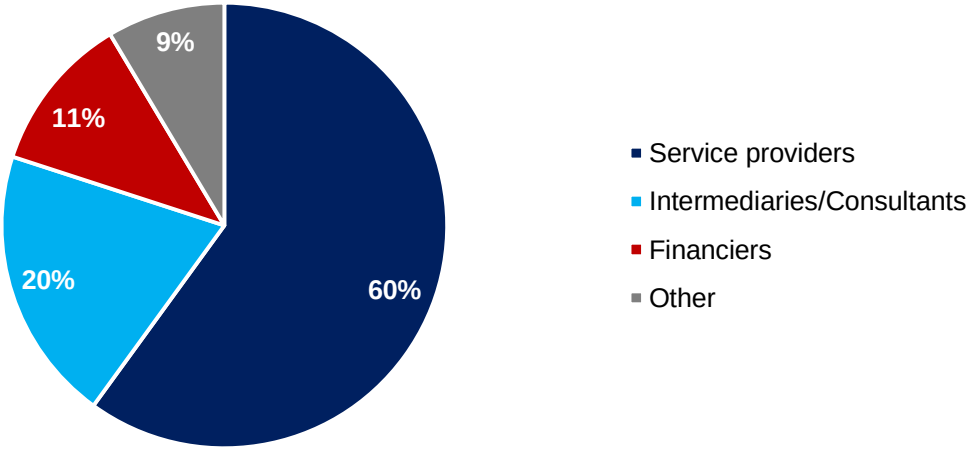
Managing chronic health conditions:
Wrap-up of market sounding session

10:45am to 1:15pm
23 February 2015
Balcombe Room, Level 28, 52 Martin Place Sydney

Key statistics

- Of 45 RSVPs, 35 stakeholders attended.



Questions and answers

1. **I'm wondering about the depth and quality of the information in the Ministry. What does success look like? Within each cohort, is there a preferred target? Is there rich information available to say a person costs $x?**

   We are open to suggestions from the market about when the intervention should occur, for example, targeting 45 year olds to achieve a benefit later in life. As a part of the implementation of activity based funding and the move towards activity based management in NSW, all patients treated in the public hospital system are costed on a six monthly basis and at a patient level where possible. Once a target cohort has been identified and proposals move to the joint development phase, more detailed costing data could be made available, provided that the appropriate privacy provisions are in place.

   During the request for proposals (RFP) process, proponents can access publicly available information. The National Efficient Price (NEP) and National Weighted Activity Unit (NWAU) are published on the Independent Hospital Pricing Authority (IHPA) website. The NEP and NWAU are calculated using the average cost of hospital services in Australia, and NSW is a major contributor of data to this calculation.

2. **Discussions with local health districts (LHDs) during the innovation funding cycle seemed to suggest that they do not make savings if one person doesn't present to the ED since another patient will take their place.**

   There used to be an assumption that effective chronic care would result in fewer beds. Now, we accept that population growth will likely outstrip any inroads we make in this respect. So, it has become more about slowing demand so we don't have to keep adding new beds, which in turn slows the growth in the cost of the system.

3. **Thinking about payment-by-results concepts – is reducing hospitalisations an appropriate measure? To receive payments, will we need to achieve fewer hospitalisations in the target group compared to the control group?**

   Different payment mechanisms are possible. In the bonds, we pay 50 per cent of the service delivery costs, plus more if you achieve better outcomes. Effectively, this is a risk that you, as the service provider, take on because you have to wait to see if you achieve those outcomes before receiving full payment. Investors can help you meet that cash flow deficit, and will if they think it's likely that you will meet the agreed outcomes. Ultimately, it depends on the proposal and the anticipated outcomes proposed.

4. **If there are providers that can take the risk themselves, there is no need for investors. Will that type of arrangement be included in this RFP?**

   Yes, provided that you can demonstrate the ability to take on that risk.

5. **What is the role of LHDs? Are they partners or purchasing entities?**

   The exact role will be determined by individual proposals. It is likely that LHDs will have an integral role given the locality of service delivery.

6. **I'm interested to understand the implications for the Integrated Care Strategy. Outcomes will accrue over a significant period of time. How will a changing policy environment impact or support a contract entered into under this program?**

   Chronic disease management is a challenging and complex matter. Work under the Integrated Care Strategy provides a strong base for this program and that there is fertile ground to do more in this space. Ultimately, we will see what the market says.

7. **There will be circumstances where LHD employees are already providing services in an area where a new provider wants to go. What thinking has been given to incorporating these existing staff members?**

   Many of these issues are likely to be worked out during the joint development phase.

8. **You've stated a preference for less complexity in the design of the transaction. How do you see that playing out in this area, given the complexity of chronic health conditions? Are you open to a longer process?**

   We realise that outcomes will flow over a longer period of time so we will have to factor that in. We are open to direction from you about where the benefits come from and how long they will take to accrue.

9. **There was a transaction in your bond pilot that didn't go ahead. What are your reflections on that process?**

   One aim of bonds is to provide value to investors, the community and the NSW Government. Unfortunately, despite the best efforts of the government, Mission Australia and Social Ventures Australia working together in good faith, no agreement on a model that satisfied this aim with an acceptable level of risk to all parties could be reached.

   The decision not to proceed with the proposed recidivism bond model was based on the challenges and risks of the proposed model in aggregate, including consideration of the evolving nature of the justice and corrective services policy environment.

   The NSW Government appreciates the goodwill and efforts of Mission Australia and Social Ventures Australia in the development of the model. This experience can be leveraged in future social impact investment activities. We're open to a range of models, not just social benefit bonds, which we expect won't be as complex to design and negotiate.

10. **Can you confirm that Commonwealth savings won't be taken into consideration? Changes to the Commonwealth regime could significantly impact on the landscape, affecting control groups, et cetera.**

    Part of our ongoing dialogue with the Commonwealth is to reduce cost shifting between governments. The relationship will be constantly shifting and something that we will always have to manage.

11. **Are you planning on releasing baseline costs for a bed day for the purposes of this process? It would be useful to have when weighing up the costs and benefits.**

    It's possible that costs will be different for each condition, so it's variable. There are already some efficient prices for presentation and admission to emergency departments with the National Weighted Activity Unit, which are available online. We will consider how to do this for the RFP.

12. **The Premier announced data will be available for this process. We need the data to work out the benefits.**

    The Office will facilitate requests for data, with a focus on directing you to what is publicly available. This is an issue that we'll be working on more broadly over time to facilitate these types of transactions, for example, developing a unit cost database.

13. **Will cost/savings data include the Commonwealth PBS (Pharmaceutical Benefits Scheme) and the like?**

    No, not at this stage.

14. **Community health networks exist and are intended to address this issue. Do we have data that compares the effectiveness of this program against the data in the presentation?**

    We define primary healthcare as everything outside of hospitals, those services have grown up over time and change often. It's not quite a coherent and integrated system so it's difficult to establish how effective all the parts of the system are.