Special Commission of Inquiry into Healthcare Funding

Outline of Evidence of Kevin Lawrence

Name:	Kevin Lawrence
Occupation:	Director Finance and Performance, Murrumbidgee Local Health District

1. This is an outline of evidence that it is anticipated that the witness will give to the Special Commission of Inquiry into Healthcare Funding.

My role

2. I am the Director of Finance and Performance for the Murrumbidgee Local Health District (**MLHD**). I have held that role since December 2019.

3. As Director of Finance and Reporting, I am responsible for the planning and reporting on the use of financial resources and monitoring of the MLHD's budget performance, including reporting to the Chief Executive and Board. My portfolio includes both financial and management accounting, procurement, and the Strategic Improvement Office.

Strategic Improvement Office

4. The Strategic Improvement Office provides governance and strategy on improving financial sustainability within MLHD. It was first established in May 2022. The office comprises a team of 3 people, including a change manager, and a health economist to assist with frameworks and decision making. The health economist was first engaged in December 2023 and is responsible for implementing and embedding economic methods into organisational decision making. This includes the development of internal economic resources and training, and application of micro-economic methodologies to demonstrate both cost effectiveness and financial sustainability of proposed changes in policy, process, and models of care.

5. The Strategic Improvement Office works on discrete projects. Some of its recent projects include:

    a. Improving processes on nursing agency engagement to increase efficiencies.

    b. Improving reporting capabilities within the rostering system, so that MLHD can have more oversight of the rostering system.

    c. Reviewing and improving utilisation of the Transitional Aged Care Program.

6. The Strategic Improvement Office is currently in the process of reviewing the post-implementation benefits of its various projects.

Procurement

7. MLHD utilises a number of shared services which are provided by NSW Health organisations, including catering, linen and transactional services. The most significant shared service from HealthShare NSW which MLHD does not utilise is the patient transport system. That is because MLHD is too geographically remote to take advantage of this service. Instead MLHD operates its own internal fleet.

8. The Chief Information Officer at Southern NSW Local Health District is a shared role with MLHD.

9. Overall, the procurement systems works well for MLHD. However areas with challenges are:

    a. Warehousing – due to the geographical remoteness of large parts of MLHD, our freight costs are relatively high. The change to a centralised warehouse arrangement based in Sydney has increased MLHD's total freight costs to approximately $700,000 per year (which is an increase of approximately 30% CPI adjusted). A return to a regional distribution centre may reduce freight costs.

    b. Threshold for procurement referrals – a contract with a lifetime value higher than $250,000 needs to be referred to HealthShare NSW. In my view this cap is low and creates inefficiencies, because even relatively small procurement activities require referral, including for the tender process. A $1 to $2 million cap over the life of a contract would be more reasonable.

    c. Transparency in performance of shared services – access to more transparent data about the performance of shared services, such as market and interstate benchmarking, would assist MLHD in assessing whether it is receiving value for money for these services.

    d. While statewide contracts generally work well, there are opportunities where MLHD may be able to locally achieve a better price if it engaged in negotiations with individual suppliers.

Funding

10. At MLHD, Wagga Wagga Base Hospital, Griffith Base Hospital, Deniliquin Health Service, and admitted mental health services (Wagga Wagga) receive activity-base funding (**ABF**). The balance of the facilities are block funded.

11. Overall, I am of the view that the principles of ABF are sound. However, the ABF model may not be fit for purpose for smaller facilities, such as facilities in MLHD smaller than Wagga Wagga Base Hospital. That is because these sites do not have the volume of activity to react in an efficient ABF manner due to higher fixed costs having to be absorbed by reducing activity. Smaller sites within our LHD operate at costs 36% higher than the State Price, and whilst the funding model does take into account the higher costs of regional and rural health service delivery, to what extent these are adequately addressed is subjective.

12. Collaborative commissioning work with the Murrumbidgee Primary Health Network (**MPHN**) also commissions MLHD to carry out programs to provide certain care services, such as chronic disease management. I am not directly responsible for collaborative commissioning.

Workforce

13. In my view, the biggest issue which MLHD faces is its workforce. This is particularly acute in the western parts of MLHD, which are more remote and rural. MLHD faces difficulties in attracting and retaining medical and nursing staff.

14. In addition to the challenge of attracting staff, previously GPs in rural towns would also work in hospitals. There is now a trend that medical officers do not have the experience or are not otherwise minded to work in the hospital environment. In addition, there is trend in VMO GPs to work pursuant to sessional contracts, as opposed to fee-for-service contracts. These challenges translate to a significant and increasing amount each year on premium labour (nursing agencies and locums) at MLHD. For example, VMO costs have increased by approximately 20% to 25% over the last few years without a corresponding increase in activity.

15. MLHD has also looked to address these issues by way of a number of strategies, including:

    a. Implementing the Rural Health Workforce Incentive Scheme, which aims to attract and retain workers to MLHD through a range of financial incentives.

    b. The Single Employer Model employment pathway for junior doctors seeking a career as a rural generalist.

16. My involvement in these initiatives is minimal, and I am not directly responsible for these programs.

Data

17. The key healthcare data sources include data from MLHD and data from MPHN (which has the same geographical footprint). MLHD borders Victoria and the ACT, and there are some challenges with accessing data for people living in MLHD who travel interstate for medical treatment. If this interstate data was readily accessible, MLHD could make more informed decisions regarding patient flow and healthcare services.