Special Commission of Inquiry into Healthcare Funding

Statement of Tony Gilbertson

Name:	Tony Gilbertson
Professional address:	Lookout Rd, New Lambton NSW 2305
Occupation:	Executive Director, Finance, Hunter New England Local Health District

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary to give to the Special Commission of Inquiry into Healthcare Funding ("**the Inquiry**") as a witness. The statement is true to the best of my knowledge and belief.

2. It is provided in response to topics identified by the Inquiry in a letter to the Crown Solicitor's Office dated 14 August 2024 (**MOH.0010.0542.0001**), to the extent that such topics are relevant to my role, and to the Inquiry's letter to the Crown Solicitor's Office dated 22 August 2024 (**MOH.0010.0541.0001**).

A. INTRODUCTION

3. I am the Executive Director, Finance, Hunter New England Local Health District (**HNELHD**). I have been in this role since February 2019. Prior to this, I was Executive Director, Finance, at NSW Health Pathology. A copy of my curriculum vitae is exhibited (**MOH.0010.0609.0001**).

4. In my current role, I am responsible for the financial governance structures and strategy of HNELHD, including those relating to financial sustainability and financial performance. For example, I am responsible for supporting the operational function of HNELHD, by allocating financial resources to the right places to meet Key Performance Indicators (**KPIs**) within our Service Agreement, for example in relation to emergency access, or surgical performance. I am responsible for managing assets and procurement.

5. Additionally, I am responsible for the imaging service internal business unit of HNELHD, which provides imaging services to the whole district as opposed to services provided on a hospital-by-hospital basis. For example, radiology and nuclear medicine reporting

6. A copy of the organisational structure for my Directorate is exhibited (**MOH.0010.0608.0001**). I have 9 direct reports in addition to my Executive Assistant, and approximately 750 staff in my Directorate.

B. FUNDING OF HNELHD FACILITIES

7. HNELHD facilities are funded as follows:

Facility	Funding type
Principal Referral Hospital	
John Hunter Hospital	Activity Based Funding
John Hunter Children's Hospital	Activity Based Funding
Major Hospitals	
Maitland Hospital	Activity Based Funding
Manning Hospital	Activity Based Funding
Tamworth Hospital	Activity Based Funding
District Hospitals	
Armidale Hospital	Activity Based Funding
Belmont Hospital	Activity Based Funding
Cessnock Hospital	Activity Based Funding
Gunnedah Hospital	Small Hospital
Inverell Hospital	Activity Based Funding
Kurri Kurri Hospital	Activity Based Funding
Moree Hospital	Activity Based Funding
Muswellbrook Hospital	Activity Based Funding
Narrabri Hospital	Small Hospital
Singleton Hospital	Activity Based Funding
Community Hospitals	
Bulahdelah Hospital	Small Hospital
Dungog Hospital	Small Hospital
Glen Innes Hospital	Small Hospital
Gloucester Soldiers Memorial Hospital	Small Hospital
Quirindi Hospital	Small Hospital
Scott Memorial Hospital - Scone	Small Hospital
Tenterfield Hospital	Small Hospital
Tomaree Hospital	Small Hospital
Wee Waa Hospital	Small Hospital
Wilson Memorial Hospital - Murrurundi	Small Hospital
Wingham Hospital	Small Hospital
Multipurpose Services (MPS)	
Barraba MPS	Small Hospital / MultiPurpose Service (**MPS**)
Bingara MPS	Small Hospital / MPS
Boggabri-John Prior MPS	Small Hospital / MPS
Denman MPS	Small Hospital / MPS
Guyra MPS	Small Hospital / MPS
Manilla MPS	Small Hospital / MPS
Merriwa MPS	Small Hospital / MPS
Tingha MPS	Small Hospital / MPS
Vegetable Creek- Emmaville MPS	Small Hospital / MPS

Facility	Funding type
Walcha MPS	Small Hospital / MPS
Warialda MPS	Small Hospital / MPS
Werris Creek MPS	Small Hospital / MPS
Psychiatric Hospitals	
Mater Mental Health	Activity Based Funding
Morisset Hospital	Block
Affiliated Health Organisation (AFO)	
Calvary Mater Newcastle	Activity Based Funding

8. Community Health Services provide Non-Admitted Patient care which is incorporated into the hospital they are parented to, and thus funding type aligns with the information provided above. For example, Armidale Community Health falls under Armidale and is funded via ABF.

9. Mental Health Non-Admitted Patient services are funded via Block Funding, with transition to Activity Based Funding (**ABF**) from 2025/2026.

10. The benefit of the ABF model is that it is a transparent model, and provides certainty in funding. During my time in this role I have not worked under other models of funding, and therefore cannot comment on opportunities for changes or alternative models.

11. From my perspective, the challenge of ABF is that the budgets are largely historical, detracting from a clear link between facility budgets and the ABF model. The ABF approach is that it is based on average costing, with funding provided at a state efficient price. This averaging means some HNELHD ABF sites are below the average, and some are above. The result is cross-subsidisation across HNELHD because of its mix of metropolitan, rural and regional locations. The larger metropolitan facilities subsidise the regional and rural ABF facilities which have a higher relative cost. In this regard, the costs to run our rural and remote facilities, such as Tamworth and Manning Hospitals and others in smaller towns, are high due to the reliance on locums, and geographical challenges such as greater reliance on patient transport.

C. HNELHD FINANCIAL PERFORMANCE

12. As a part of the executive, I work with the executive leadership team to meet HNELHD's KPIs under the Service Agreement. At times, KPIs can be in conflict, but balancing these demands is part of the role. For example, increasing resources in emergency

departments (**EDs**) to improve ED access KPI's, whilst managing within available funding and resources

13. HNELHD currently has a budget shortfall in 2023/2024. The key factors contributing to the financial challenges are increases in the length of stay and demand, increasing premium labour expenditure (for example, locum, agency and overtime), cost escalation across drugs and medical-surgical supplies above Consumer Price Index (CPI) escalation provided, and increasing costs and frequency of transporting patients between HNELHD facilities. However, HNELHD is currently working with the Ministry of Health on a financial recovery plan.

i. Length of stay and patient demand

14. Each of the large facilities within HNELHD, being John Hunter Hospital, Maitland Hospital, Manning Hospital, Tamworth Hospital, and Armidale Hospital, are seeing increases in the length of stay of patients as well as increases in demand for services. This has been a key change over the last few years. I understand that the general managers and operational executives are working to understand and manage the increase in length of stay, which remains stubbornly high.

15. As a result, the hospitals are required to have more beds open. From a cost perspective, each time an additional bed is opened, we are required to meet certain industrial requirements and ensure quality and safety, and this corresponds to additional resources that need to be applied (for example, nursing resources).

16. At HNELHD, we have not had the flexibility in our permanent nursing workforce to consistently enable additional beds to be staffed, and instead, they are being staffed with overtime or agency nurses at a cost premium.

17. For the last three financial years, HNELHD agency nursing expenditure paid via the payroll was $4.83m (FY2021/2022), $4.98m (FY2022/2023), and $9.12m (FY2023/2024). These figures reflect salary and wage costs only and does not include additional costs associated with accommodation, travel, and agency costs and commissions.

ii. Medical Workforce

18. A major challenge is obtaining a stable and permanent medical workforce, particularly to larger regional towns such as Tamworth, Armidale, Manning, Moree. These facilities have a high reliance on locum staff, both at junior and senior medical officer level. These locums command very high fees. These facilities require "on the ground" staff to maintain the necessary services. They also require an on-call medical workforce out of hours and on weekends to maintain 24/7 coverage, particularly for specialities such as obstetrics, surgery (for example, orthopaedics), and anaesthetics.

19. We have seen the cost of the medical workforce increase both as a result of an increase in the number of locum/agency staff that are required to be engaged, and the fees charged by those staff, which has been driven by the lack of supply and lack of willingness of many medical professionals to permanently relocate to regional towns.

20. For the last three financial years, HNELHD locum medical expenditure was $34.287m (2021/2022), $49.958m (2022/2023), and $60.887m (2023/2024). These figures reflect salary and wage and visiting medical cost (VMO) costs only and do not include additional costs associated with accommodation, travel, and agency commissions.

iii. Patient Transport

21. HNELHD also faces ongoing costs in transporting patients. As a result of the role delineation and medical coverage of hospitals and patient acuity, it is not possible to provide all of the required care in regional, rural and remote towns that we service. As a result, HNELHD needs to cater for interhospital patient transfers within HNELHD by way of patient transport or ambulance, with associated large distances and costs involved.

22. Given the geographical size of the district, there is also medical retrieval, where a specialist team goes to a patient and retrieves them back to a hospital for further care. We have retrieval teams operating in Newcastle and Tamworth.

iv. Financial recovery plan

23. HNELHD is currently working with the Ministry of Health on a financial recovery plan. Discussions are currently ongoing with respect to the details of the plan, which is expected to be formally signed off in October 2024.

24. HNELHD considers that financial recovery is best addressed through a mix of strategies, including:

    a. Reducing the costs of goods and services through increased engagement with whole-of-health and whole-of-government contracts,

    b. Working on reducing the length of stay of patients,

    c. A restructuring of the organisation, which was endorsed in February 2024, to a more efficient management structure,

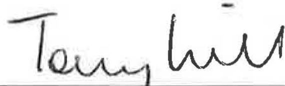
    d. Improved rostering practices, and

    e. Improving systems and controls for the recruitment of staff.

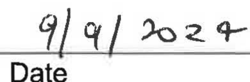
D. OTHER CHALLENGES

25. Given the geographical scale of the organisation, HNELHD has many facilities and buildings that require ongoing maintenance and repairs. The building age and quality varies from new and modern to old and heritage. The HNELHD repairs maintenance and replacement budget comes under constant pressure to do the minimum that is required to maintain building and fire compliance and ensure staff and patient safety. There is very little capacity within budgets to address large scale or emergency issues (for example, roof replacement) if they arise.

26. In addition, only limited capital funding is available to replace major medical equipment (for example, imaging equipment like CT and MRI; surgical equipment like microscopes, laparoscopes; cardiac catheterisation lab replacements; patient monitoring equipment).

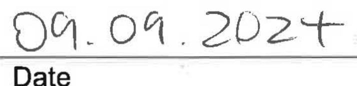


Tony Gilbertson



Date

Witness:



Date