NSW Health

Small Hospitals Funding Model Review

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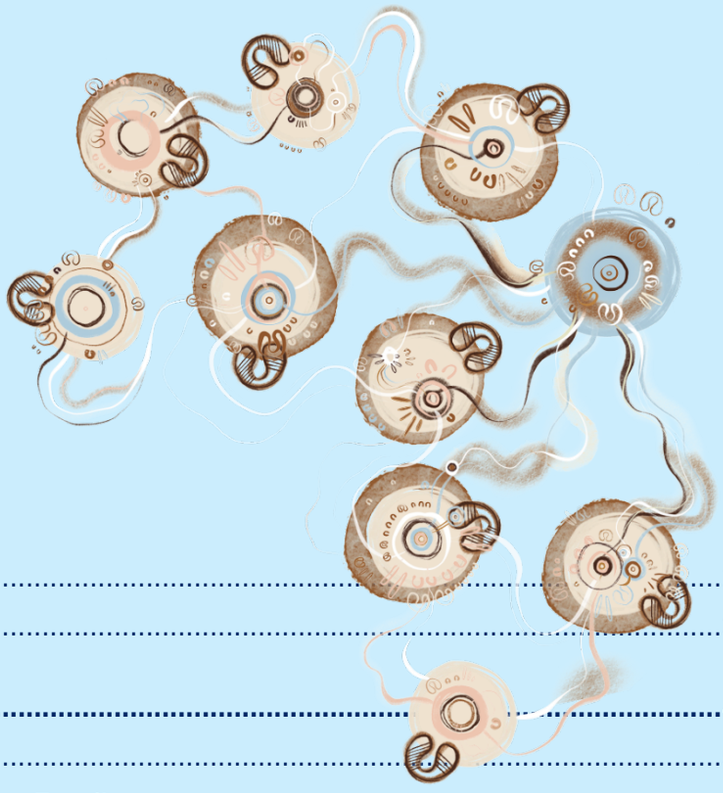

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Executive Summary

In NSW, there are over 100 small public hospitals across seven regional local health districts (LHDs). Small hospitals stretch from Tibooburra Health Service in far west NSW to Urbenville Multi-Purpose Service (MPS) in the north and south to Delegate MPS. These facilities play an important role in providing vital health services for people in rural and remote communities.

Small hospitals are defined by the way they are funded. All small rural hospitals receive a block funding amount each year which is based on the NSW Small Rural Hospitals Funding Model (SHFM), Small hospitals also receive funding to accommodate other expected costs and for specific services. Small hospitals have low patient volumes and generally include an emergency department, an acute or sub-acute component and some outpatient services. Just over half of NSW small hospitals also provide residential aged care services and are categorised as multi-purpose services (MPS).

Over the last few years there have been growing financial challenges facing small hospitals due to rising costs of providing healthcare and declining rural and remote populations. This report outlines the findings of a review by NSW Health to explore how small hospitals in NSW are funded and look at ways to ensure small hospitals remain sustainable into the future.

The review included a desktop analysis of funding and cost data, consultation with seven regional LHDs, identification of case studies to examine how funding is working in practice, and a literature search. A Steering Committee with representatives from across NSW Health guided the focus of the review and supported the development of nine recommendations.

There are five overarching review findings:

1. The approach to funding small hospitals is not responsive enough to changes in costs and models of care.
2. The Australian Government's share of funding for small hospitals has reduced.
3. The costs of providing care in multi-purpose services are increasing.
4. Understanding of funding models and processes is limited in small hospitals and affects LHDs' ability to advocate where needed.
5. There is an opportunity to develop a more sustainable funding model for small hospitals in the longer term.

Based on the findings, nine recommendations have been made for action. NSW Health will seek to implement all recommendations over the coming months, to ensure small hospitals are funded and supported to deliver high quality care across rural and remote NSW.

Recommendations

1. NSW Health should consider how to better account for Recognised Structural Costs through the Small Hospitals Funding Model, as there is evidence these costs are not currently adequately accounted for in small hospitals. (*Financial Services and Asset Management Division)*
2. NSW Health should better align escalation of costs with expected increases in small hospitals, noting inflation may have a more significant impact on small hospitals due to diseconomies of scale. (*Financial Services and Asset Management Division)*
3. NSW Health should consider how capital funding for small hospitals can be prioritised and ensure whole of life cycle costs are considered. *(Strategic Reform and Planning Branch / Finance Services and Asset Management Division)*
4. NSW Health should continue to invest in strategies to attract and retain health staff in small hospitals to reduce the reliance on premium labour that has a considerable impact on small hospital budgets. *(Workforce Planning and Talent Development Branch)*
5. NSW Health should ensure the National Health Reform Agreement 2025-30 addresses barriers impeding the Australian Government from meeting the 45% share of funding for public hospitals in NSW. *(Government Relations Branch)*
6. NSW Health should continue to work with the Australian Government to increase funding for aged care in multi-purpose services. *(Health and Social Policy Branch /Regional Health Division)*
7. NSW Health should develop a business management capability program and community of practice to ensure staff are appropriately upskilled and supported to understand small hospital funding mechanisms. (*Financial Services and Asset Management Division)*
8. NSW Health should establish a working group to explore future funding models for small hospitals in NSW. Such a funding model should ensure small hospitals can provide sustainable, integrated care that best serves the needs of rural and remote communities long into the future. (*Financial Services and Asset Management Division)*
9. NSW Health should prioritise investment in virtually enabled models of care to support face to face care in small hospitals (*Financial Services and Asset Management Division / System Performance Support Branch)*

1

Background

Rural Health Inquiry

On 16 September 2020 an inquiry was established to report on health outcomes and access to health and hospital services in rural, regional and remote New South Wales (Rural Health Inquiry). On 5 May 2022, the report for the Rural Health Inquiry was published which included 44 recommendations.

Recommendation 1 of the Rural Health Inquiry states:

> *That NSW Health review the current funding models for all rural and regional Local Health Districts in order to identify any service delivery gaps and provide any recommendations for funding increases.*

In early 2023, NSW Health engaged an independent auditor (EY) to assess implementation of the Rural Health Inquiry recommendations. EY confirmed NSW Health regularly reviews current funding models for all regional LHDs to identify service gaps and provide recommendations for funding increases and action. EY also established that, where the review process deems the NSW SHFM appropriate for a facility, funding allocations are based on actual expenses incurred previously, with adjustments for cost escalation.

NSW Health supported recommendation 1 in principle and committed to reviewing the appropriateness of the Small Hospital Funding Model to applicable hospitals as necessary. This report was prepared in response to this commitment. The report complements other reviews underway including the Special Commission of Inquiry into Healthcare Funding in NSW and renegotiation of the National Health Reform Agreement (NHRA).

Special Commission of Inquiry into Healthcare Funding

On 24 August 2023, the NSW Government announced the creation of a Special Commission of Inquiry to conduct a review of healthcare funding in NSW. The Inquiry will identify opportunities to deliver higher quality, more timely, and more accessible patient-centred care.
Hearings commenced in late 2023 and continue throughout 2024 with many of the regional LHDs invited to give evidence. All LHDs made submissions to the inquiry. The Commissioner is expected to hand down the findings by March 2025.

National Health Reform Agreement 2025-30

The National Health Reform Agreement (NHRA) is an agreement between the Australian Government and state and territory governments to work together to improve health outcomes and ensure a functional, sustainable health system in Australia. The NHRA outlines federal, state and territory responsibility for providing health care services and enshrines the Australian Government's funding commitments for state and territory public hospitals.

A Mid Term Review of the NHRA 2020-25 was published in October 2023.[1] Recommendations from the Mid Term Review were considered for the Small Hospitals Funding Review, including:

- Recommendation 25 – Block funding arrangements should be retained especially for rural/remote areas.
- Recommendation 36 – The NHRA should have a dedicated rural and remote Schedule that includes:
  - Minimum standards of access to primary, disability, aged and hospital services to ensure these services are maintained in rural and remote areas.
  - Implementing models of care within infrastructure and workforce limitations
  - Developing a sustainable health workforce.
  - Reviewing the regionality weighting to ensure rural and remote hospitals are funded fairly.
  - Ensuring the teaching, training and research (TTR) funding pool is equitably distributed to rural and remote hospitals to support sustainable health workforce training.

The 45 recommendations outlined in the Mid Term Review are being considered as part of the negotiations currently underway between the Australian Government and state and territory governments for the NHRA 2025-30.

Glossary

The following table contains definitions of key terms used throughout this report:

Key term	Definition
Activity based funding (ABF)	ABF is a way of funding hospitals for the number and mix of patients they treat. ABF takes into account that some patients are more complex and resource intensive to treat than others. Under ABF in NSW, health services are funded at a unit price (weighted activity unit) based on activity agreed in Service Agreements between LHDs/specialty health networks (SHNs) and the Secretary, NSW Health. ABF methodology applies to facilities which deliver activity per annum greater the 3,500 total NWAU (rural and remote hospitals) and greater than 1,800 admitted patient NWAU (metro hospitals).
Block funding	Block funding is based on the latest full financial year clinical costing data submission (District and Network Return), plus escalation. In NSW, block funding applies to facilities/services which are not under Small Hospitals Funding Methodology or ABF.
Clinical costing (cost data)	Clinical costing is the allocation of health care related costs to patient activity. A health care facility combines financial data (expense) with patient activity data, and the cost is allocated to individual patient activity. Within NSW, clinical costing is undertaken to prepare the District and Network Return (DNR) which is a condition of subsidy.

[1] R. Huxtable, 'Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 Final Report', in *Australian Government Department of Health and Aged Care*. October 2023, viewed on 11 March 2024, https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf.

District and Network Return (DNR)	The mandatory clinical costing data submission from each LHD/SHN to the NSW Ministry of Health. DNR includes patient activity and utilisation data, along with general ledger expenses to calculate hospital costs in a fully absorbed costing model. DNR is audited by local internal audit teams and used to inform the State Efficient Price, the National Efficient Price, and several national data submissions, such as National Hospital Cost Data Collection, Public Hospital Establishment and Health Expenditure.
Escalation	The provision of an estimate for increases in the costs due to continuing price changes over time.
Fixed and variable costs	Fixed costs are expenses that remain the same independent of activity levels. Variable costs are expenses that change based on the volume of services delivered.
Independent Health and Aged Care Pricing Authority (IHACPA)	Independent organisation that oversees significant reforms to improve Australian public hospitals. IHACPA used to be known as the Independent Health Pricing Authority (IHPA).
Patient volume	The number of patients who attend services to a hospital over a period. Volume is calculated by dividing practice cost by the average amount of money each patient encounter brings.
Modified Monash Model (MMM)	The Modified Monash Model (MMM) is how the Australian Government define whether a location is metropolitan, rural, remote or very remote. The model measures remoteness and population size on a scale of Modified Monash (MM) categories MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote.
Multi-purpose service (MPS)	A service that provides integrated health and aged care services in regional, rural and remote communities.
National Health Reform Agreement (NHRA)	An agreement that outlines the shared responsibility of the federal, state and territory governments to work in partnership to improve health outcomes for all Australians.
National Weighted Activity Units (NWAU)	The unit for counting healthcare service activity, based on the clinical complexity of patients and legitimate variations in costs. The NWAU can be described as a single 'currency' that expresses relative resource use for healthcare across all settings. The 'average' health service is equivalent to one NWAU. More intensive and expensive activities are funded by multiple NWAUs, and simpler and less expensive activities are funded by fractions of an NWAU.
NSW Small Rural Hospitals Funding Model (SHFM)	The NSW SHFM is based on activity and fixed and variable operating costs of small public hospitals. It aims to better harmonise funding and activity flow between small hospitals and activity based funding (ABF) hospitals in rural settings. The NSW SHFM is used to allocate the budget for small rural hospitals which do not meet the criteria for ABF or block funding. Facilities eligible for funding by the NSW SHFM are: • rural facilities which deliver activity of ≤3,500 total national weighted activity unit (NWAU) per annum; or • major city (metropolitan area) hospitals with activity ≤1,800 admitted patient NWAU per annum.
Own Source Revenue	Funding from sources other than the NSW Government, such as Australian Government funding, grants and contributions or Private Patient revenue.
Patient encounter	An interaction between a patient and a healthcare provider for the purpose of providing healthcare services or assessing the health of a patient.

Repairs, maintenance and renewals (RMR)	Expenses for normal maintenance and upkeep of capital assets that are necessary to keep the assets in their usual condition.
Recognised Structural Costs (RSC)	In response to the challenges faced by regional LHDs, such as diseconomies of scale and transportation issues, the NSW Health budget contains a provision for Recognised Structural Costs (RSCs). This allocation recognises specific cost items that contribute to a higher fixed cost structure for rural districts.
Regional local health districts (LHDs)	There are nine regional LHDs in NSW (Central Coast, Far West, Hunter New England, Illawarra Shoalhaven, Mid North Coast, Murrumbidgee, Northern NSW, Southern NSW and Western NSW. Of the regional LHDs, seven operate small hospitals funded under the NSW SHFM (excludes Central Coast and Illawarra Shoalhaven).
Section 19 (2) exemption	The Council of Australian Governments (COAG) section 19 (2) provides an exemption to the 1973 Medicare Act, supporting practitioners at approved Modified Monash Model (MMM) sites to bulk-bill the Medicare Benefits Schedule (MBS) for eligible services.
Small hospital	A small hospital is defined as any facility funded through the NSW Small Rural Hospitals Funding Model (SHFM) (see above definition).

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Methodology and scope

Scope of the review

Between January and April 2024, the Regional Health Division (RHD) and the Financial Services and Asset Management Division (FSAM) in the NSW Ministry of Health, in partnership with seven regional LHDs, conducted a review of the NSW SHFM.

The review was set up as a short term, internal investigation into how small hospitals in NSW are funded, to assess areas for improvement to ensure regional LHDs with small hospitals can continue to provide high quality, sustainable health services.

The review examined four key questions:

1. *How are small hospitals funded in NSW?*
    a. *For service delivery (through understanding the NSW SHFM and how the LHD then funds their facilities)*
    b. *For capital works (new infrastructure, refurbishment and maintenance)*
2. *What mechanisms/levers are in place to enable the model to respond in a timely way to new innovations (such as virtual care), fluctuating patient volume, and greater structural costs (such as transport and staffing) in small hospitals?*
3. *What is the current process for determining the Australian Government funding contribution to small hospitals in NSW (e.g. for multi-purpose services) and is this in line with the actual costs of delivering care?*
4. *Are there any recommendations NSW Health should make to improve the funding approach for small hospitals?*

Hospitals are in scope if they were funded under the NSW SHFM in the 2022-23 financial year. In 2022-23 there were 108 small hospitals including 63 MPS. The vast majority of these were in Hunter New England, Murrumbidgee and Western NSW LHDs. There are six major city hospitals, and 10 specialist mental health hospitals that are block funded on a separate basis, which are not included in this review.

The review was guided by a Steering Committee and included a desktop review, stakeholder consultation and a literature review.

Steering Committee

A Steering Committee was established to provide expert advice and guidance on the review, identify focus areas and endorse recommendations. Membership included:

- Activity Based Management Branch (Ministry of Health)
- Financial Data Analytics, Reporting & Governance Branch (Ministry of Health)
- Hunter New England Local Health District
- Murrumbidgee Local Health District
- Regional Health Division (Ministry of Health)
- Special Commission of Inquiry Response Team (Ministry of Health)
- System Purchasing Branch (Ministry of Health)
- System Information and Analytics (Ministry of Health)
- Western NSW Local Health District.

Desktop analysis methodology

The desktop analysis looked at activity and financial information for hospitals funded under the NSW SHFM from the District and Network Return (DNR) data for the period 2020-21 through to 2022-23 and associated NHRA funding. The desktop analysis examined:

- Funding sources
- Potential small hospital transitions between block funding and activity based funding
- Services offered by small hospitals and their costs
- Assumptions made in developing funding models
- Recognised structural costs.

Consultation approach

The Regional Health Division conducted interviews and focus groups with representatives from the seven regional LHDs with small hospitals. Consultations took place between 11-19 March 2024 and involved directors of finance from all seven LHDs, and a mix of chief executives, general managers of small hospitals, health service managers and planners, managers of financial analytics and performance, managers from capital works and asset teams, executive officers, and directors of nursing, clinical operations and allied health.

The consultations explored topics related to small hospital funding including efficiency, service gaps, MPS, infrastructure and capital funding and the future of funding for small hospitals.

Literature search

A rapid review of relevant literature was conducted to inform this review and validate themes identified through consultation. Google Scholar, the Brian Tutt Library and the Macquarie University Library online databases were searched for relevant literature about funding for small and/or rural hospitals in Australia and other OECD (Organisation for Economic Cooperation and Development) countries. References to the literature are included in this report where there are key links to the findings from this review.

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The funding model

This section provides an overview of small hospital funding, with a particular focus on responding to key questions specified in the scope of the review. It explains the separate mechanisms by which funding flows across the different levels of government and specifies the separate process for capital funding.

Small hospital funding mechanisms

The funding for small hospitals in NSW flows via separate mechanisms:

- *Australian Government contributions to NSW:* The Australian Government contributes to NSW small hospitals funding via various agreements. The most significant funding mechanisms are the National Health Reform Agreement (NHRA) funding and funding for residential aged care beds in MPS.
- *NSW Budget allocation to Ministry of Health:* Each year the NSW Treasurer prepares and tables an Appropriation Bill alongside the NSW Budget. The Bill authorises the Minister of Health (and other Ministers) to spend various sums of money from the Consolidated Fund that are required to deliver government services during the financial year.
- *Ministry of Health to LHD:* The Ministry of Health and LHDs enter into Service Agreements, which set out the service and performance expectations for funding and other support provided to LHDs, to ensure the provision of equitable, safe, high quality and human-centred healthcare services. Service Agreements facilitate accountability to government and the community for service delivery and funding.
- *LHD to small hospital:* LHDs and their Boards are charged with responsibility for determining how they deliver healthcare services within the framework of the Service Agreement and the LHD's annual and strategic plans to maximise the health of local populations.
- *Other revenue sources:* Small hospitals may receive revenue from other sources including patient fees, facility fees and other grants and contributions.

Australian Government funding contribution

NHRA funding

Australian Government funding through the NHRA is based on the IHACPA model which calculates the efficient cost of small hospitals and is the basis for determining block funding amounts. The IHACPA model includes a fixed component and a variable component. The fixed component is dependent on hospital size where the smaller the hospital, the greater the fixed component. Facilities considered 'very remote' based on the Accessibility and Remoteness Index of Australia (ARIA+) classification also receive a stabilising funding adjustment in acknowledgement of their small size and the relative high cost of delivering care.

Aged Care funding

The Australian Government provides funding via a grant system for MPS aged care beds and, in some sites, home care places. Residential aged care beds in MPS are funded by the Australian Government at a set rate, regardless of resident acuity or occupancy. The Australian Government opens an allocation round every year for approved providers to apply for additional places to expand an existing MPS or to apply for new places to establish a new MPS. Under the NHRA 2020-25 Addendum the Australian Government is responsible for planning, funding, policy, management and delivery of the national aged care system.

Medicare Benefits Schedule (MBS)

Small hospitals can generate revenue via the MBS by claiming for services performed by clinicians exercising their rights of private practice. There are strict criteria for billing Medicare for services performed in a NSW public hospital. Patients must elect to be treated as a private patient or services can be provided at through an exemption under Section 19(2) of the Health Insurance Act 1973.

MBS services can be claimed for both admitted and non-admitted patient services in small hospitals. To claim a service through MBS, the patient must have chosen to be treated as a private patient, been informed of any potential costs and be eligible for a Medicare benefit. The medical practitioner must have a valid provider number for each location at which private outpatient services are provided and billed. The medical practitioner must have received a valid referral prior to providing treatment.

In 2006–2007 the Council of Australian Governments (COAG) introduced the Section 19(2) Exemptions Initiative – Improving Access to Primary Care in Rural and Remote Areas. The initiative aims to improve access to primary health care services in rural and remote communities, including after hours, in public hospital and other health service settings. It does this by granting states conditional access to Australian Government funding through the MBS to assist with the challenges in attracting and retaining an adequate primary health care workforce in these communities. Practitioners at approved hospitals can bulk-bill the MBS for eligible primary care services, thereby improving access to primary care. The MBS revenue raised helps fund equipment, locum cover and professional development to increase primary health care access in rural and remote communities.

Eligible services under the Section 19(2) exemption scheme now extend beyond primary care, and Medicare benefits can now be claimed for eligible non-admitted and outreach, non-referred ED services in approved Section 19(2) facilities. Eligible providers include approved NSW Health general practitioner visiting medical officers (GPVMOs), nurse practitioners, Aboriginal health practitioners and allied health clinicians.

NSW Budget allocation to Ministry of Health

Each year, the Ministry of Health puts forward policy proposals for new or additional funding consideration by the Expenditure Review Committee (ERC) of Cabinet as part of the annual budget process and within the context of the whole-of-government prioritisation process. These proposals are informed by the purchasing process undertaken each year when the Service Agreements are developed. The success of these submissions influences the funding allocation amounts ultimately included in the Service Agreements.

Ministry of Health to LHD

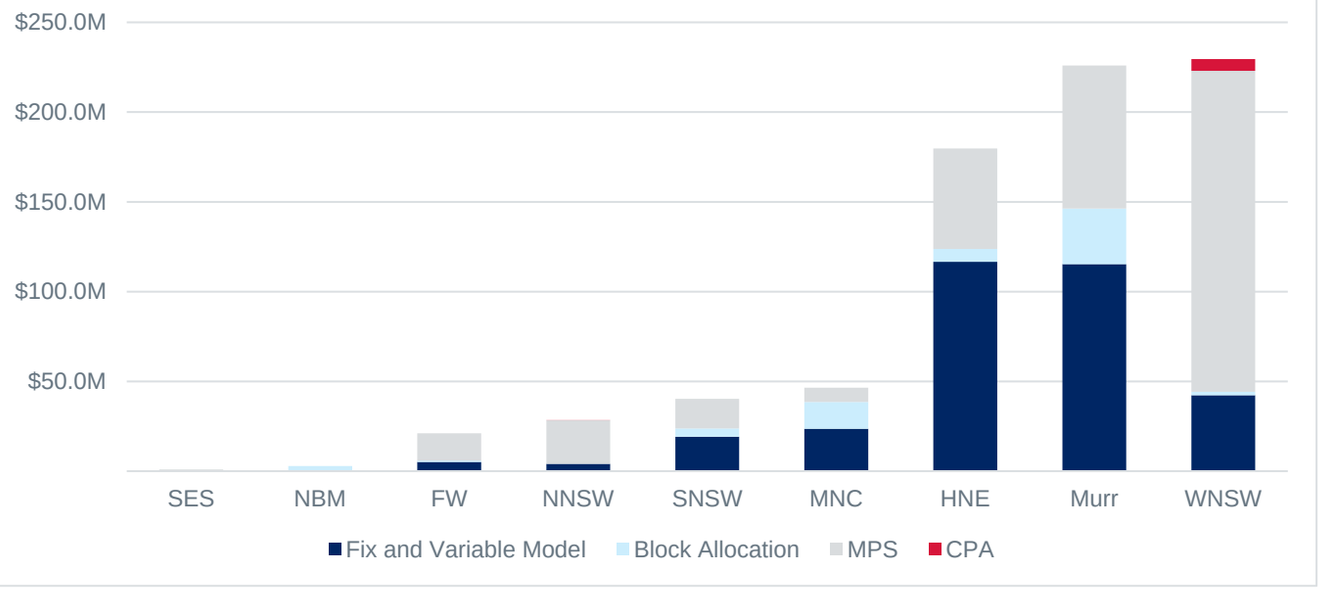
The Ministry of Health includes its funding allocation to small hospitals each year in the Budget Schedule of the relevant LHD Service Agreement, where this allocation includes:

- Small Hospital Funding Model (SHFM) amount: This is a fixed and variable modelled amount calculated using the NSW SHFM. NSW Health developed the NSW SHFM to reduce funding instability associated with variations in activity in small hospitals and account for the higher fixed costs of delivering care in rural settings. The fixed and variable components ensure that small hospitals are funded to deliver essential services despite lower activity than larger regional and metropolitan hospitals.
- Recognised Structural Cost amounts: Recognised Structural Costs are additional overheads that result when providing care in rural and remote areas such as premium labour and patient transport costs, for which additional funding is allocated in recognition of the challenges in

achieving operational efficiencies that are beyond the LHDs control. This is quantified by assessing the LHD costs at the cost item level against the state average, Additional allocations are considered where there exists a consistent pattern of rural districts reflecting costs above the upper limit.

- Other block funded amounts: The NSW SHFM excludes the block funded services, which are allocated amounts reflecting their costs escalated. These services include Population health, Teaching, Training and Research, Non-admitted Mental Health, Aged Care Related Services and MPS facilities.
- Cost Price Adjustment (CPA) amount to accommodate LHD costs: LHDs are allocated additional funding via CPA calculated by comparing the final amount to its latest DNR cost data escalated.
- Negotiated Funding: There is a purchasing process undertaken in development of Service Agreements whereby LHDs have the opportunity to negotiate various items, including but not limited to funding for innovations and activity growth, etc. Any additional activity negotiated is funded in line with the ABF methodology.

Figure 1: Distribution of small hospital funding by LHD in 2023-24



The Ministry of Health also provides additional funding throughout the year in the form of budget supplementations. The Ministry of Health is working toward reducing the need to issue budget supplementations by including funding in the initial budget where possible.

LHD to small hospital

There are variable processes in LHDs for allocating funding to small hospitals. Some LHDs apportion funding to facilities largely based on the Ministry of Health's funding allocation, while other LHDs re-allocate overall funding based on locally assessed needs. Funding for small hospitals may also be allocated to centrally run services including patient transport.

Many LHDs report they regularly supplement small hospital funding with funding and revenue from ABF facilities or through the budget supplementation process.

Small hospital funding for capital works

The review also investigated how small hospitals are funded for capital works (including new infrastructure, refurbishment and maintenance).

LHDs submit Capital Investment Proposals (CIPs) to the NSW Ministry of Health Strategic Reform and Planning Branch annually, to seek funding for major infrastructure projects (greater than $250,000) which may include small hospital redevelopments.

The Ministry of Health reviews submitted CIPs to ensure they are aligned with local and statewide plans and that the projects are sustainable and help improve patient care. Proposals must also align with all of the strategic criteria in the State-wide Investment and Prioritisation Framework and be supported by data in the Strategic Asset Management Plan and Asset Management Plan.

Once a CIP is assessed by the Ministry of Health to meet requirements, it may be incorporated into the 10-Year NSW Capital Investment Strategic Plan for submission to NSW Treasury for consideration as part of the annual budget process.

The process for obtaining capital funding is rigorous, noting that the prioritisation and sequencing of funding commitments being considered is based on a range of factors including the funding available and delivery capacity in consideration of Health's existing capital program.

In addition to CIPs, the Regional Minor Works Program coordinated by the Strategic Reform and Planning Branch supports regional LHDs with additional capital funding for small-scale projects or 'Minor Works' (less than $250,000) that help improve health outcomes and quality of care.

Regional LHDs are also allocated an annual budget for repairs, maintenance and renewals (RMR). If an LHD requires additional RMR funding in excess of the annual budget, this can be granted by the Ministry of Health. All applications for capital budget or funding must be aligned to data provided by the respective LHD in their annual Asset Management Plan (AMP) submission to the Ministry of Health's Asset Management Branch. The Ministry applies a strategic review across all capital applications to ensure alignment with local and statewide plans and to ensure the application will support enhancements to delivering patient care, maintain a sustainable asset base for the system and continue to build asset management capability within the LHD.

Multi-Purpose Services

The NSW and Australian governments share responsibility for providing capital funding for MPS. LHDs can apply to the Ministry of Health for capital funding for MPS through the CIP process. The Australian Government also offers grants to build, extend or upgrade MPS (and other aged care services) through the Aged Care Capital Assistance Program. The program also grants funding for staff accommodation to support recruitment and retention of staff in MPS and aged care services. Through this program up to $605.7 million in funding is available up to June 2027 and $161 million will be available each financial year that follows.

Health staff accommodation

Funding for health staff accommodation is a key component of capital funding for small hospitals given the challenges attract and retaining staff in rural and remote areas. In June 2024, the NSW Government announced $200 million for health staff accommodation in regional areas to help attract and retain staff. The Ministry of Health is working with regional LHDs to determine where accommodation will be located to support areas of greatest need. This allocation follows previous funding in 2021 from the then NSW Government of $73.2 million to five regional LHDs for health staff accommodation.

4

Findings and recommendations

Finding 1: The current approach to funding small hospitals is not responsive enough to changes in costs and models of care

It is known that there are higher costs of delivering care as remoteness increases.[2] Most (87%) of the 108 small hospitals in NSW are located in small rural, remote and very remote locations (Modified Monash 5-7 areas) (*Table A*). People living in these areas can find it harder to get medical help and accessing doctors can take longer and cost more due to travel.[3]

Higher fixed costs for providing services due to diseconomies of scale is commonly cited as a key factor resulting in greater per person costs in delivering care in small hospitals.[4] These costs are challenging to mitigate and underpin inefficiencies of providing care in small hospitals.

While the NSW SHFM has mechanisms to fund the higher costs in rural and remote areas, there is evidence these costs are difficult to accurately quantify and account for.[5] The NHRA 2020-25 Mid Term Review found that current Australian Government funding may not accurately reflect the higher costs of delivering care in rural and remote areas and recommended regionality weightings be reviewed to ensure small hospitals are funded fairly.[6]

Table A: Small hospitals in NSW by Modified Monash Model classification

	MMM (1)	MMM (2)	MMM (3)	MMM (4)	MMM (5)	MMM (6)	MMM (7)	Total
FW					2		4	**6**
WNSW					21	8	3	**32**
Murr				5	21	2		**28**
HNE			1	4	20			**25**
MNC			1		2			**3**
SNSW				2	4			**6**
NNSW			1		5			**6**
SES							1	**1**
NBM					1			**1**
Total	_	_	**3**	**11**	**76**	**10**	**8**	**108**
			3%	*10%*	*70%*	*9%*	*7%*	***100%***

[2] Performance Analysis for Transformation in Healthcare Group, UTS Business School, 'Patient level costing in Australia – uses, challenges, and future opportunities', in *Independent Health and Aged Care Pricing Authority.* June 2021, viewed on 4 March 2024, https://www.ihacpa.gov.au/sites/default/files/2022-08/patient_level_costing_in_australia_-_uses_challenges_and_future_opportunities.pdf.
[3] Australian Institute of Health and Welfare, 'Rural and remote health' in *Australian Government Australian Institute of Health and Welfare.* April 2024, viewed on 22 May 2024, https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health.
[4] B. Palmer, J. Appleby and J. Spencer, 'Rural health care: A rapid review of the impact of rurality on the costs of delivering health care', in *Nuffield Trust.* January 2019, viewed on 4 March 2024, http://www.nuffieldtrust.org.uk/research/rural-health-care.
[5] B. Palmer, J. Appleby and J. Spencer, 'Rural health care: A rapid review of the impact of rurality on the costs of delivering health care', in *Nuffield Trust.* January 2019, viewed on 4 March 2024, http://www.nuffieldtrust.org.uk/research/rural-health-care.
[6] R. Huxtable, 'Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 Final Report', in *Australian Government Department of Health and Aged Care.* October 2023, viewed on 11 March 2024, https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf.

Recognised Structural Costs

There are considerable costs associated with providing patient transport and employing workforce in rural and remote settings. While the higher costs of delivering care are considered in funding for small hospitals, this review heard the full extent of these Recognised Structural Costs may not be adequately offset in the current funding model.

Providing care in rural and remote areas can be challenging due to an economic tension between the costs of providing a service locally and the costs of transporting patients to a larger, more specialised facility to receive care. Low patient volumes can mean local facilities are not able to satisfy safety and quality requirements for maintaining these services and there is an additional burden on small hospitals in rural and remote areas to transport patients who present for care.

The average patient transport costs per acute admitted episode are higher for regional LHDs than metropolitan LHDs. Regional LHDs face a range of transport challenges that contribute to increased costs including longer distances, poorer road conditions, greater impacts of natural disasters, greater reliance on costly modes of transport such as air retrieval and navigating cross border transport, which can have its own challenges.[7]

In many small hospitals there is limited access to non-emergency patient transport, particularly after-hours, due to a lack of resourcing (both funding and workforce). Higher transport costs in small hospitals also arise due to the need for staff to escort patients during transfer between sites. The greater distances and increased travel time puts additional pressure on an already limited small hospital workforce, and it can be challenging and costly to cover workforce gaps due to staff travel while on shift.

Increased contingent labour costs also influence cost increases in small hospitals. Contingent labour (employment of locum and agency staff) is a critical component of the small hospital workforce that provides cover for permanent employees. This review heard small hospitals in NSW are heavily reliant on contingent labour and this aligns with evidence from the literature.[8] The cost of contingent labour has increased since the COVID-19 pandemic due to closed national and state borders during the pandemic which disrupted workforce supply and led to significant competition in a reduced medical workforce environment. While the pandemic has ended, the national market is yet to see a return to pre-pandemic cost structures and supply levels. In small hospitals, expenditure on contingent labour has increased significantly in 2023-24 financial year to date (up to the end of May 2024) compared with financial years prior.

The traditional service delivery model at small hospitals focuses on medical and nursing models of care and most expenditure on contingent labour is dedicated to engaging medical and nursing staff. However, there are also allied health workforce shortages in rural and remote areas which poses a challenge to providing multidisciplinary care in small hospitals.[9] There is evidence that turnover of allied health staff increases with remoteness and it is costly to replace allied health staff. [10] Allied health professionals tend not to be engaged through contingent labour arrangements and only a small number of agencies are able to offer allied

[7] New South Wales Special Commission of Inquiry into Healthcare Funding, 'Submission 008 Far West Local Health District', in *The Special Commission of Inquiry into Healthcare Funding*. October 2023, viewed on 22 April 2024, https://healthcarefunding.specialcommission.nsw.gov.au/assets/Uploads/publications/Listing-of-Submissions-48/Submission-008-Far-West-LHD.pdf

[8] L. Vaughan and N. Edwards, 'The problems of smaller, rural and remote hospitals: Separating facts from fiction'. *Future Healthcare Journal*, vol. 7(1), 2020, pp. 38-45, doi: 10.7861/fhj.2019-0066.

[9] R. Kruk, 'Independent review of Australia's regulatory settings relating to overseas health practitioners final report', in *Australian Government Department of Finance*. December 2023, viewed on 13 May 2024, https://www.regulatoryreform.gov.au/sites/default/files/Final%20Report%20-%20Overseas%20Health%20Practitioner%20Regulatory%20Settings%20Review%202023%20-%20endorsed%20by%20National%20Cabinet_0.pdf.

[10] M. Chisholm, D. Russell, and J. Humphreys, 'Measuring rural allied health workforce turnover and retention: What are the patterns, determinants and costs?'. *Australian Journal of Rural Health*, vol. 19(2), April 2011, pp. 81-8. doi: 10.1111/j.1440-1584.2011.01188.x. PMID: 21438950.

health workers. Consequently, these roles can sit vacant in small hospitals for months. The shortage of allied health staff in small hospitals reduces access to care and is one of many factors impacting poorer health outcomes in rural and remote areas.[11]

Funding for contingent labour in small hospitals should be carefully considered, and NSW Health should retain a primary focus on initiatives to increase and retain a permanent workforce. NSW Health continues to implement a range of initiatives to mitigate workforce challenges and remediate contingent labour costs, including working towards a coordinated national locum and agency workforce strategy.

Economic inflation

This review also found that the current approach to small hospital funding is limited in its ability to respond to economic inflation and new (or changed) models of care.

One of the key drivers of recent cost increases in small hospitals is increased inflation in the economy over the past two years. Economic inflation arguably has a greater impact on rural and remote areas, where diseconomies of scale and the tyranny of distance incur additional costs not experienced in metropolitan areas.

The NSW SHFM uses cost data from two financial years prior and applies an indexation rate to determine the funding amount for a small hospital in the upcoming financial year. Any rises in inflation beyond the applied indexation rate are not accounted for in the funding allocation. This can result in a misalignment between funding and actual costs of delivering care.

At the end of the financial years 2021-22 and 2022-23, the consumer price index (CPI) rose by 6%[12], however the NSW SHFM applied an indexation rate of 2.44% for small hospital funding.

New or changed models of care

With the exception of negotiated funding, funding from the Ministry of Health to LHDs is derived from two year lagged cost data. The data lag creates challenges when implementing new models of care as the costs will not yet be reflected. These services would need to be negotiated separately via the purchasing process to receive the required funding until the costs are reflected in the data.

An example of the challenges with implementing new models of care was identified by Southern NSW Local Health District. The Virtual Rural Generalist Service (VRGS) was introduced in July 2023 to provide remote medical coverage in five small hospitals, supporting staff and ensuring patients can continue to access care. While one-off funding was allocated to establish the service, the LHD has assessed there will be costs of around $1.2 million to continue the service which will not be accounted for in the hospitals' annual block funding until the 2025-26 financial year. Determining investment and costing for virtual models, particularly in pilot phases is complex, as purchasing arrangements need to consider wider holistic benefits of such models. For example, early preliminary findings from the evaluation of VRGS in Western NSW LHD indicate benefits including: demonstrated sustainable benefits for doctor wellbeing, patient care and patient safety, locum cost savings, NWAU favourability with identified reduction in hospitalisations, readmissions, ED visits and length of stay; and improved patient involvement with health services in Aboriginal populations. While these may

[11] Nous Group, 'Evidence base for additional investment in rural health in Australia', in *National Rural Health Alliance*. June 2023, viewed on 12 May 2024, https://www.ruralhealth.org.au/document/evidence-base-additional-investment-rural-health-australia,.
[12] Australian Bureau of Statistics, 'Consumer Price Index, Australia', in *Australian Bureau of Statistics*. April 2024, viewed on 7 May 2024, https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia/latest-release#:~:text=The%20Consumer%20Price%20Index%20(CPI)%20rose%201.0%25%20this%20quarter,hospital%20services%20(%2B2.3%25).

not materialise as a direct return on investment to a specific facility, this investment will enhance the access to and quality of healthcare in the region and deliver more holistic cost benefits to the LHD. The current funding model is not flexible enough to account for this complexity.

Capital funding and asset maintenance in small hospitals

There is an increasing need for infrastructure and capital funding to address ageing small hospital infrastructure. However, the availability of major capital funding for large refurbishments or redevelopments is limited and the timeframes for delivering these projects are quite lengthy. As such, the availability and timing of capital funding for major infrastructure projects (more than $250,000) in small hospitals may not align with the immediate clinical need.

When major capital funding is approved by ERC, the whole of life cycle costs (including costs to plan, acquire, use, maintain, and dispose of new assets or new and upgraded infrastructure) has historically not been fully provisioned as part of the budget allocation.

At the same time, there is evidence that funding for repairs, maintenance and renewals (RMR) in small hospitals is not adequate and regional LHDs report a considerable backlog of requests for redevelopments and maintenance in small hospitals. One LHD cited a backlog of $55 million for basic and required technology for maintaining infrastructure and equipment. Another LHD identified 39 facilities requiring infrastructure upgrades totalling around $7 million in additional funding.

It is the responsibility of the LHD to manage and allocate RMR funds across all hospitals in the district and these processes may vary across LHDs. However, given significant increases in costs for construction and maintenance, it has become more costly to repair and maintain small hospitals, particularly in the face of ageing infrastructure and with the compounding effect of rurality and remoteness. While the Ministry of Health provides funding for upgrading facilities and maintaining infrastructure, LHDs report these do not cover the overall costs required to maintain and upgrade current facilities and equipment in small hospitals.

Conclusion

NSW Health must ensure the approach to funding small hospitals accounts for contemporary cost and service changes.

Recommendations

Recommendation 1

NSW Health should consider how to better account for Recognised Structural Costs through the Small Hospitals Funding Model, as there is evidence these costs are not currently adequately accounted for in small hospitals.

Financial Services and Asset Management Division

Recommendation 2

NSW Health should better align escalation of costs with expected increases in small hospitals, noting inflation may have a more significant impact on small hospitals due to diseconomies of scale.

Financial Services and Asset Management Division

Recommendation 3

NSW Health should consider how capital funding for small hospitals can be prioritised and ensure whole of life cycle costs are considered.

Strategic Reform and Planning Branch / Finance Services and Asset Management Division

Recommendation 4

NSW Health should continue to invest in strategies to attract and retain health staff in small hospitals to reduce the reliance on premium labour that has a considerable impact on small hospital budgets.

Workforce Planning and Talent Development Branch

Finding 2: The Australian Government's share of funding for small hospitals has reduced

The Australian Government and state and territory governments are both responsible for funding and managing different parts of the health care system. Broadly speaking, the Australian Government is responsible for system management and funding of primary and aged care, while states and territories are responsible for system management of public hospitals and taking the lead role in managing public health activities.

The Australian Government and state and territory governments are jointly responsible for funding public hospital services. Under the 2020-25 NHRA Addendum, the Australian Government committed to increasing its share of public hospital funding through a 45% contribution to the costs of growth, subject to a funding cap. However, the Australian Government's funding share for NSW hospitals has decreased compared to where it was before the commencement of the current Addendum period and has not met the 45% contribution commitment.

Over the past few years, the cost of providing care in NSW small hospitals has increased by 16.3% from $747 million in 2020-21 to $869 million in 2022-23. The NSW Government contribution to small hospital funding has increased by 28% from $341 million in 2020-21 to $436 million in 2022-23. Meanwhile, funding from the Australian Government contribution for small hospitals increased 6.0% from $234 million in 2020-21 to $248 million in 2022-23. Accordingly, the Australian Government share of small hospital funding is decreasing. Funding for small hospitals through the NHRA decreased from 31% in 2020-21 to 29% in 2022-23, while aged care funding decreased from 14% in 2020-21 to 13% in 2022-23.

Figure 2: Cost and funding sources for 2020-21 to 2022-23

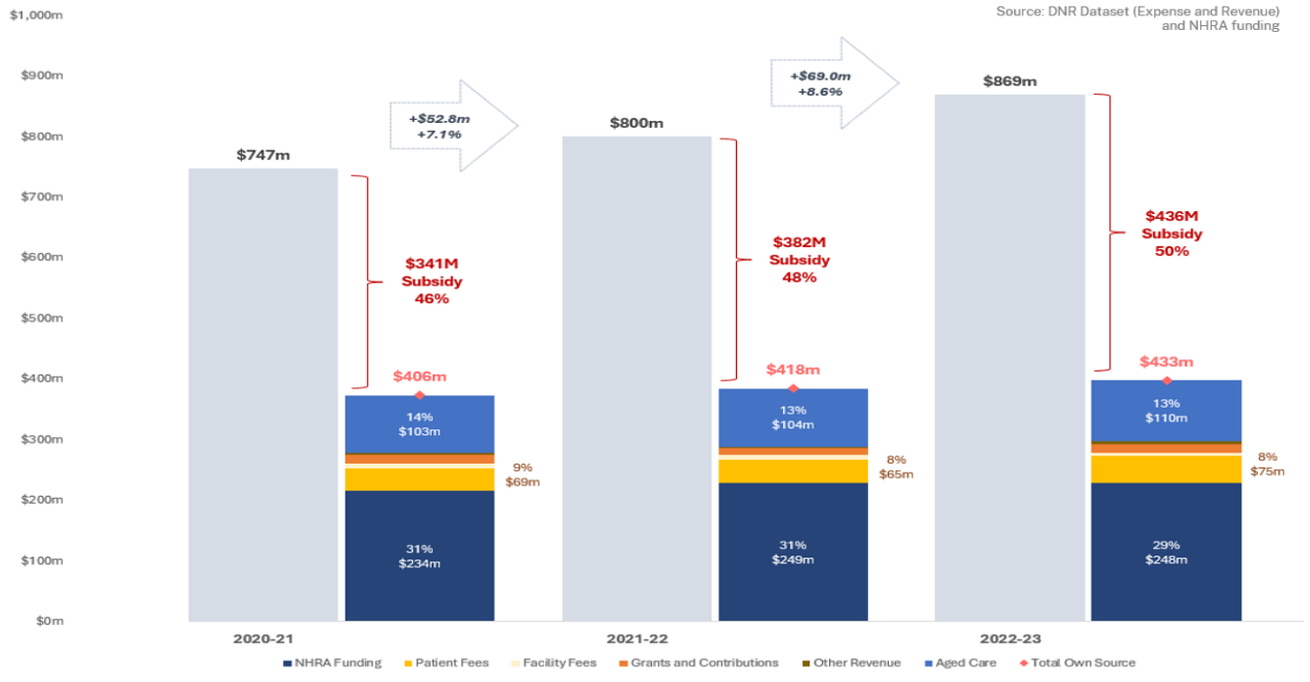


Figure 3 shows the growth in Own Source Revenue – funding from the Australian Government and other sources outside NSW Government funding. The overall growth of Own Source Revenue was 6.7% between 2020-21 and 2022-23. The funding sources that made up Own Source Revenue for 2022-23 are shown in *Table B*.

Figure 3: Growth in Own Source Revenue items 2020-21 to 2022-23

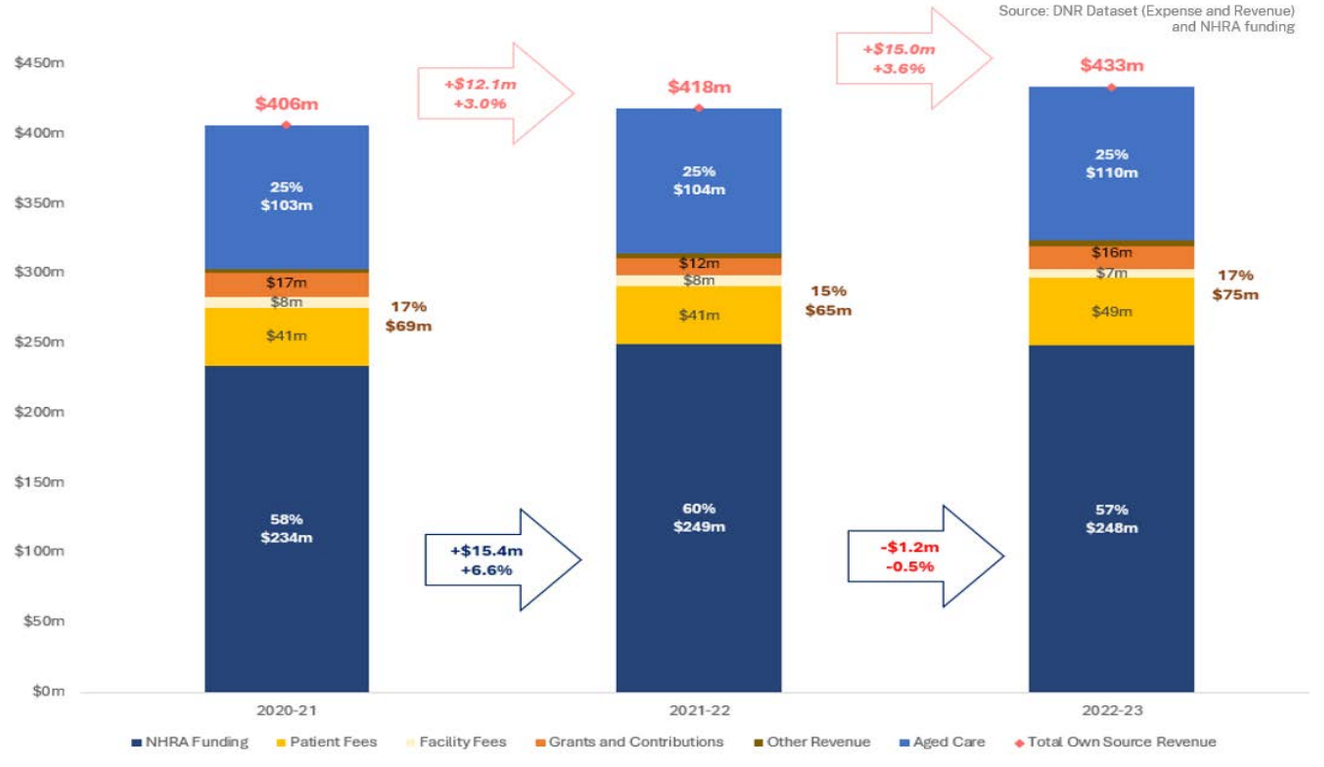


Table B: Composition of Own Source Revenue for 2022-23

Revenue Source	$	%
NHRA Funding	$248.2m	57%
Aged Care	$109.8m	25%
Patient Fees	$48.5m	11%
Grants and Contributions	$16.1m	4%
Facility Fees	$6.5m	2%
Other Revenue	$4.1m	1%
Total	**$433.1m**	**100%**

Negotiations are currently underway between the Australian and state and territory governments to establish the next NHRA addendum for 2025-30. These negotiations will consider the recommendations from the Mid Term Review and explore how the new addendum can ensure rural and remote health services are adequately funded and supported over the next five years. It is important that the NSW Government advocates strongly for changes so the Australian Government can meet its responsibility to fund 45% of public hospital growth to ensure public health services including small hospitals are sustainable.

Conclusion

The NSW Government should work with the Australian Government to ensure Commonwealth funding for small hospitals is sufficient.

Recommendation

Recommendation 5

NSW Health should ensure the National Health Reform Agreement 2025-30 addresses barriers impeding the Australian Government from meeting the 45% share of funding for public hospitals in NSW.

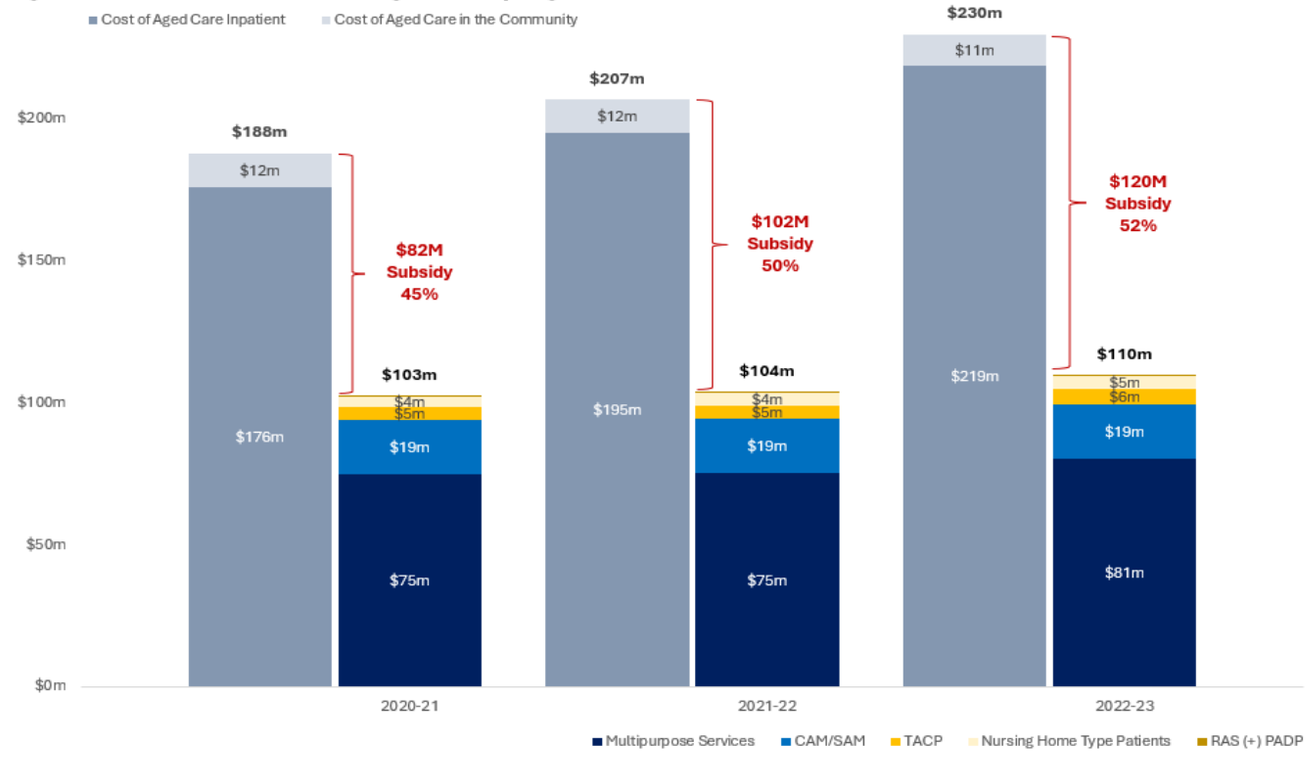
Government Relations Branch

Finding 3: The costs of providing aged care in multi-purpose services are increasing

Between 2020-21 and 2022-23, the costs of providing aged care in MPS increased by 24.5% from $176 million to $219 million (*Figure 4*). In the same period, the NSW Government contribution for aged care programs (including a small proportion for aged care in the community) increased from 45% to 52% of total costs. In essence, as costs of providing aged care are increasing, the NSW Government is funding more of the total cost.

The Australian Government is responsible for planning, funding, policy, management and delivery of the national aged care system, as enshrined in the NHR A 2020-25.[13] There is an appetite from the Australian Government and among regional LHDs to expand the MPS model for residential aged care. However, it is important that the full extent of these costs do not shift to the NSW Government while the Australian Government retains funding responsibility for aged care.

Figure 4: Cost and revenue of aged care programs 2020-21 to 2022-23



MPS are perceived as a critical service in small rural towns and are often one of few aged care providers, if not the only local provider, in these locations. The MPS model is regarded favourably by staff in regional LHDs who reinforced the important of recognising the MPS model is unique and requires a different approach to providing care compared with the acute hospital. This review heard there may be opportunities to strengthen approaches to providing high quality, person-centred care in MPS by ensuring there is the right mix of staff, activities and other supports to meet residents' physical, emotional, cultural, spiritual and psychological needs.[14]

Adequate funding for MPS will ensure NSW Health can continue to provide aged care in rural and remote communities where private and non-government aged care markets have failed or are not feasible. The Australian Government funding model for aged care beds in MPS is different from the funding model for non-government or private residential aged care facilities and funding per bed is lower in MPS. The Australian Government has also indicated its desire to change the funding model for MPS so that it is similar to mainstream aged care funding. This may include a revised approach to client contributions for MPS. As of 2023, the Australian

[13] Australian Government Department of Health and Aged Care, 'Addendum to National Health Reform Agreement 2020-2025', in *Australian Government Department of Health and Aged Care*. May 2020, viewed on 11 March 2024,https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NHRA_2020-25_Addendum_consolidated.pdf.
[14] Australian Commission on Safety and Quality in Health Care, 'National Safety and Quality Health Service Standards: Aged care module and User Guide for Multi-Purpose Services', in *Australian Commission on Safety and Quality in Health Care*. Second Edition, February 2021, viewed on 21 May 2024, https://www.safetyandquality.gov.au/sites/default/files/2021-02/nsqhs_standards_aged_care_module_and_user_guide_for_multi-purpose_services._february_2021.pdf.

Government was exploring a hybrid Australian National Aged Care Classification (AN-ACC) funding model for MPS whereby there is a base level of funding (not dependent on occupancy) and funding based on the acuity of residents. NSW Health is continuing to work with the Australian Government as they consider changes to the MPS funding model.

In the recent 2024-25 Federal Budget, the Australian Government allocated $2.2 billion over five years (from 2023-24) for aged care.[15] This funding focuses on enhancing digital aged care systems, increasing home aged care packages, attracting and retaining aged care workers especially in thin markets, and improving dementia care. The NSW Government must continue to work closely with the Australian Government to ensure aged care is funded sufficiently, whether this is through MPS expansion or other means.

Conclusion

NSW Health must work with the Australian Government to increase funding for aged care in multi-purpose services.

Recommendation

Recommendation 6

NSW Health should continue to work with the Australian Government to increase funding for aged care in multi-purpose services.

Health and Social Policy Branch /Regional Health Division

Finding 4: Understanding of funding models and processes is limited in small hospitals and affects LHDs' ability to advocate where needed

Local capability for ensuring the accuracy, timeliness, and standardisation of activity and financial data (and subsequently costing data) does not always exist in small hospitals. Regional LHD staff do not always have a clear understanding of the funding process, including how funds are allocated by the Ministry of Health and distributed by the LHD, and how funds are allocated from the Australian Government. Poor understanding of funding processes can impact the quality of costing data prepared by staff working in LHDs. If costing data is inaccurate, this may flow through into funding allocations.

Costing data is an important driver of evidence-based decisions within the healthcare sector. NSW Health and IHACPA use costing data to make informed funding decisions to improve patient care and the efficiency of providing care. Accurate costing of health services in rural areas, especially for high-cost low-volume health services (such as small rural hospitals)[16], is crucial for several reasons:

[15] Australian Government, 'Budget Paper No. 1: Budget Strategy and Outlook', in *Budget NSW*, May 2024, viewed 18 May 2024 https://budget.gov.au/content/bp1/download/bp1_2024-25.pdf.
[16] Performance Analysis for the Transformation in Healthcare Group UTS Business School, 'Patient level costing in Australia – Uses, challenges, and future opportunities', *Independent Health and Aged Care Pricing Authority*. June 2021, viewed on 11 March 2024, https://www.ihacpa.gov.au/sites/default/files/2022-08/patient_level_costing_in_australia_-_uses_challenges_and_future_opportunities.pdf.

- Healthcare administrators can better plan and manage resources to meet the needs of rural communities when they understand the true cost of delivering healthcare services.
- Accurate cost data enables policymakers to allocate funding more efficiently, ensuring that rural hospitals receive adequate financial support to deliver quality care.
- Cost data provides the foundation for effective financial planning, helping healthcare organisations allocate budgets, set prices, and forecast expenditure accurately.
- Healthcare providers can improve access to care, enhance service quality, and ultimately achieve better health outcomes for rural populations by optimising resource utilisation and funding allocation.

Capability for costing services for National Disability Insurance Scheme (NDIS) patients in small hospitals was identified as a key area for development in this review. This is particularly important given people with disability in outer rural and remote areas (based on the ARIA+ index) are more likely, than their metropolitan counterparts, to visit a hospital emergency department (ED) and less likely to see a GP.[17]

Targeted education for staff managing small hospitals (for example health service managers and executive officers) could improve understanding of how funding decisions are made and how to escalate where additional funds are needed.

Conclusion

NSW Health should ensure there is good understanding of funding mechanisms in regional LHDs with small hospitals.

Recommendation

Recommendation 7

NSW Health should develop a business management capability program and community of practice to ensure staff are appropriately upskilled and supported to understand small hospital funding mechanisms.

Financial Services and Asset Management Division

Finding 5: There is an opportunity to develop a more sustainable funding model for small hospitals in the longer term

Small hospitals provide necessary services for the community, yet they are becoming more costly to run in the face of rising overhead costs and declining population sizes. Despite low volumes, it is important to maintain small hospitals to ensure access to care for people who would otherwise be disadvantaged by needing to travel long distances for care. There is a

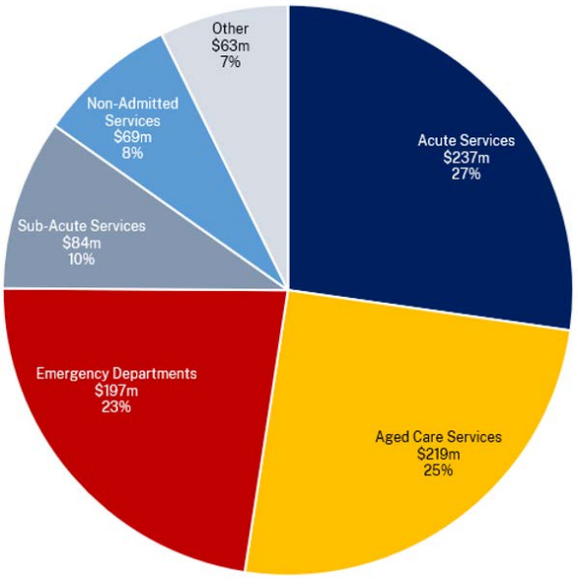
[17] Australian Institute of Health and Welfare, 'People with disability in Australia 2022', in *Australian Government Australia Institute of Health and Welfare*, catalogue number DIS 72, 2022, viewed on 25 March 2024, https://www.aihw.gov.au/getmedia/3bf8f692-dbe7-4c98-94e0-03c6ada72749/aihw-dis-72-people-with-disability-in-australia-2022.pdf?v=20230605172353&inline=true.

clear need to invest in innovative, integrated and virtual models of care in small hospitals and look at how NSW Health can ensure these services are sustainable into the future.

In 2022-23, around half of the total cost of delivering care at small hospitals was spent on emergency and acute care provision (*Figure 5*). Regional LHDs find it financially challenging to maintain traditional models of care in small hospitals, however these models are necessitated by current funding and regulatory structures such as staffing awards. Due to the financial cost of maintaining traditional service models in small hospitals, regional LHDs are often unable to allocate funding to establish more innovative, integrated, multidisciplinary models of care that may better meet the health needs of their local communities.

There is a growing appetite among regional LHDs to explore new models of care that could better serve the needs of rural communities and ensure small hospitals are sustainable far into the future, however a new funding approach may be needed to support new approaches to delivering care.

Figure 5: Cost by service in small hospitals in 2022-23



Service	Cost	%	
Acute Services	$237m	27%	
Aged Care Services	$219m	25%	
Emergency Departments	$197m	23%	
Sub-Acute Services	$84m	10%	
Non-Admitted Services	$69m	8%	**93%**
Community Based Services	$36m	4%	
Aged Care Community Services	$11m	1.3%	
Mental Health Community Based Services	$9m	1.0%	
Drug & Alcohol Services	$5m	0.6%	
Dental Services	$1.5m	0.2%	
Health Protection Services	$0.8m	0.1%	
Teaching & Training Mental Health	$0.2m	0.02%	
Teaching & Training	$0.1m	0.02%	
Mental Health Services	$0.0m	0%	
Health Prevention Services	$0.0m	0%	**7%**
Total	**$869m**	**100%**	

A Community Service Obligation approach

The introduction of a Community Service Obligation in NSW Health could help support financial sustainability for small hospitals by subsidising rural and remote services with geographical challenges and/or varying costs of service provision.

A Community Service Obligation is when the government subsidises the cost of delivering a necessary community service in areas where the community service would otherwise not be financially viable. This approach seeks to address disparities in access and ensure that all residents, regardless of their location, have equitable access to essential services. Community Service Obligations have been established with Australia Post and Telstra to ensure equitable access to postal and telecommunications services across Australia regardless of where a person lives. The Australian Government subsidises these organisations to offset additional costs involved in providing a nationwide service. NSW Treasury policy enables a Community Service Obligation to be established in NSW in a variety of circumstances including due to market

failure, in response to social or public policy issues or in provision of social benefits to a targeted group in the community. [18]

Establishing a Community Service Obligation for rural and remote health service provision is not a new concept. In 1998, the National Rural Health Alliance explored the potential role of Community Service Obligations to support access to healthcare, comparing it to a traditional government subsidy approach.[19] In 2006, a Community Service Obligation Funding Pool was established to support community pharmacies in rural and remote areas and ensure people in rural and remote areas can access a wide range of medicines on the Pharmaceutical Benefits Scheme.[20] The Australian Government has also set up a Community Service Obligation with Hearing Australia to deliver hearing services for babies, children and young people.[21]

Implementing a Community Service Obligation for NSW Health could enhance access, quality, and sustainability of health services throughout NSW. This approach would promote accountability, certainty, transparency and innovation within the NSW healthcare system and benefit the health and well-being of rural and remote communities.

Leveraging virtual care

This review found that while virtual care is already a priority for NSW Health, (underpinned by the NSW Virtual Care Strategy 2021-26) more funding is needed to establish infrastructure and implement virtual models of care in small hospitals at the pace regional LHDs desire.

A prime example of an impactful virtual care model which facilitates cost savings in premium labour is the Virtual Nurse Assist and Midwifery Care partnership between rpaVirtual and small facilities across Murrumbidgee Local Health District and Far West Local Health District. This program assists frontline nurses and midwives in rural and remote facilities by enabling seamless communication and collaboration with senior nurses in metropolitan areas who virtually support local triage processes and critical patient care decisions. However, the initial establishment costs of these models need to be adequately funded and resourced and ongoing costs must be promptly accounted for in annual block funding.

Lack of internet connectivity in rural and remote areas is a barrier to accessing the benefits of virtual care. Connectivity barriers for patients can arise in the form of lack of internet infrastructure, the cost of personal data plans, or lack of personal IT equipment (such as a smart phone) for virtual care appointments. There is an opportunity to engage with the Department of Infrastructure and telecommunications providers to trial connectivity solutions in rural and remote areas.

Another virtual care barrier unique to small hospitals is the reliance on premium workforce and its effect on capability in delivering virtual care services. For example, in some small sites more than 50% of the staffing profile is made up of contingent workforce which challenges the ability to implement Emergency Care Assessment and Treatment (ECAT) protocols and other nurse-led initiatives to support virtual care service delivery.

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[18] NSW Government Treasury, 'TPG23-19 Guidelines for Community Service Obligations', in *NSW Government Treasury*. August 2023, viewed on 22 April 2024, https://www.treasury.nsw.gov.au/documents/tpg23-19-guidelines-community-service-obligations.

[19] National Rural Health Alliance, 'Rural Health Information Paper no. 3 - Community Service Obligations: Meaning, Impact and Application', in *National Rural Health Alliance*. June 1998, viewed on 15 May 2024, https://ruralhealth.org.au/sites/default/files/rhip/rhip-3.pdf.

[20] Australian Government Department of Health and Aged Care, 'Community Service Obligations for Pharmaceutical Wholesalers collection', in *Australian Government Department of Health and Aged Care*. October 2022, viewed on 15 May 2024, https://www.health.gov.au/sites/default/files/documents/2022/10/community-service-obligation-cso-for-pharmaceutical-wholesalers-funding-pool-operational-guidelines-guidelines.pdf.

[21] Hearing Australia, 'The Community Service Obligations (CSO) Program' in *Australian Government Services Australia,* September 2019, viewed on 13 May 2024, https://www.transparency.gov.au/publications/services-australia/australian-hearing-services-hearing-australia/hearing-australia-annual-report-2018-19/delivering-excellent-client-outcomes/the-community-service-obligations-(cso)-program

The growth of virtual care is integral to delivering a sustainable health system in rural and remote areas. Increasing funding for virtual care in NSW Health and/or implementing a shared funding approach between the Australian and state governments to invest in technology infrastructure for virtual care could have several benefits:

- *Enhanced access to care:* Virtual care technologies enable patients in rural and remote areas to access healthcare services remotely, overcoming geographical barriers and improving access to specialists and healthcare professionals who may not be locally available.
- *Improved efficiency:* Virtual care can streamline healthcare delivery by reducing the need for patients to travel long distances for appointments. This saves time and resources for both patients and healthcare providers, leading to more efficient use of healthcare resources.
- *Continuity of care:* Virtual care facilitates ongoing communication and follow-up between patients and clinicians, promoting continuity of care. This is particularly beneficial for patients with chronic conditions who require regular monitoring and management.
- *Cost-effectiveness:* Investing in virtual care infrastructure can result in cost savings for the healthcare system by reducing unnecessary hospitalisations, ED visits, and travel expenses for patients.
- *Supporting the rural healthcare workforce:* Virtual care can alleviate workforce shortages in rural and remote areas by enabling healthcare providers to deliver services remotely. This can help attract and retain healthcare professionals in rural and remote communities by providing opportunities for flexible work arrangements.

There are opportunities to explore virtual care funding arrangements in rural and remote EDs under the COAG Section 19(2) exemption. Currently, virtual care services are only eligible for MBS billing if they are provided by a clinician at a Section 19(2) exempted health facility. This limits the use of virtual care as:

- it does not consider if the primary care virtual service is being provided for a patient *living* in an exempted MMM 5-7 area
- it limits facilities that qualify only as MMM 4 but have limited face-to-face GPVMO access to their hospitals and/or rely fully on virtual doctors to provide services.
- virtual medical services providing support to EDs in rural and remote areas have limited capability to attract MBS billing outside of 'unsociable' hours which limits access to timely care for communities.

With increased funding for virtual care, NSW Health can harness the potential of technology to address healthcare challenges in rural and remote areas effectively. This investment not only improves access to care but also enhances efficiency, continuity, and cost-effectiveness of healthcare delivery, ultimately contributing to the sustainability of the health system.

Integrated care through shared services

Better integration of health care in rural and remote areas can help improve health service sustainability and improve access to care.[22] [23] When looking to the future of funding for small hospitals, better integration of care should be prioritised.

[22] L. Mullan, K. Armstrong and J Job, 'Barriers and enablers to structured care delivery in Australian rural primary care'. *The Australian Journal of Rural Health*, vol. 31(3), June 2023, pp. 361-384, doi.org/10.1111/ajr.12963.
[23] E.M. Rygh and P. Hjortdahl, 'Continuous and integrated health care services in rural areas. A literature study'. *Rural and Remote Health*, vol. 7(3), July 2007, viewed on 4 March 2024, https://www.rrh.org.au/journal/article/766.

MPS are an example of how small hospitals can provide a flexible, multi-functional, integrated service offering for the community. They provide an expanded service offering for the community, have increased service usage and can help increase revenue for the site through additional Australian Government funding, thereby supporting service sustainability.

In rural and remote areas with thin health care markets, primary, community and hospital services could be co-located with small hospitals to expand the service offering and improve local access to care. An integrated hub-style model is convenient for the community, and encourages joined up, multidisciplinary, continuous care. It is logical to leverage existing, well-known assets in rural and remote communities like small hospitals, to maximise their use. This capitalises on physical assets like buildings and infrastructure as well as human capital and community networks. Expanding the utility of small hospitals may enhance the delivery of all health services in a region and avoid unnecessary duplication or inefficiencies.

Co-locating health and non-health government services with small hospitals can also support the community to better access a range of government services. The installation of Government Access Centres in some small hospitals makes use of already existing infrastructure and promotes ease of access to this service. In Dorrigo MPS, a Government Access Centre is integrated within the health service and provides a range of government services including Roads and Maritime Services, Centrelink and Countrylink. Co-locating health and government services broadens the range of stakeholders who have an interest in maintaining and sustaining the service and generates greater cross-government investment in small hospitals.

Community engagement: An essential element for future small hospital design

Future funding models for small hospitals must be developed in line with rural and remote communities' needs and should be informed by the existing evidence base. There is a good understanding of the health needs of communities in rural and remote areas, developed through ongoing engagement, research and analysis done by LHDs, primary health networks (PHNs) and Aboriginal Community Controlled Organisations (ACCHOs). For example, Western NSW Local Health District publishes a Health of the Population Report which analyses population-based data to support planning and delivery of health services across the LHD. Murrumbidgee Primary Health Network publishes a health needs assessment outlining the health priorities and health service gaps in the region.[24] Maari Ma Health, an ACCHO that covers the far western NSW region, publishes a report on the health and wellbeing of children and young people in the region every five years.[25]

As well as relying on the evidence, rural and remote communities should be closely involved in design and implementation of a future funding model. This should include not only patients, families and carers but a broad range of community stakeholders including PHNs, ACCHOs and local councils.

Local councils play a significant role in rural and remote communities and can contribute to the planning and delivery of health and aged care services. Given their responsibilities for aspects of community well-being, including aged care services, involving local councils in the planning process can ensure alignment with local priorities and resources. Overall, the goal should be to transition towards a more proactive and community-driven model of funding that

[24] Murrumbidgee Primary Health Network, 'MPHN Health Needs Assessment 2022-2025', in *Murrumbidgee Primary Health Network*, Version 2 2021, viewed on 15 May 2024, https://mphn.org.au/health-needs-assessments.
[25] S. Sumithra, C. Kennedy, G. Alperstein, E. Best and C. Dyer, 'Health, Development and Wellbeing in Far Western New South Wales: Our Children and Youth', in *Maari Ma Health Aboriginal Corporation*. December 2019, viewed on 17 May 2024, https://maarima.com.au/uploads/documents/MM_CHP_Report_2019_All_Chapters_draft%207.pdf.

supports the provision of services in rural and remote areas. By understanding and responding to the evolving needs of these communities, we can ensure that resources are allocated efficiently and effectively to support their long-term sustainability and growth.

Conclusion

NSW Health should further explore future funding models for small hospitals.

Recommendation

Recommendation 8

NSW Health should establish a working group to explore future funding models for small hospitals in NSW. Such a funding model should ensure small hospitals can provide sustainable, integrated care that best serves the needs of rural and remote communities long into the future.

Financial Services and Asset Management Division

Recommendation 9

NSW Health should prioritise investment in virtually enabled models of care to support face to face care in small hospitals.

Financial Services and Asset Management Division / System Performance Support Branch

Appendix A:
NSW Health Work in Progress

There is significant work in progress across NSW Health to address many of the key issues highlighted in this report. Relevant initiative and programs are listed below.

Improving asset management capability

The Ministry of Health continues to improve its asset management capability by implementing a focused approach which includes:

Investment planning based on a sustainable, whole-of-life approach: This includes asset planning which is informed by an assessment of whole of life asset considerations, business case development which demonstrates an appropriate assessment of whole of life asset considerations and future asset-based expenditure forecasts which support the identification and reporting of the forward program of expenditure including justifications and prioritisation, and scenario testing.

Asset operations and maintenance activities that effectively deliver the required asset levels of service: Asset service performance and intervention criteria are defined for relevant assets considering asset criticality with a planned approach to operate and maintain the assets. Maintenance management incorporates optimisation and continuous improvement activities including performance reporting and analysis, benchmarking and life cost optimisation. Asset Management Plans (AMPs) include knowledge and state of all assets including asset age, condition, performance, value, cost and location.

Maintenance of a Forward Works Plan (maintenance and renewals) that responds to the needs of NSW Health assets: Robust and evidence-based Forward Works Plans help manage future maintenance and renewal needs (5-year horizon at a minimum and longer term as appropriate). The Forward Works Plan prioritises the maintenance and investment of projects based on risk, multi-criteria cost/benefit, outcomes, asset criticality and data reliability. AMPs support the identification and reporting of the forward program of expenditure including justifications and prioritisation, and scenario testing.

Enhancing access to care and patient transport

The Regional Health Division is undertaking a review of the Transport for Health policy. The purpose of the review is to inform the next steps to enhance NSW Health's approach to non-emergency health-related transport. It will identify opportunities to replicate existing successful programs, consider innovative solutions including partnering with Transport for NSW and seeks to address any identified gaps or barriers related to non-emergency patient transport.

Addressing recruitment challenges and premium labour costs

NSW Health has significant work underway to address workforce challenges facing small rural hospitals, including reducing locum agency costs. Programs of work include, but are not limited to:

Rural Health Workforce Incentive Scheme: Funding program to recruit and retain staff in hard to fill positions at health services in rural and regional NSW.

Tertiary Health Study Subsidy Program: Funding program to provide subsidies to students studying health qualifications and incentives to enter the NSW Health workforce.

NSW Health Deployment Program: Provides opportunities for nurses, midwives and allied health professionals to fill short-term vacancies (2-13 weeks) in regional, rural and remote health services. Deployed staff receive incentives to take part including payment of travel and accommodation.

NSW Area of Need Program: Commonwealth program that assists NSW employers (including NSW Health) to recruit international medical graduates to hard to fill positions in defined areas of need.

Electronic Vendor Management System: NSW Health is mandating a vendor management system in all local health districts and specialty health networks to provide greater governance and oversight between hospitals and medical locum agencies. The program is expected to enhance local health district capability to manage medical locum agency matters, including communication, pricing, quality and performance.

Statewide approach to nursing agency use: NSW Health is establishing a statewide approach to using nursing agencies to improve consistency and reduce competition between local health districts.

Collaboration with NSW Rural Doctors Network: NSW Health supports several Rural Doctors Network initiatives that facilitate rural medical workforce recruitment and assist rural medical practitioners to maintain currency of practice and medical students to undertake rural placements through cadetships.

Building a shared understanding of healthcare delivery in NSW

Community involvement in local health decision making plays a vital role in keeping people living in NSW healthy. Increasing growth and demand pressures will require NSW Health to deliver care more efficiently in different ways, while maintaining safety, quality, and access for all communities across NSW. NSW Health is undertaking a project which will explore ways to foster a shared understanding with the community about how the system is changing to ensure future health services and innovative models of care are understood, trusted and adopted by community. This project seeks to identify recommendations for the development of a targeted workplan.

Delivering Collaborative Commissioning for integrated care

Collaborative Commissioning is a partnership between local health districts (LHD), primary health networks (PHN), and other service providers to address community health needs and reduce hospital visits. This approach promotes local autonomy and accountability in delivering patient-centred care. In New South Wales, various regional partnerships are being developed to demonstrate the effectiveness of value-based payment methods and to assess potential financial benefits. In Western NSW and Far West LHDs the Living Better and Stronger program targets poorly managed diabetes by providing patient-centred care with flexible, team-based models of care centred around general practice. In Murrumbidgee LHD, the Living Well Your Way program targets people diagnosed with Congestive Heart Failure and/or Chronic Obstructive Pulmonary Disease who have presented to hospital and supports them to stay healthier at home for longer by delivering primary care and community-based services aligned with best practice.

Collaborating to deliver Multi-purpose Services (MPS)

NSW Health is developing an MPS Strategy to inform decisions about where to invest or disinvest in the MPS model i.e. where the MPS model is the right fit for a community. This strategy will also define what best practice looks like in an MPS.

As part of the aged care reforms, the Australian Government is looking to expand the MPS model more widely across Australia. The Australian Government has also indicated its desire to change the funding model for MPS so that it is similar to mainstream aged care funding. This may include a revised approach to client contributions for MPS.

IHACPA will be involved in revising the funding model. As of 2023, the Australian Government was exploring a hybrid Australian National Aged Care Classification (AN-ACC) funding model for MPS whereby there is a base level of funding (not dependent on occupancy) and funding

based on the acuity of residents (this is to be explored further, there might be a blanket level of funding based on acuity of some residents only).

The revision of the funding model is part of their proposed workplan and is scheduled to be implemented in July 2027. In July 2026, an interim funding boost will be considered where warranted. There will be an allocation round for new or additional MPS aged care places in October 2024. In July 2024, there will be increases to MPS subsidy to reflect indexation and any other Government decisions.

A capital investment allocation round was opened in December 2023. MPSs were only eligible to apply for funding for staff accommodation if they provided a co-contribution. While nothing has been announced, we expect the Commonwealth to open another capital investment allocation round this year. The expectation is that NSW provides a co-contribution. Funding may be available for the trial of 24/7 registered nurses and care minutes arrangements in 2024.

NSW Health has been advocating for the harmonisation of accreditation of health and aged care standards. The Commonwealth has indicated that they are working on how to streamline accreditation/compliance in MPSs.

The new Aged Care Act is a rights-based Act that will put older people who need aged care at the centre of the system. It will introduce a Statement of Rights, outlining the rights that older people in the aged care system should expect when seeking or accessing Government-funded aged care services. This will help ensure that older people and their needs are, and remain, at the centre of the new system.

From 1 July 2024, the new National Aged Care Design Principles and Guidelines will guide refurbishments and new residential aged care accommodation builds to ensure they: promote independence, function and enjoyment for residents and support the delivery of high-quality, safe, respectful and dignified care. The new Design Principles and Guidelines will focus on creating more accessible, dementia-friendly and home-like living environments. This will help improve quality of life for older people living in residential aged care and working environments for aged care staff.

The Agency for Clinical Innovation (ACI) Living well in multi-purpose services resources support staff to provide care for residents of these facilities. The aim is for people to be treated as though they are living in their homes rather than as patients in a hospital. These resources are currently under review by ACI and will be refreshed in the coming months. The principles from the guidelines will be incorporated into the MPS Strategy.

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The Regional Health Division's artwork was created by Lakkari Pitt, a proud Gamilaroi Ularoi yinarr.

Lakkari created a digital artwork representing the Regional Health Division and NSW Health's nine regional LHDs.

NSW GOVERNMENT