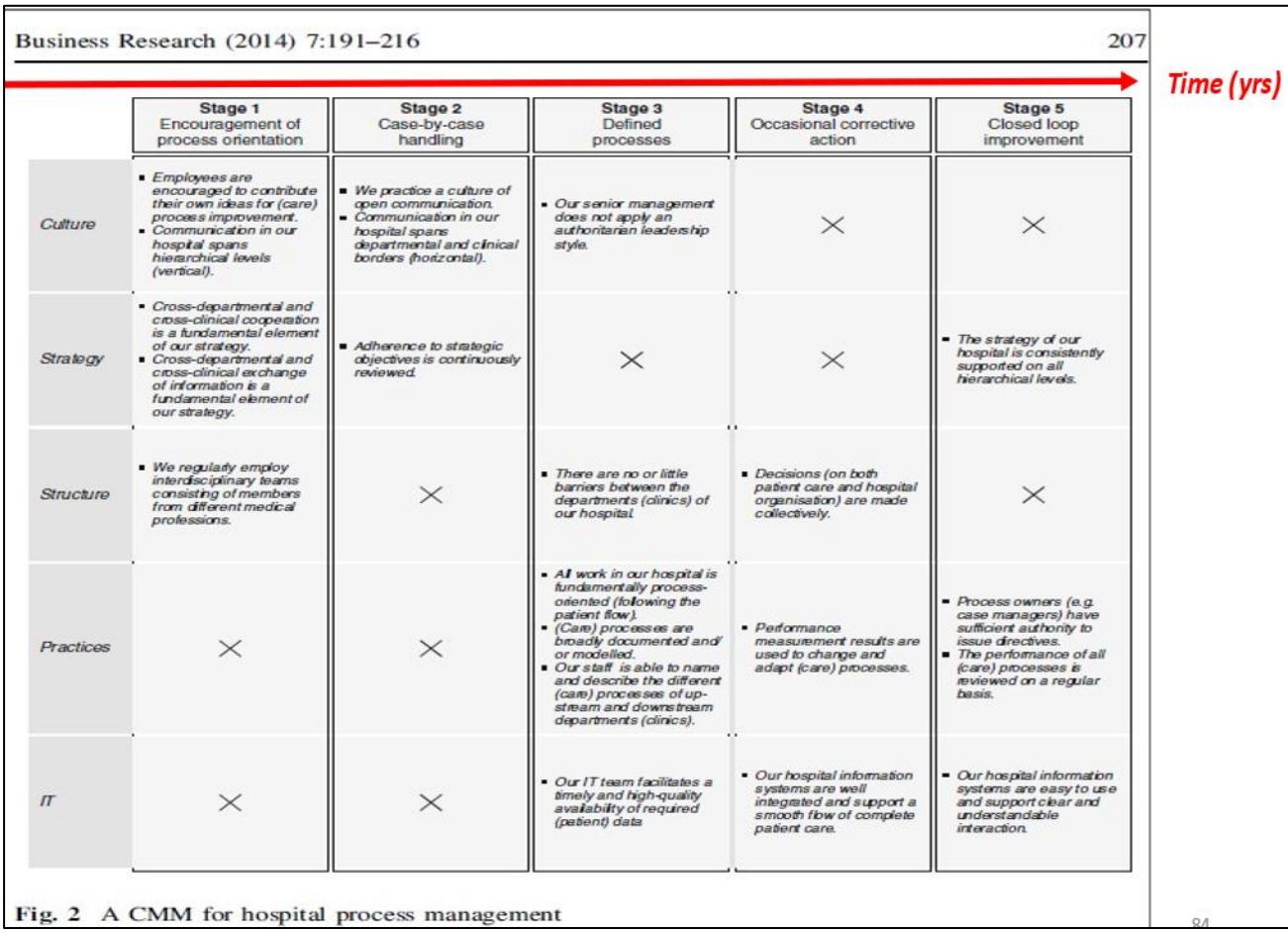


5.3 Time to Maturity for a Complex Health Service

It takes 5-15 years for new departments and services at hospitals to mature and network efficiently (new allied health staff, nurses, doctors need to coalesce as a multidisciplinary team – and nonhospital personnel must be aware of appropriate access channels) .



Decade Cycles and Lag : Time required after Suburban planting, for *"Growth Hospital"* services to Mature into Maximal Efficiency


Business Research (2014) 7:191–216 207

Time (yrs)

	Stage 1 Encouragement of process orientation	Stage 2 Case-by-case handling	Stage 3 Defined processes	Stage 4 Occasional corrective action	Stage 5 Closed loop improvement
Culture	▪ Employees are encouraged to contribute their own ideas for (care) process improvement. ▪ Communication in our hospital spans hierarchical levels (vertical).	▪ We practice a culture of open communication. ▪ Communication in our hospital spans departmental and clinical borders (horizontal).	▪ Our senior management does not apply an authoritarian leadership style.	×	×
Strategy	▪ Cross-departmental and cross-clinical cooperation is a fundamental element of our strategy. ▪ Cross-departmental and cross-clinical exchange of information is a fundamental element of our strategy.	▪ Adherence to strategic objectives is continuously reviewed.	×	×	▪ The strategy of our hospital is consistently supported on all hierarchical levels.
Structure	▪ We regularly employ interdisciplinary teams consisting of members from different medical professions.	×	▪ There are no or little barriers between the departments (clinics) of our hospital.	▪ Decisions (on both patient care and hospital organisation) are made collectively.	×
Practices	×	×	▪ All work in our hospital is fundamentally process-oriented (following the patient flow). ▪ (Care) processes are broadly documented and/or modelled. ▪ Our staff is able to name and describe the different (care) processes of up-stream and downstream departments (clinics).	▪ Performance measurement results are used to change and adapt (care) processes.	▪ Process owners (e.g. case managers) have sufficient authority to issue directives. ▪ The performance of all (care) processes is reviewed on a regular basis.
IT	×	×	▪ Our IT team facilitates a timely and high-quality availability of required (patient) data	▪ Our hospital information systems are well integrated and support a smooth flow of complete patient care.	▪ Our hospital information systems are easy to use and support clear and understandable interaction.

Fig. 2 A CMM for hospital process management

5.4 Health Literacy

Navigating the fragmented health system, taking ownership for one's health journey, being able to translate vague symptoms efficiently to facilitate engagement for diagnoses and complying with complex treatment regimens for chronic diseases, is not simple.

Chest Pain

Patient Factsheet Hospital:

Chest Pain

Nuances…

1. **Character** – what is it like– knofe, crush, sharp, pleuritic, burning
2. **Exacerbating factors** – exercise, anxiety, eating, drinking, breathing
3. **Relieving factors** – medications, positions, diet, bowels
4. **Duration of this new symptoms**- > 10-20 minutes
5. **Duration of each episode**
6. **Radiation of pain** – jaw, shoulder
7. **Associated symptoms** -nausea, vomit, sweat, SOB
8. **Family history**
9. **Risk factors** – hypertension, cholesterol, cigarettes
10. **Medication** – usual and compliance
11. **Past Medical and surgical history**
12. **Allergies**

By first principles : Health Literacy complicates day-to-day hospital care that patients receive as …

Communication between the physician and the patient is critical. Various authors have asserted that the diagnosis is evident from the history alone in 80 – 90% of cases; if

1. Late presentations
2. Diagnostic uncertainty
3. More severe, longer recovery
4. More investigations
5. More Challenging Family conferences

DR M. Graber : Society to Improve Diagnosis in Medicine, Chief Medical Officer

36

The cost of LHL is not unsubstantial and can be quantified.

Does low Health Literacy impact the cost of hospital service provision ?

Final Report

Economic Cost

of

Health illiteracy for Blacktown Hospital

Blacktown-Mt Druitt Health Medical Staff Council

19 October 2020

Western Sydney University Details

Legal Entity Name	Western Sydney University
ABN	53 014 069 881
Postal Address	Locked Bag 1797, Penrith NSW 2751
Primary contact	Dr W. Kathy Tannous
Position	Senior Research Lecturer, Economics, Finance and Property
Contact Number	(02) 9685 9345

Authors

Dr W. Kathy Tannous
Moin Uddin Ahmed
James Rufus John

Contact details

Dr W. Kathy Tannous, Western Sydney University. Email: k.tannous@westernsydney.edu.au.

Acknowledgements

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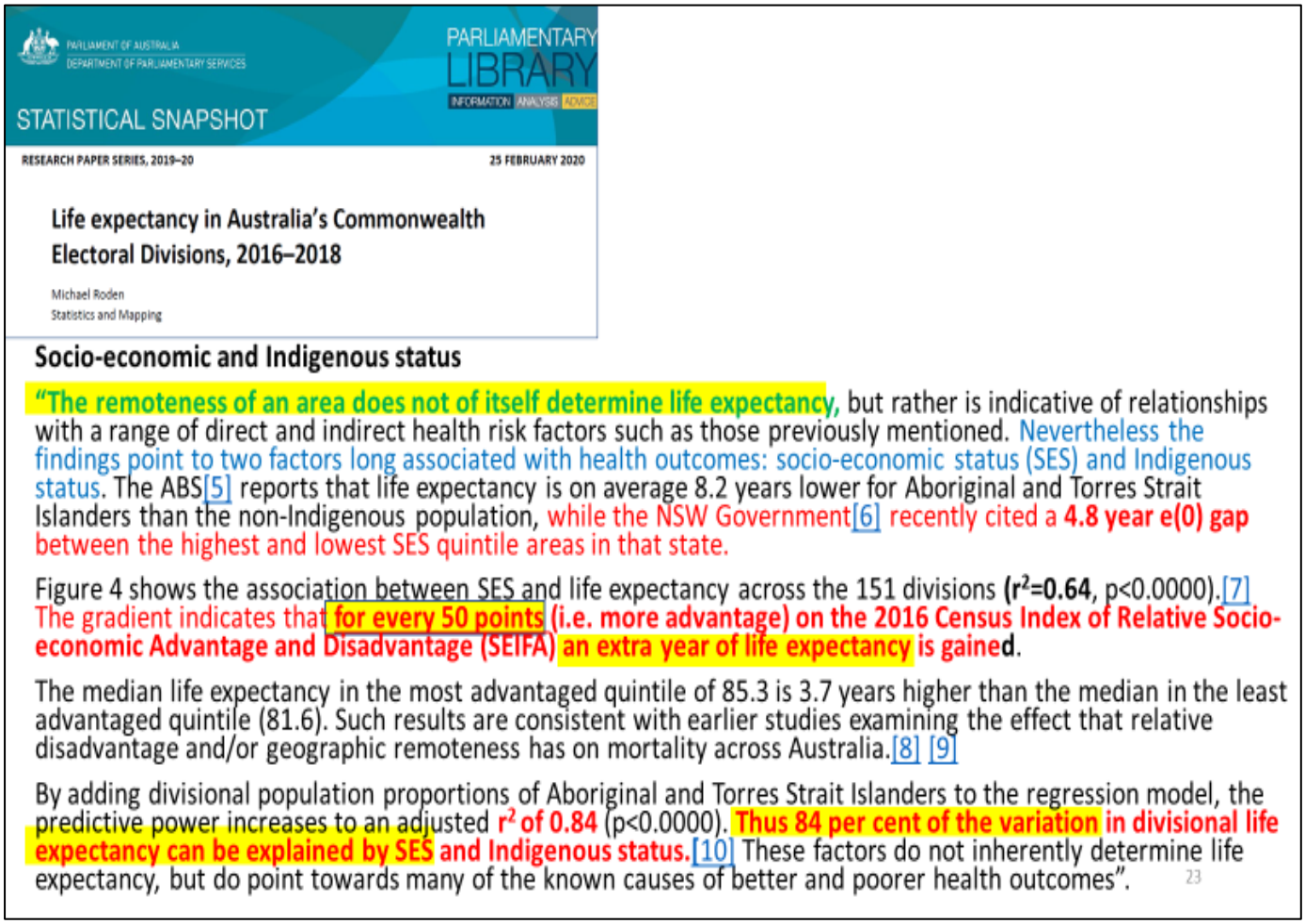
46

Financial Cost of LHL @Blacktown Hospital

Source	Formula	Calculation Factor
Literature R/V	3-17 % Total Costs	9%
US (2009)	$2,000/admission	16, 000 Adm/yr
Blacktown Point Prevalence Survey		47 %
Financial Impact Statement (Stage 2 BMDH Expansion, 2018)	Reviewed by 1. WS LHD and 2. **AC External Auditors**	Department by department ground up analysis, reviewed by Divisional Directors, DMS, DDMS, GM, DON, BMDH Expansion Project and LHD Workforce Planning
WSU School of Economics, Finance and Property October 2020 Costing study	Only … 1.analysed chronic diseases – no acute diseases. 2. if born outside Aus. and 3. age > 20.	1. ABS 2011 and 2016 2. ABS National Health Survey (2017-8) 3. NSW Population Survey 2019 4. Public Health Information Development Unit 5. Independent Hospital Pricing Authority report 6. Disease Expenditure in Australia 2015-6.

48


AUSTRALIAN INSTITUTE OF HEALTH INNOVATION
Hospital Funding Models
A rapid review
PREPARED FOR
THE MEDICAL STAFF COUNCIL,
WESTERN SYDNEY LOCAL HEALTH DISTRICT
OCTOBER 2020
Robyn Clay-Williams, Yvonne Zurynski, Janet C. Long, Isabelle Meulenbroeks, Elizabeth E. Austin, Zeyad Mahmoud, Louise A. Ellis, Gilbert Knaggs, Diana Fajardo Pulido, Jeffrey Braithwaite
How are the best national health systems in the world coping?
Australian Insitute of Health Innovation (Prof. Braithewaite) : October 2020
1. Inputs : appropriately nuanced
2. Outputs : meaningful, objective, transparent, standardised, dynamic.
41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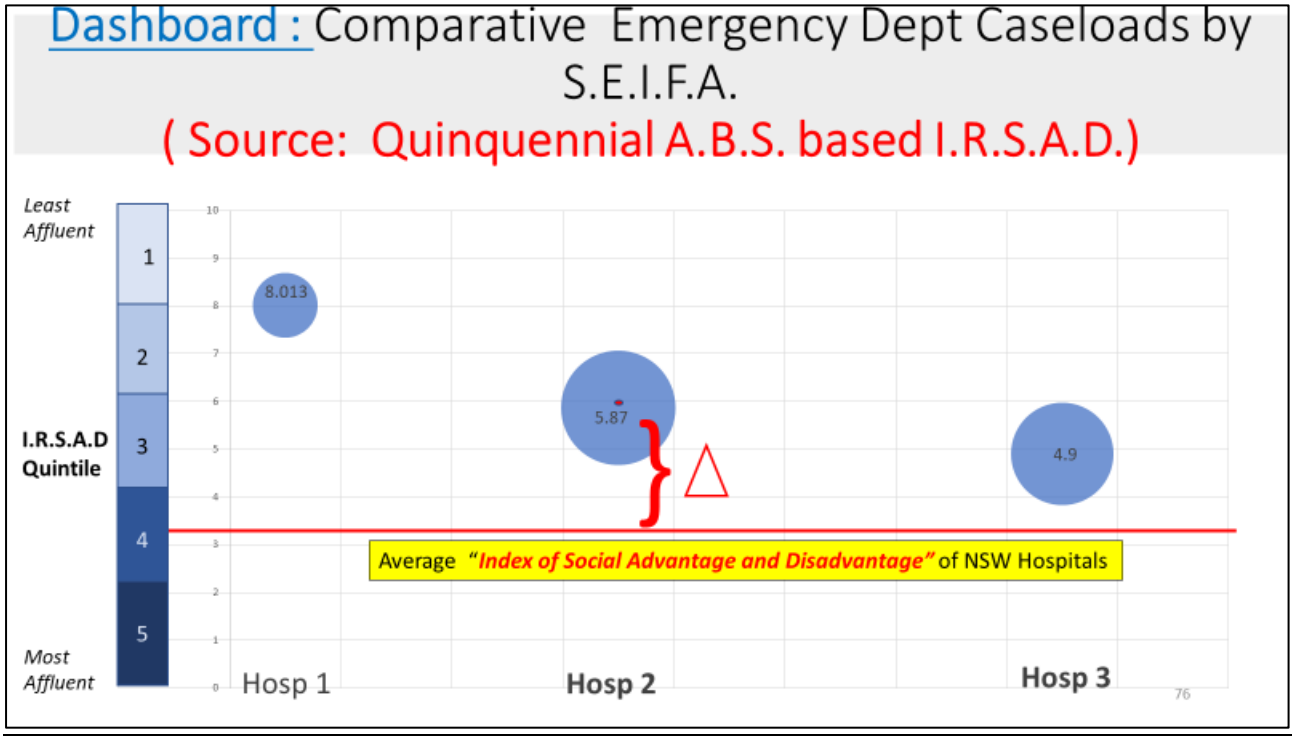
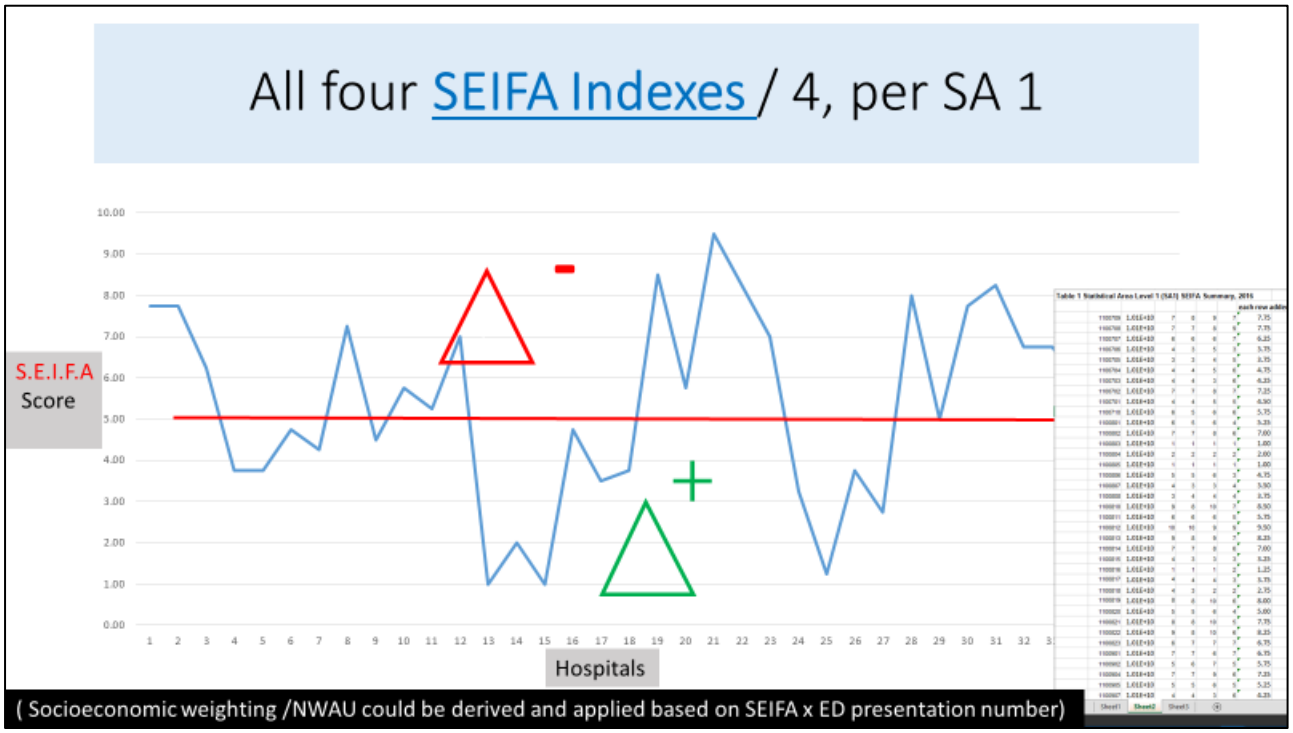
25 FEBRUARY 2020
Life expectancy in Australia's Commonwealth Electoral Divisions, 2016–2018
Michael Roden
Statistics and Mapping
Socio-economic and Indigenous status
"The remoteness of an area does not of itself determine life expectancy, but rather is indicative of relationships with a range of direct and indirect health risk factors such as those previously mentioned. Nevertheless the findings point to two factors long associated with health outcomes: socio-economic status (SES) and Indigenous status. The ABS[5] reports that life expectancy is on average 8.2 years lower for Aboriginal and Torres Strait Islanders than the non-Indigenous population, while the NSW Government[6] recently cited a 4.8 year e(0) gap between the highest and lowest SES quintile areas in that state.
Figure 4 shows the association between SES and life expectancy across the 151 divisions (r^2=0.64, p<0.0000).[7] The gradient indicates that for every 50 points (i.e. more advantage) on the 2016 Census Index of Relative Socio-economic Advantage and Disadvantage (SEIFA) an extra year of life expectancy is gained.
The median life expectancy in the most advantaged quintile of 85.3 is 3.7 years higher than the median in the least advantaged quintile (81.6). Such results are consistent with earlier studies examining the effect that relative disadvantage and/or geographic remoteness has on mortality across Australia.[8] [9]
By adding divisional population proportions of Aboriginal and Torres Strait Islanders to the regression model, the predictive power increases to an adjusted r^2 of 0.84 (p<0.0000). Thus 84 per cent of the variation in divisional life expectancy can be explained by SES and Indigenous status.[10] These factors do not inherently determine life expectancy, but do point towards many of the known causes of better and poorer health outcomes".
23

I.R.S.A.D. of attendees an Emergency Department may not be purely a reflection of the SA1 of the hospital's location. With the *LHD's Business Development Unit*, this parameter has been analysed across WS LHD. A nationwide dashboard, updated each 5 years by the A.B.S., could be generated.





5.5 **Large Fraction Consultant Medical Staff**

Visible *onsite, experienced senior medical leadership* is essential to minimise fragmentation of clinical care, as well as for J.M.O. supervision, resilient multidisciplinary team building, optimised morale, teaching, succession training and research.

Two NSW Health Director Generals and current senior Administrators, have flagged this key issue.

2021, B2 Hub :

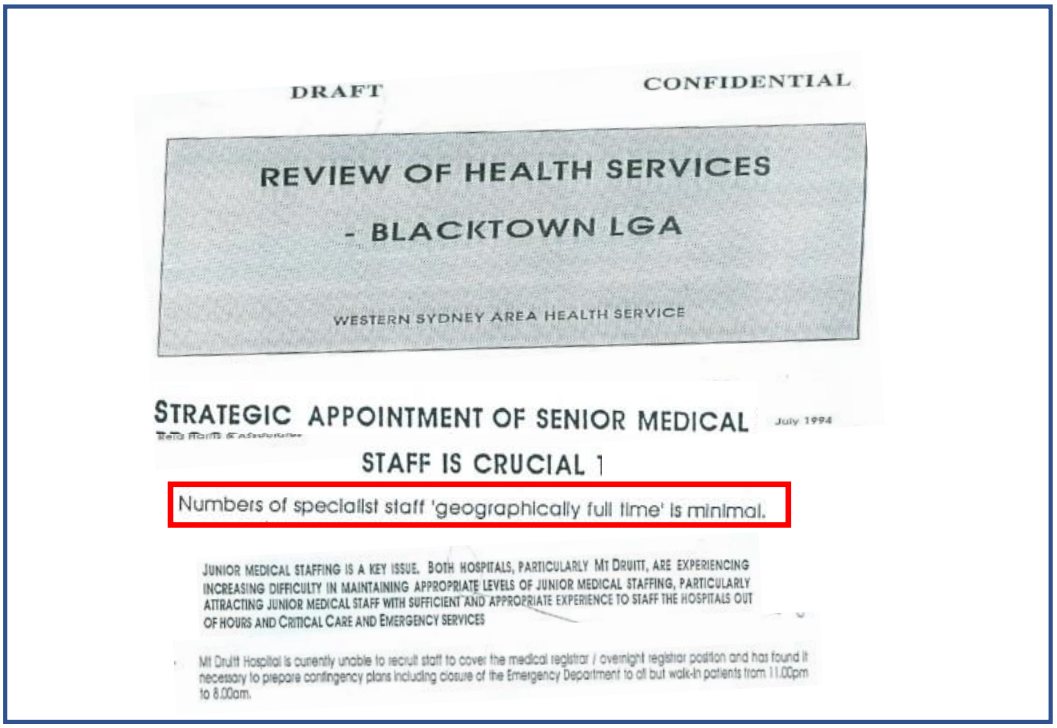
- **Executive Director,**
  System Information and Analytics at NSW Health (**"The Francis Report"**)

What must we do to attract more "high fraction" Staff Specialists to it ?"

- **Director General (2011)**
  Blacktown and Campbelltown are special cases due to
  - **socioeconomic status** and
  - **growth**

therefore they require special arrangements.

45



46

Greater Sydney Commission

GREATER SYDNEY REGION PLAN

A Metropolis of Three Cities

– connecting people

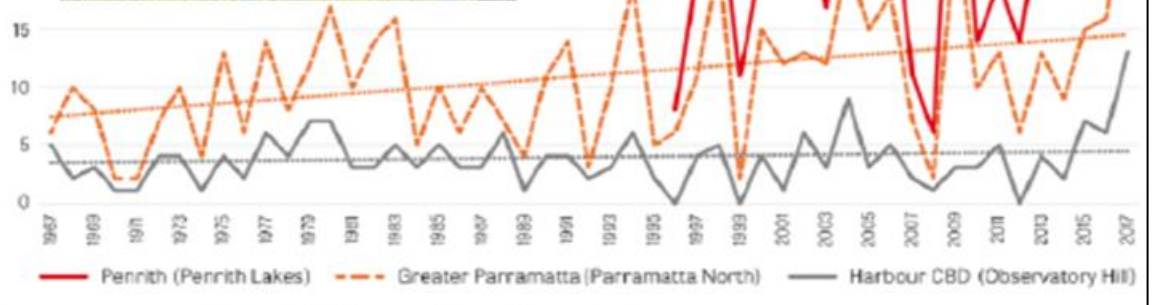
Given the sociodemographics and poorer health outcomes, in fact Western Sydney paradoxically actually requires the best doctors if health outcome inequality is to be *reduced*.

Greater Sydney is at a stage where changing its structure, from one city on the eastern edge to three cities, is needed to maximise economic growth and cater for population growth. The strong eastern bias in the location of its main economic attractors and job types, means many residents in the growth areas of the Western Parkland City are increasingly remote from these activities and have less choice of local jobs and other opportunities.

Are the available jobs in Western Sydney just as attractive for staff retention ?

50

Figure 57: Number of days above 35 °C in Harbour CBD, Greater Parramatta and Penrith



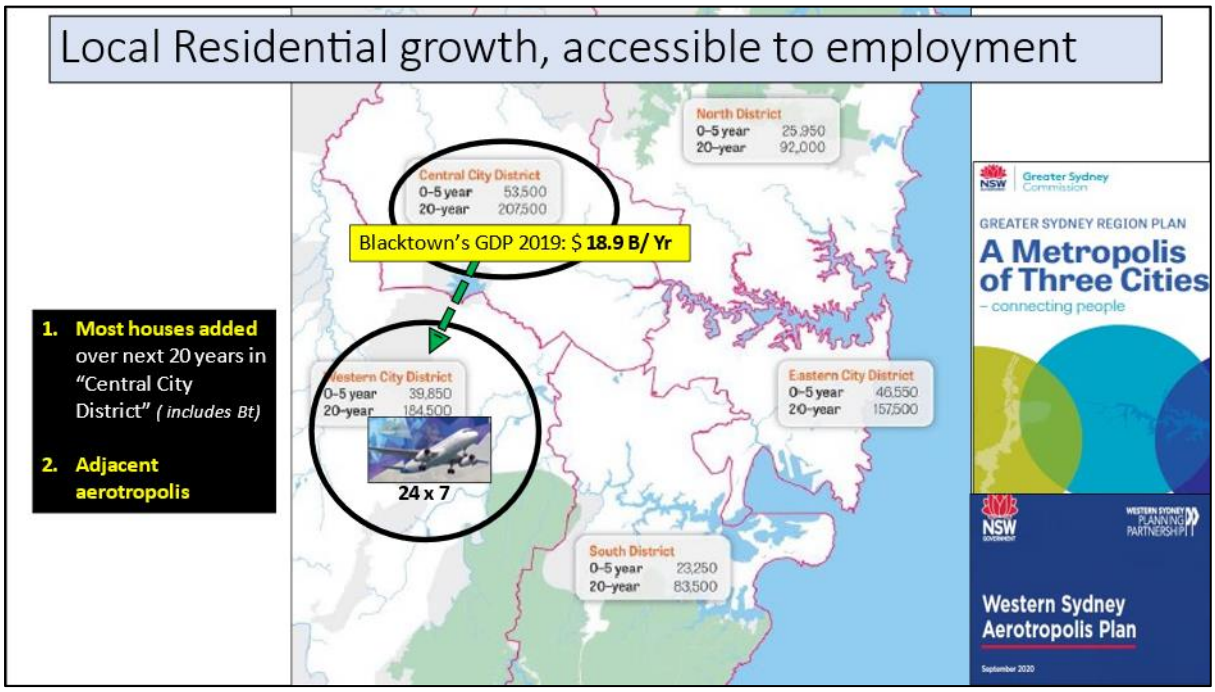
Source: Greater Sydney Commission (2018) using data from the Bureau of Meteorology

51

6. Opportunities

Health is a **key economic enabler.** COVID demonstrated this principle.

Western Sydney is Australia's third largest manufacturing region.



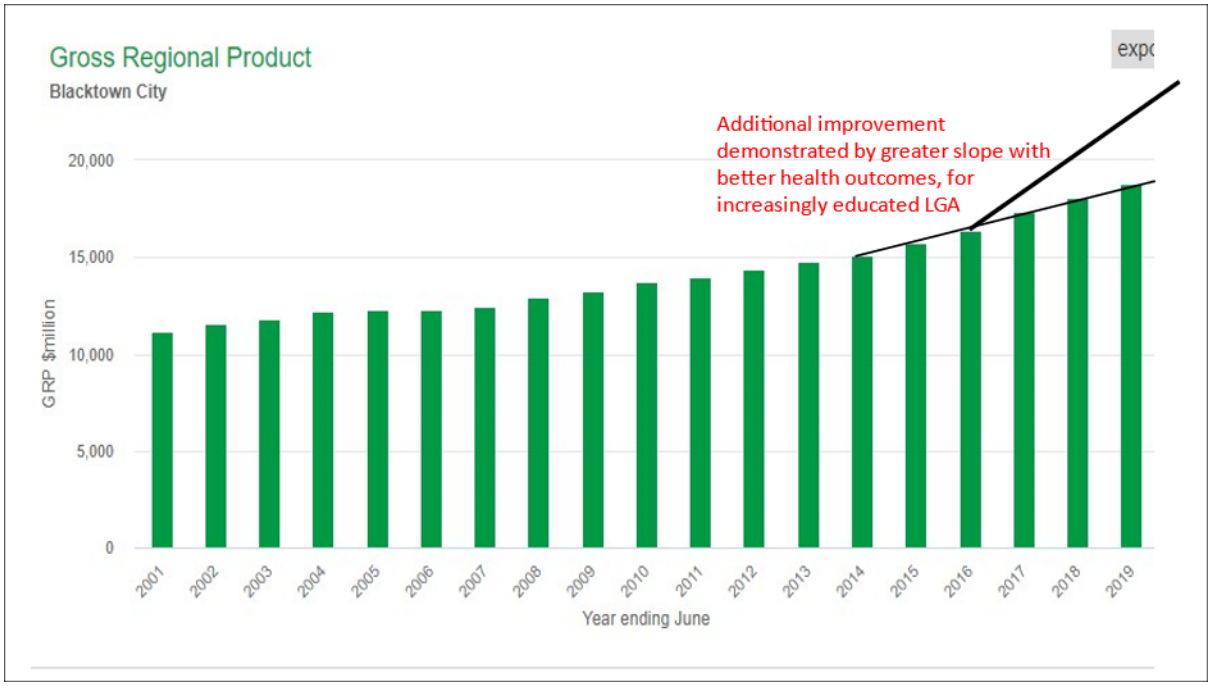
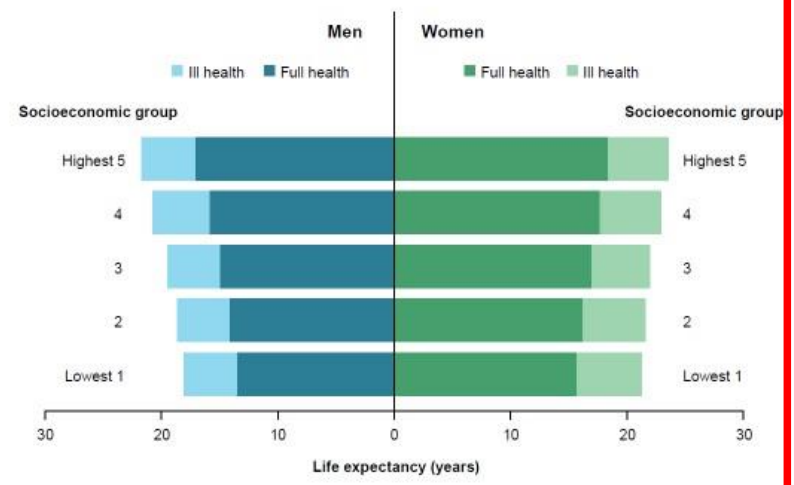


Figure 5.6: Life expectancy at age 65 in full health (HALE) and ill health, men and women, by socioeconomic group, 2015



Source: Appendix Table D4.

National Health Reform Agreement – Addendum 2020-25

ADDENDUM TO NATIONAL HEALTH REFORM AGREEMENT 2020-2025

P 61. "Low health literacy compounds the disadvantage already experienced by marginalised groups"

This document is a compilation and is provided for ease of reference.

The Addendum as signed by First Ministers is available at:

Outcome Inequities compounded

	NSW	Canberra	Blacktown
Population, (L.G.A.) 2020		395,000	395,000
Public Hospital Beds		**672**	**405**
Private Hospital beds (< 15 minutes)		**674**	-
Hospital 1		250	
Hospital 2		118	
Hospital 3		156	
Hospital 4		150	
I.R.S.D (2018)	~ 1000	1075	**986**
I.R.S.D. Decile (10=highest)		10	**6**
S.M.R. (AB.S. 2019)	**5.3**	**4.7**	**5.7**

79

7. Conclusion

Opportunities currently exist at a *national l*evel to continue constructive conversation with states (e.g. N.S.W.) regarding recognising variabilities within costs of production according to recently demonstrated, ABS imputed parameters, normalising variations within the R.V.I., mobilising growth funds adequately in advance of population expansion and providing a *one-off* infrastructure restitution compensation, where transparently indicated.

National Health Reform Agreement 2020-2025

National Health Reform Agreement – Addendum 2020-25

PRELIMINARIES, SYSTEM WIDE OBJECTIVES AND ROLES AND RESPONSIBILITIES

Preliminaries

1. This Addendum:

   a. sets out the shared intention of the Commonwealth, State and Territory governments (the States) to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system;

   b. re-affirms that all governments:

      i. agree that the healthcare system will strive to eliminate differences in health status of those groups currently experiencing poor health outcomes relative to the wider community; and

8

BMDH's ongoing dialogue with NSW Health over the last decade - *but particularly* during the last two years - has been consistently marked by the Ministry's goodwill, transparency, an indisputable willingness to listen, clear commitments and significant action.

National Health Reform Agreement 2020-2025

Review

21. An external review of the Addendum commissioned by CHC will be undertaken at the midpoint of this Addendum, completed by December 2023. The review will assess if the Addendum is meeting its stated objectives and will consider the following matters:

   a. implementation of the long-term reforms and other governance and funding arrangements, and whether practice and policy in place delivers on the objectives of the Addendum;

   b. the impact of external factors on the demand for hospital services and the flow-on effects on Addendum parameters;

   d. whether any unintended consequences such as cost-shifting, perverse incentives or other inefficiencies that impact on patient outcomes have arisen, and the capacity of Parties to adopt and deliver innovative models, as a result of financial and other arrangements in this Addendum;