New South Wales

Special Commission of Inquiry into Healthcare Funding

Submission Number: 1

Name: NSW Health Submission

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NSW Health Submission

The Special Commission of Inquiry into Healthcare Funding

NSW GOVERNMENT | Health

1. This is an initial submission from NSW Health. It is provided with the intention that it will be supplemented by supportive material during the Special Commission of Inquiry (**Inquiry**).

2. The Inquiry will likely hear a range of different views from interested parties on a variety of issues based on local contexts and situations. This submission covers matters from the perspective of the Ministry of Health as system manager rather than purporting to address specific local issues.

3. The funding environment for health care provision is complex. Whilst the focus of this Inquiry will be on state funding, the impact of the predominantly Commonwealth funded sectors of primary care and aged care together with disability care is significant.

4. NSW Health sees this Inquiry as an opportunity for meaningful reform and will continue to do everything it can to assist and engage with the Inquiry.

EXECUTIVE SUMMARY

5. This Inquiry provides an opportunity to examine the operation of health care provision in NSW. NSW Health, as largest public health system in Australia, provides high quality, safe care to communities across NSW. There has been a raft of challenges over recent years requiring the adaptation of systems, processes and people. The burden of disease has changed significantly over the last 20 years, with an increased prevalence of conditions associated with ageing and mental health issues and escalating numbers of those with chronic disease. This has placed increasing pressure on health and social care systems which are not sufficiently connected or coordinated in the provision of care.

6. Funding models must enable the system to respond to these changing conditions. The current operation of funding models does not effectively support the delivery of innovative and new models of care. The current models too often leave NSW Health as a provider of last resort, with failures in primary care, aged and disability care. Risk and responsibility must be shared.

7. The capacity of the system to deliver these new models of care is reliant on the health workforce. New capabilities and skills are required together with modern industrial awards that facilitate the operation of a 24/7 health care system. Changes in who leads the delivery of care, and where that care is delivered need to be more flexible and agile. This includes enabling clinical staff to work at full scope of practice where needed. Greater multidisciplinary care is also needed to better support patients across their lifespan.

8. Accurate statewide health workforce data must inform effective planning and evaluation of future workforce needs. The health workforce pipeline must reflect these needs, which requires work at the national level and with the medical colleges as well as other industry partners.

9. Much work is underway to address workforce maldistribution, particularly for regional and rural areas. However, many factors influence an individual's decision on where to live and work and strategies require a cross agency approach.

10. NSW Health sees this Inquiry as an opportunity to drive further reform to ensure a health system that is fit for the future and can meet the health needs of NSW communities.

11. The NSW Health *Future Health Strategic Framework 2022-2032* provides the roadmap. To achieve this vision, changes are required. These include:

    a. More flexible and agile funding models, both national and state, to support innovative models of care, greater investment in prevention and drive improved health equity;

    b. Industrial reform to support the future workforce;

    c. Improving the alignment between workforce supply and needs of the health system including a refocusing of the role of training institutions;

    d. National workforce reforms to improve regulatory and economic settings;

    e. Increased support and investment for multidisciplinary care, focusing on generalists, allied health and nurse practitioners and enhancing scope of practice;

    f. Better integrated regional health planning and delivery through regional health hubs delivering primary and community care;

    g. Embedding value based care as a core principle across the NSW public health system;

    h. More meaningful engagement and empowerment of clinicians and the community, including working with community to adopt new ways of health care delivery;

    i. Strengthening Aboriginal governance structures to better enable formal partnerships to facilitate service delivery, shared decision making and improved cultural safety;

    j. Harnessing digital solutions and technology to deliver new models of care and enhance the experience for consumers, carers and their families;

    k. Further standardisation of key procurement and ICT activity to drive efficiencies and savings; and

    l. Investing in linked data assets to drive analytics to inform care delivery.

A. CONTEXT

12. NSW Health provides safe, high-quality healthcare to the people of NSW. NSW Health's vision is for a sustainable health system that delivers outcomes that matter most to patients and the community, is personalised, invests in wellness and is digitally enabled.

Health Outcomes

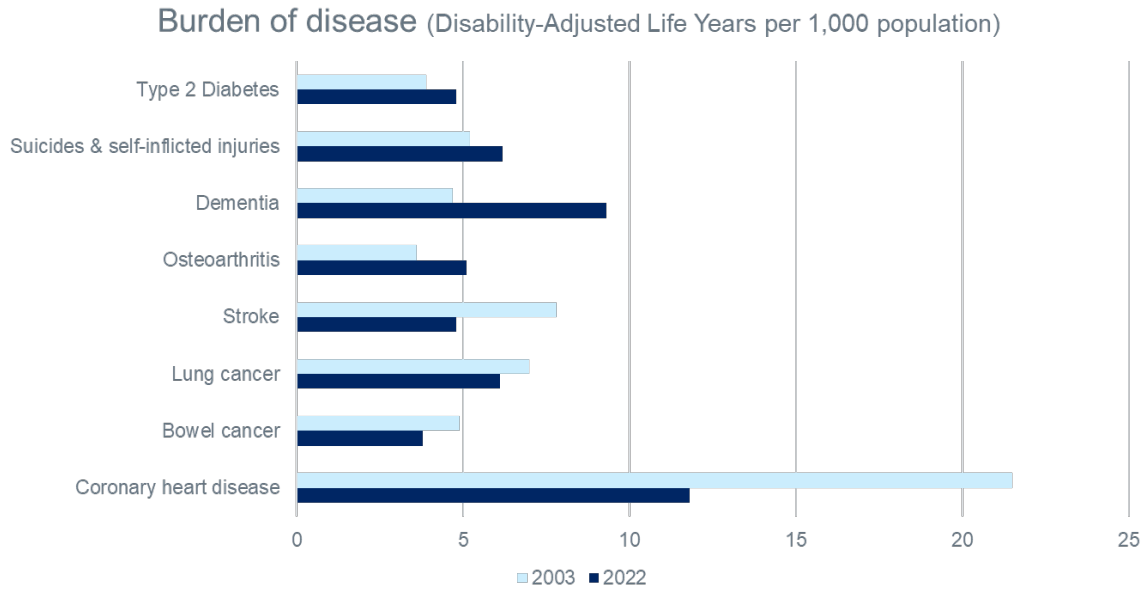
13. Australians are living longer, with a life expectancy of 84.5 years for a baby born in NSW in 2020 up from 82.6 years in 2010. This is longer than both the UK (81 years) and the USA (76.4 years). Australia also has one of the lowest infant mortality rates in the world.

14. However, the national gap in life expectancy between Indigenous and non-Indigenous Australians remains high at 8.6 years for males and 7.8 years for females. While all children are at increasing risk of chronic diseases with more

overweight and obese children due to insufficient physical activity and unhealthy diets.

15. The burden of disease is also changing, with the past twenty years showing declines in incidence of heart disease, stroke and lung and bowel cancer, but increases in type 2 diabetes, dementia, osteoarthritis and suicides and self-inflicted injuries. This reflects the ageing population, lifestyle changes and an increase in disease associated with mental health conditions.

Figure 1: Changes in disease burden from 2003 to 2022



Source: Australian Burden of Disease Study 2022 Australian Institute of Health and Welfare

16. The rise in life expectancy has seen a rise in the number of years living with an illness or disability. Although people are living longer and premature deaths have reduced, rates of chronic diseases have continued to increase. Many of the conditions with an increased prevalence could be managed outside of the hospital through effective primary care, however the continued growth in emergency department presentations suggests that primary care has not kept pace with demand.

17. Despite the overall improvements in health status, there is still health inequity, as demonstrated by the differing rates of life expectancy for non-Indigenous and Indigenous Australians. This inequity is also reflected in other areas, including across socio-economic status.

18. The social determinants of health, such as housing, education, social relationships, employment and income also significantly impact health outcomes. Inequities arise when there are systemic differences in health status, health risks or access to health care between groups that are avoidable and unfair. Efforts to reach and engage disadvantaged communities in health care, including outreach services and tailored and flexible services such as drop-in clinics, can be more costly to deliver.

19. There is also a clear link between mental health and physical health. Physical activity and healthy eating have been shown to reduce symptoms of depression. Structured lifestyle interventions can reduce tobacco smoking and increase healthy behaviours. Four out of every five people living with mental health issues

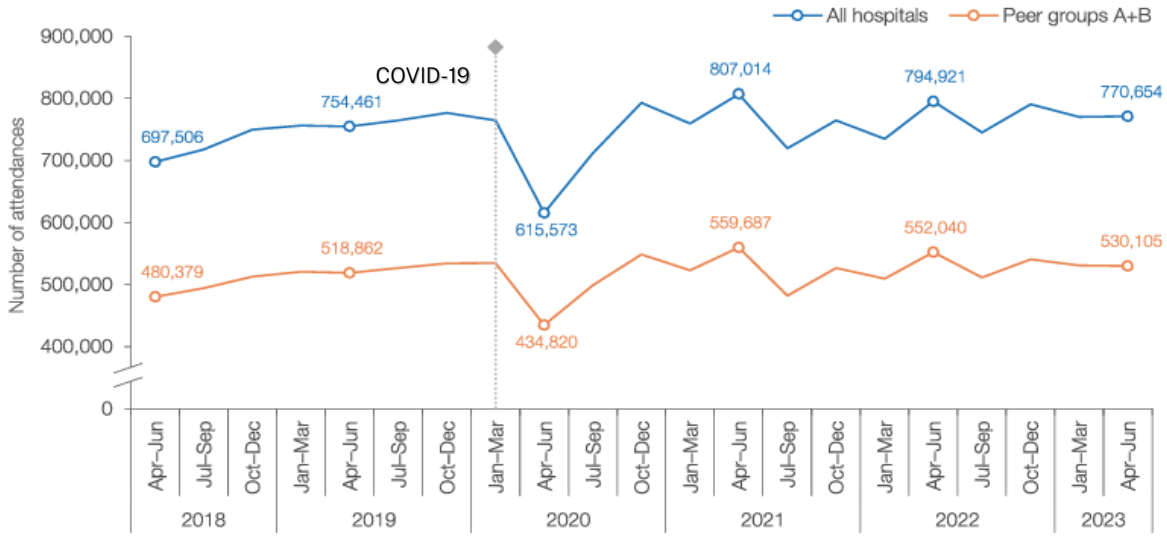
have a co-existing physical illness, and those with mental ill health have higher rates of chronic conditions.[1]

NSW Health Performance

20. The latest national comparative data for 2021-22 shows NSW had over 3 million emergency department presentations (366 per 1,000 population - the 2nd highest nationally after the Northern Territory) with the shortest median wait time for treatment of all states and territories at 14 minutes, compared to 20 minutes nationally.[2] NSW emergency departments also performed stronger than those in other states and territories, with the most patients seen on time and the lowest wait times.

21. Emergency department presentations are becoming more complex with higher acuity patients arriving in greater volumes. The latest Bureau of Health Information (**BHI**) Healthcare Quarterly Report shows overall emergency department presentations in 2022-23 increased 5% compared to pre-pandemic levels in 2018-19. Triage category 1 presentations increased by 18%, triage category 2 presentations increased by 20%, while triage category 3 presentations increased 9% over this period.

Figure 2: Emergency department attendances NSW



Source: Healthcare Quarterly April-June 2023 Bureau of Health Information NSW

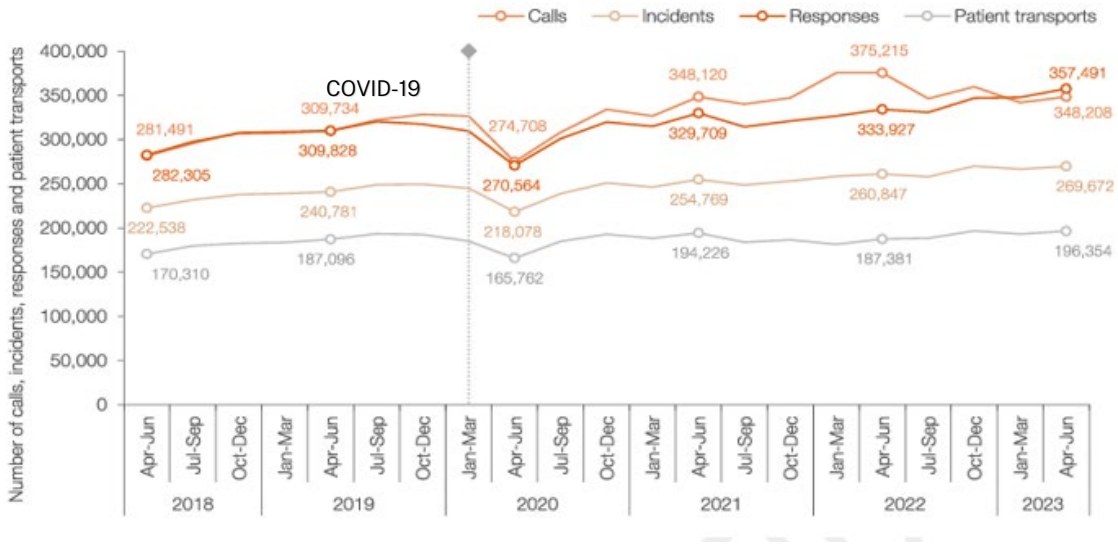
22. Ambulance activity continues to trend upward with 357,491 responses in the last reported quarter (April to 30 June 2023), There were 177,594 highest priority cases

[1] NSW Health Guideline: Physical Health Care for People Living with Mental Health Issues, issued 30 April 2021 accessed 25 October at https://www.health.nsw.gov.au/pds/ActivePDSDocuments/GL2021_006.pdf

[2] Emergency Department Care Data Tables, Australian Institute of Health and Welfare accessed 27 September 2023, https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care

and 13,525 cases in the second highest priority both of which are the highest of any quarter since the BHI began reporting in 2010.

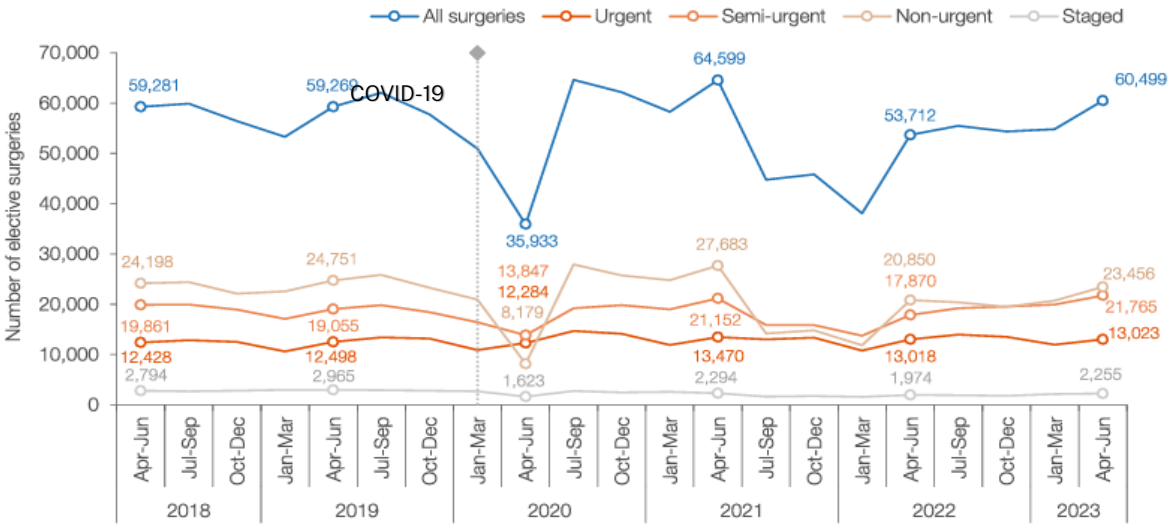
Figure 3: Ambulance calls, incidents, responses and patient transport NSW



Source: Healthcare Quarterly April-June 2023, Bureau of Health Information NSW

23. Waves of COVID-19 and influenza and other respiratory viruses have impacted surgical throughput (activity). In June 2022, the number of patients with overdue planned surgeries peaked at 18,748. A statewide program is underway to address overdue surgeries. As at end September 2023, the overdue number is down to 7,010. The BHI Healthcare Quarterly Report April to June 2023 shows there were 60,499 elective surgeries performed for this quarter.

Figure 4: Elective surgeries performed by urgency category NSW



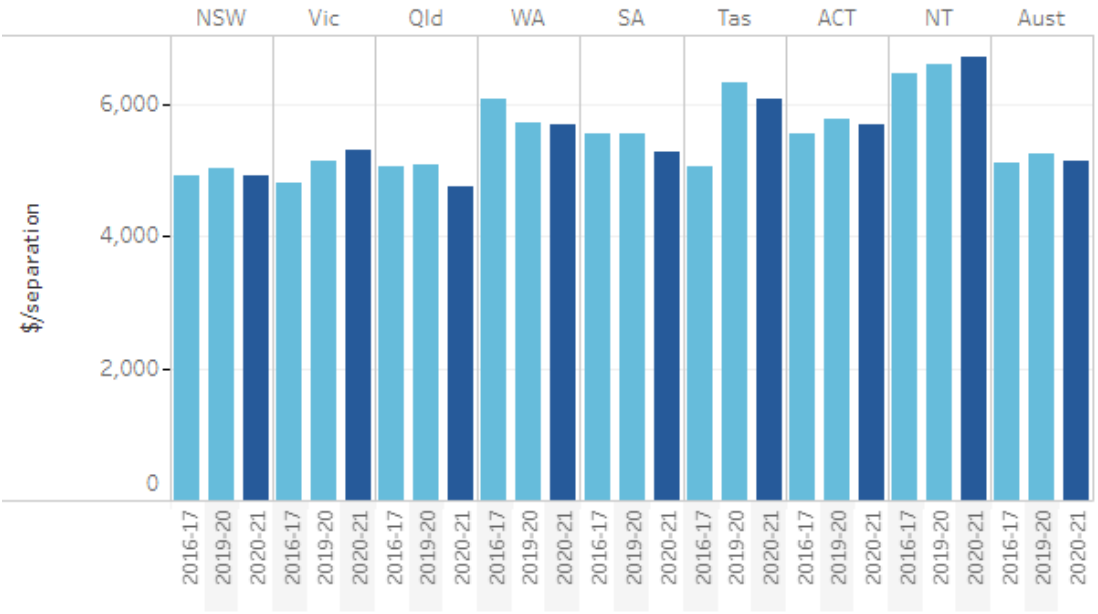
Source: Healthcare Quarterly April-June 2023, Bureau of Health Information NSW

24. Ultimately, patients, their families and carers are at the centre of everything that is done across NSW Health. Ensuring the design and delivery of services is informed

by patients, their families and carers as well as clinicians and the broader community is critical. This input forms part of the iterative feedback used to refine and improve the public health system. In 2021, 92% of admitted patients and 90% of virtual care patients in NSW rated their care as 'good' or 'very good', while almost 80% of patients said health professionals always explained things in a way they could understand.[3]

25. The latest national comparative data also shows NSW performs very well in terms of the average cost of providing care for an admitted patient (overnight or same day), having the second lowest figure nationally.

Figure 5: Recurrent cost per weighted separation all public hospitals (2020-21 $)



Source: Report on Government Services 2023, Productivity Commission

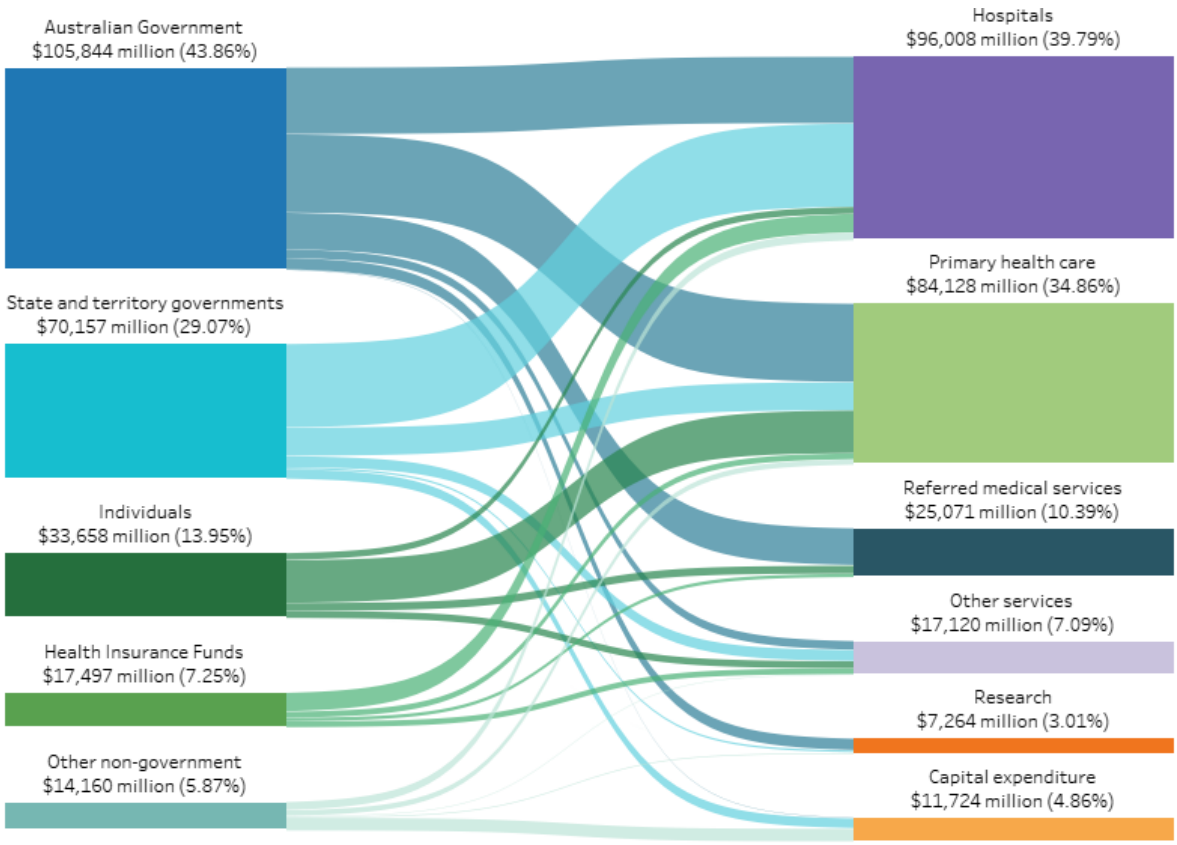
Funding of the NSW Health system

26. NSW Health operates in a complex funding environment. The Australian Government is a funder, regulator and provider of health and social services. Other NSW Government agencies have responsibilities across the social determinants of health, while local government, the private sector and non-government organisations are also key players.

27. The governance architecture and funding arrangements reflect the complexity of this broader environment. NSW public healthcare is funded primarily by the NSW and Australian Governments with additional funding received from direct source revenue such as private health insurance payments and individual payments.

[3] Adult Admitted Patient Survey 2021, Bureau of Health Information 2022

Figure 6: Broad national health spending flows 2021-22



Source: Health Expenditure Australia 2021-22 Australian Institute of Health and Welfare Health 2023

28. The NSW Health Budget is $34.3 billion for 2023-24. This includes $3.3 billion for infrastructure. NSW Health currently has more than 130 capital projects in progress comprising both upgrades and the development of hospitals and health facilities.

Roles, responsibility and funding under the National Health Reform Agreement

29. Two key national agreements articulate the roles and responsibilities of all jurisdictions in the delivery of health services and recognise the importance of collaboration in driving improved health outcomes for all communities. The National Health Reform Agreement 2011 (**NHRA**) is a companion piece to the National Healthcare Agreement and provides the architecture, governance and guidance required to calculate the Commonwealth's financial contribution to the cost of delivering public hospital services. All jurisdictions agreed to an Addendum to the NHRA which is operating from 1 July 2020 to 30 June 2025.

30. Central to long-term funding sustainability of the NSW public hospital system is ensuring that hospitals are receiving a price that reflects the cost to deliver care. The funding methodology set out in the NHRA is a 'growth funding' model where only growth is funded at a 45% contribution from the Commonwealth while the base is funded at the prior year's Commonwealth Contribution Rate. The Commonwealth contribution to NSW public hospital costs currently sits at around 40%.

31. The NHRA Addendum restricts growth funding in any one year to a national 6.5% growth cap. Where the cap is breached, the Commonwealth effectively shifts funding risk to the States irrespective of whether cost growth is within States' control, with the impact being the Commonwealth's contribution rate is effectively reduced.

32. Under the NHRA the intention is for the Commonwealth eventually to pay 45% of public hospital costs, however with Commonwealth contributions now subject to the annual growth cap of 6.5%, it is estimated it will take up to 80 years for this to occur for NSW.

33. The NHRA also established the National Bodies, including the Independent Hospitals Pricing Authority (now the Independent Health and Aged Care Pricing Authority) and the National Health Funding Body and associated Administrator.

34. The Independent Health and Aged Care Pricing Authority (**IHACPA**) has a role in determining public hospital and healthcare pricing including the National Efficient Price (**NEP**) for public hospital services that are funded on an activity basis. IHACPA is also responsible for adjusting the NEP to reflect legitimate and unavoidable variations in cost of delivering healthcare services and determining which services are in scope to receive funding under the NHRA. Each year, the IHACPA publishes the General List of In-Scope Public Hospital Services (the **General List**) as part of the NEP Determination. The General List defines the public hospital services eligible for Commonwealth funding.

35. The NHRA funding model, as applied by IHACPA, relies on historical data, with a three-year lag in cost data underpinning the NEP and National Efficient Cost (**NEC**). The model was designed to operate in a stable environment. However, flow on effects of COVID-19 have seen unprecedented inflationary pressure and wage growth which are not reflected in the historical trends. Existing funding and pricing models also do not acknowledge the important role of health services in primary and secondary prevention – for example, immunisation and tobacco cessation.

36. The Activity Based Funding (**ABF**) model promotes technical efficiency and transparency in funding allocation, particularly at the state and Local Health Districts (**LHD**) or Specialty Health Network (**SHN**) levels. It is not however well designed to allocate funding at the hospital or facility level. The ABF model has brought benefits to the system and to many patients, however as with any model it is not perfect. There are a range of adjustors that can be applied to account for various factors such as remoteness, which add additional complexity to the model. Adjustors for Aboriginality rely on self-identification and have not been tied to any outcomes developed or endorsed by Aboriginal communities. Small hospitals, often in rural and regional NSW, are excluded from the funding methodology where their activity or range of services does not meet the threshold set for ABF. These facilities are block funded, being a fixed amount allocated to the facility regardless of activity.

37. While jurisdictions can apply to have services included on, or excluded from, the General List, IHACPA conducts an analysis of each application to determine if services are transferred from the community to public hospitals for the primary purpose of making services eligible for Commonwealth funding. This process is burdensome and difficult and takes some time to conduct, resulting in a model that is not responsive to innovation or changing models of care.

38. The NHRA Addendum also saw national agreement on six long term reform priorities including paying for value and outcomes and joint planning and funding

at the local level to be driven by enhanced health data, however progress has been limited and hampered by COVID-19.

39. An independent mid-term review of the NHRA Addendum to evaluate effectiveness and identify any areas requiring change is currently underway. NSW has raised the issues above in the context of that review and acknowledges any review on the funding model requires a significant focus on collaboration to ensure the model is fit for purpose, is able to respond to external shocks and can effectively support the delivery of care across different settings.

Other responsibilities of the Australian Government

40. The Australian Government is responsible for the provision of primary care, the regulation of aged care and private health insurance and provides funding through the Medicare Benefits Schedule (**MBS**) and the Pharmaceutical Benefits Scheme (**PBS**) in addition to its contribution to the funding of public hospitals. The states and territories work in partnership with the Commonwealth to fund and deliver a range of health services, including preventive health services. The Commonwealth's contribution to public health in the NHRA Addendum (Clause A14) is historically based and not been reviewed or updated since the commencement of the NHRA. The Commonwealth and NSW have also entered into a bilateral agreement reflecting shared responsibility in supporting the National Disability Insurance Scheme (**NDIS**).

41. The Australian Government also provides funding for health services through a range of time limited national partnership agreements, including for some public adult dental services. Dental care is a key element of health care, but most individuals access care largely through the private sector. NSW Health operates publicly funded dental services for eligible patients such as pensioners and health care card holders. Having a sustainable funding model for basic dental care and access pathways for dental care is critical to ensuring the health of the population.

42. To assist in the coordination of health services across local populations, the Australian Government established 31 independent Primary Health Networks (**PHNs**) nationally (10 in NSW) in July 2015. These PHNs work directly with general practitioners (**GPs**), other primary health care providers, hospitals, and the broader community. A board oversees their work, and clinical councils and community advisory committees provide advice.

43. In practice however, the approach and capacity can vary across PHNs and LHDs with little incentive for effective joint local planning across agencies, governments, and other sectors, which is responsive to community needs. Engagement can also be hampered due to the differences in boundaries between PHNs and LHDs, with some PHNs needing to engage with multiple LHDs in NSW.

44. There are also limitations in effectively engaging primary care providers that are not part of the PHNs. For example, NSW Health has a range of specialised primary care services such as sexual health, drug and alcohol and women's health. These services prioritise priority populations but the ability to provide access to these services for new patients is compromised if existing patients once stabilised on a treatment plan are unable to be referred to mainstream primary care for ongoing care.

45. Demand and supply issues across health and social care systems are directly impacting the ability of NSW Health services to operate safely and efficiently -

leading to staff frustration and burnout, fragmented care, and poorer patient experiences and outcomes. These issues are amplified in remote and rural and regional areas, and for priority population groups. Most policy and funding responsibilities for these programs rest with the Australian Government.

46. These programs are struggling to deliver on community expectations with subsequent market failures directly flowing through to increasing demand for public hospital and health services. Commonwealth-funded service providers are experiencing similar challenges to the public health system, and the policy and practices employed to manage and contain costs within these programs can adversely impact public health services as the provider of last resort.

47. This impact is compounded by the current issues with the accessibility and affordability of primary care. The effectiveness of the primary care system is a key driver of public hospital demand. In NSW, it is estimated that two-thirds of the disease burden is associated with conditions that could be managed outside a hospital setting.[4]

48. Improved access to primary care services reduces the demand for low-acuity hospital presentations, especially for the elderly, people with chronic disease, and socioeconomically disadvantaged and vulnerable populations. It also has a significant impact on health outcomes. Failures in primary care place an increased reliance on the local public hospital system and emergency department utilisation. It also places pressure on the ability of the hospital system to cope with both primary care and associated ongoing follow up and support.

49. Australians may delay or not use a GP service due to cost, service availability and waiting times. In 2021-22:

    - 25% of people delayed seeing a GP for reasons such as service availability or waiting time. This was an increase from 2020–21 (21%);
    - 3.5% of people who needed to see a GP delayed or did not see a GP due to cost. This was an increase from 2020–21 (2.4%); and
    - 3.9% of people with a long-term health condition who needed to see a GP delayed or did not see a GP due to cost. This was higher than for those without a long-term health condition (3.0%) and higher in regional remote areas compared to those in major cities (5% and 3.1%, respectively).[5]

50. These are all barriers to timely primary and preventative care or treatment. This adds an increased demand burden on the public hospital system which has lower costs to individuals, but higher costs to the system and often poorer health outcomes due to delayed treatment. It also means the state bears the cost and risk of providing this care.

51. As people live longer, the propensity for co-morbidities and chronic health conditions increases, which drives the need for a co-ordinated approach to care across the health, aged care, primary care and disability sectors. Provision of clinical care for older people requires an effective interface among the health system, residential aged care facilities (**RACFs**), primary care services and the disability sector, with clearly defined roles and responsibilities for all parties.

52. As for all community members, access to primary care and other services provided by PHNs is the cornerstone for providing and co-ordinating a person's clinical care.

[4] Future Health: Guiding the next decade of care in NSW 2022-2032 NSW Health 2022.
[5] Patient experiences in Australia: Summary of finding 2020-21, Australian Bureau of Statistics 2022

Demand for access to primary care in RACFs has increased due to the rising number of residents with complex and chronic illnesses. Due to the thin market of GPs in regional, rural and remote communities, NSW Health has stepped in to develop initiatives to provide more attractive training pathways to increase numbers.

53. In addition to providing general medical care for RACF residents, GPs are also needed to support and co-ordinate the care of older people with mental health conditions and to support palliative care and end of life care. GPs require an appropriate level of skills and training to undertake these roles.

54. Access to quality clinical care in RACFs is critical in preventing unnecessary admissions to hospital. This includes effective medication management, nutrition and hydration, pressure care, oral care and access to GPs and allied health professionals to provide specific advice regarding clinical needs of individual clients.

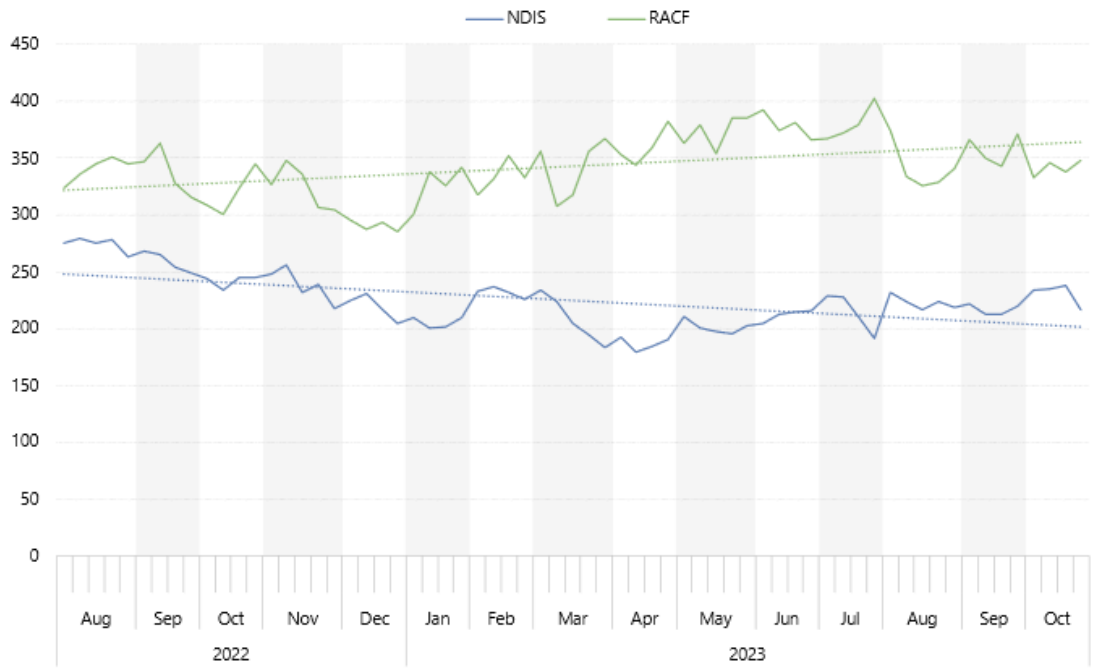
55. Increasing strain on the aged care sector is resulting in closures of facilities and/or aged care beds, and a general reluctance from providers to take on older people with significant needs, such as those with mental health conditions.

56. Hospitals and emergency departments have also been used as a last resort for older people and those living with a disability when there are no other services available to support them either at home or in the community. In more remote rural communities, LHDs have become the default provider of aged care services.

57. In addition, a lack of explicit provisions, roles and responsibilities, and accountability and escalation mechanisms, has led to NSW Health delivering care in settings where other providers (such as aged, disability or primary care) should have delivered them.

58. National aged care reforms, longstanding viability concerns and chronic workforce shortages have all contributed to these challenges. This has a significant impact on the public hospital system, with patients unable to be discharged from hospital, despite being clinically ready to do so, as they are unable to access the NDIS or RACF support they need. The total volume of RACF patients exceeding their date of discharge (**EDD**) varies week on week, however, has shown an upward trend since late 2022. On 25 October 2023 there were 565 RACF and NDIS participants exceeding EDD.

Figure 7: Patients exceeding date of discharge (NSW)



Source: NSW Health 2023

59. NSW Health sees risk to NDIS participants and the health system if issues of thin markets, limited availability of skilled providers, unmet need for accommodation and support, workforce issues, and timeliness of response are not addressed as a whole-of-government priority. Market failure and discharge delays disproportionately affect regional areas. NSW acknowledges and welcomes the Commonwealth's NDIS Review which is currently underway.

Governance of NSW Health

60. Fundamental to how NSW Health is positioned to manage this complexity is the governance of the public health system. The current governance arrangements allowed NSW Health to respond effectively to the pandemic; enabling the 'centre' through the Ministry of Health to provide coordinated statewide direction as needed while still allowing sufficient local flexibility to respond to communities through LHDs including local public health units.

61. The capacity to mobilise all districts and facilities in an integrated way is a strength of the NSW Health system compared to other jurisdictions. However, over the past 15 years, there has been movement across the continuum from the exercise of more central control to greater devolution to the local level. The ability to operate across this continuum enables NSW Health to respond more effectively to challenges and opportunities. For example, a centralised approach enabled the more efficient and effective use of pathology services during the pandemic response.

62. Whilst devolution has supported a very strong capacity to adapt care to local circumstances, it can also bring challenges with regards to equity and efficiency for initiatives that require standardisation rather than localisation, such as procurement and recruitment practices or the introduction of new technologies

that need to be implemented and used in a standardised way across the state for scale and consistency.

63. The role and function of NSW Health organisations is principally set out in two Acts, the *Health Administration Act 1982* and the *Health Services Act 1997*, reflecting requirements articulated in the NHRA.

64. Following the delivery of the final report in late 2008 from the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals conducted by Commissioner Peter Garling SC, a range of significant governance changes were implemented.

65. These were consolidated following the then Director-General's Report 'Future Arrangements for Governance of NSW Health' in 2011. This included focusing the role of the Ministry of Health on traditional Westminster functions and system management. There was also a focus on greater clinician and consumer engagement at the local level to drive improved patient care.

66. LHDs and their Boards were charged with responsibility for determining how they would deliver healthcare services within the framework of the Service Agreement between the LHD and the Secretary and the District's Annual and longer-term Strategic Plan to maximise the health of local populations.

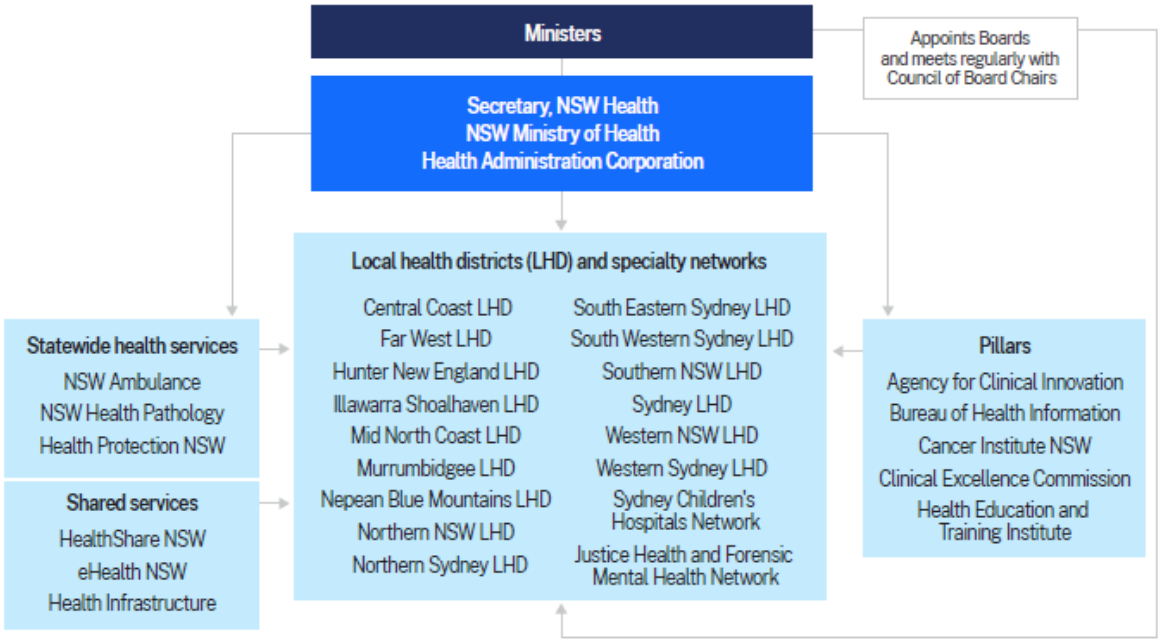
67. Affiliated Health Organisations also form part of the public health system. These are non-profit, religious, charitable or other non-government organisations and institutions whose performance is managed through relevant LHDs.

68. The "four Pillars" recommended by Commissioner Peter Garling SC, namely the Bureau of Health Information (**BHI**), the Clinical Excellence Commission (**CEC**), the Agency for Clinical Innovation (**ACI**) and the Clinical Education and Training Institute (now the Health Education and Training institute (**HETI**)) were also enhanced and strengthened.

69. Health Support Services (other than ICT) became HealthShare NSW governed by a Board with majority LHD representation and an independent Chair. HealthShare NSW was to enter into Service Level Agreements with LHDs and tasked with developing a stronger customer focus and contestability of pricing. ICT services came together under eHealth NSW.

70. In addition to managing capital projects of more than $10 million, Health Infrastructure (**HI**) was tasked with offering a support service to assist LHDs in their management of capital projects below $10 million. LHDs were given the option to purchase these services from HI or elsewhere.

Figure 8: NSW Health Organisational Structure



Source: NSW Health Annual Report 2022-23

71. The revised governance framework was designed to provide clear allocation of responsibilities, transparency in accountability and logical linkages and processes between all NSW Health entities. These changes also provided the foundation for the introduction of the new funding, purchasing and performance framework.

72. As system manager, the Ministry of Health monitors LHDs/SHNs achievement of agreed Key Performance Indicators (**KPIs**) and deliverables under the NSW Health Performance Framework. The Ministry and LHDs/SHNs communicate regularly about performance, including through Quarterly Performance Meetings between the Ministry of Health and the health service executives and monthly Health System Performance Reports produced by the Ministry which provides detail on performance against KPIs. Where under performance is identified, the Ministry and LHDs/SHNs work collaboratively to remediate the issue.

73. The NSW Health governance framework has remained relatively stable since 2011. With the experience of the pandemic, there is an opportunity to assess the balance between centralised decision making and devolution, noting that broad scale changes are disruptive, and the relative stability of arrangements has been a strength of the system over the past 10 years. This recognises that devolution does not need to apply equally to different functions in a complex health system. For example, planning for local service delivery requires more devolution than critical care networks, which operate better under less devolved arrangements.

Impact of COVID-19

74. The health system's ability to continue to perform well and to provide services to communities across NSW is under stress and this has been exacerbated by the impact of the COVID-19 pandemic.

75. The pandemic required the health system to adapt and respond to a rapidly changing environment. This created new ways of working together and accelerated the delivery of alternate models of care. There is much to be learnt from the system response to COVID-19, both to better equip the health system in responding to emergencies and in embedding positive changes.

76. In response to the pandemic, all jurisdictions agreed to a time limited agreement, the National Partnership COVID-19 Response, which provided a framework for the equitable sharing of costs between jurisdictions. This agreement ended on 31 December 2022.

77. NSW Health undertook two key debriefs to examine the response to the pandemic - *As one system: The NSW Health System's Response to COVID-19 2023* prepared by Robyn Kruk AO and the component report *Public Health – NSW COVID-19 Response*.

78. These reports acknowledged and recognised the impact and importance of previous investment in enabling systems including data and ICT, significant internal capacity across key areas including pathology, Aboriginal health, quality and safety and the expertise in local public health response. The governance system in place enabled a devolved response, but also facilitated state wide planning and response when required.

79. Most importantly, these reports recognised the single driving factor of a successful response was the capacity, capability and health and wellbeing of the clinical and non-clinical health workforce. The overriding commitment to a shared purpose and ability to respond and deliver care over a sustained period in a high-pressure environment should not be underestimated. There are challenges in supporting and retaining this workforce as the health system emerges from the pandemic.

80. Another area of note was how the health system responded to communities with differing needs, from Aboriginal communities to culturally and linguistically diverse communities and those living with a disability. Often many of these groups were more adversely impacted by the public health restrictions. The pandemic reinforced the need for a tailored, early response, informed by those communities and cohorts.

81. The pandemic transformed public health interventions.

82. These extraordinary conditions required workarounds and innovation. New strategies were developed. Communities of Practice were established, building on and complementing NSW Health's long-standing track record of clinical engagement, and new models of care and approaches were trialled and shared in an agile and focused way. With the limited resources available, traditional roles were stretched and adapted, nowhere more so than in regional and remote NSW.

83. COVID-19 has added a new respiratory virus that is easily transmissible to the mix of existing respiratory viruses that circulate in the community. COVID-19 and other respiratory viruses have been circulating at high levels in 2022 and 2023. This will have an ongoing impact on health services as infection prevention and control activities are adjusted to protect vulnerable patients in health care facilities. This adds to the cost base for health service delivery. Remote care and substantial

technological dependence have expanded, promising to reduce the burden on hospitals but with increased costs to transition the system towards this enhanced technological infrastructure.

84. A range of NSW Health expenditure items associated with the pandemic have been discontinued, including screening, quarantine and vaccination, which is consistent with the current context. However, as COVID-19 continues to circulate in the community, impacting the health and welfare of NSW residents, key elements of the pandemic operating model remain in place with transition ongoing, resulting in a higher-cost operating environment. In addition, for various conditions, the impact of the pandemic is still being felt through pent up demand and the need to address backlog generated by the pandemic through its impact on people's willingness to address health issues early.

85. The challenge for NSW Health now is to further embed the positive changes that the pandemic brought while addressing the backlog of planned surgery and continuing the provision of high-quality care while supporting and retaining the NSW Health workforce.

NSW Health Workforce

86. NSW Health has more than 138,199 full-time equivalent (**FTE**) dedicated staff to support the provision of public health care services to communities across NSW. Employee related expenses account for 65% of the $31 billion NSW Health expenses budget for 2023-24.

87. Providing high quality, safe, accessible, patient centred care is at the core of the NSW public health system. NSW Health is recognised for its high performance across a range of measures including transfer of care, emergency department performance and elective surgery performance.

88. The COVID-19 pandemic disrupted workforce supply patterns, which resulted in supply shortage against demand. This supply and demand tension led to pricing changes for contingent worker supply across the country. All states and territories are competing for a limited supply of medical and nursing workforces.

89. The use of contingent workforce is an important feature of the health system to remain agile, to scale up and down when needed. However, the pandemic saw reduced supply and increased demand on the system. Many of the recruitment/locum agencies operate across Australia and the locum/agency workforce is mobile working across states and territories.

90. NSW uses a combination of staffing arrangements including:

    a. permanent - full/part time NSW Health employees – 75% of total FTE;

    b. temporary and casual NSW Health employees – 21% of total FTE;

    c. overtime arrangements – 3% of total FTE; and

    d. agency/locum– 1% of total FTE.

91. In addition, NSW Health uses Visiting Medical Officers (**VMOs**), who are specialist medical practitioners appointed under a service contract who are not NSW Health employees. VMOs can work across multiple LHDs and agencies.

92. Workforce reforms have been challenged by complex interactions, hierarchies and professional cultures between different disciplines and clinical groups. Current arrangements in place between the Commonwealth and States/Territories also create inconsistent arrangements for the funding, accountability, reporting and regulation of hospitals, health services and workforce. These barriers need to be addressed to support the future health system.

93. Workforce shortages across a range of clinical specialties, particularly in primary care and regional areas, create challenges in accessing care. For the medical workforce, a reduced number of GPs has the greatest impact on regional LHDs' ability to provide services. There are also specialist medical shortages particularly in emergency medicine, across all LHDs. Similarly, all regional LHDs have nursing shortages, primarily around the recruitment of nurses with emergency skills particularly required for the smaller facilities. Similar pressures exist for allied health professionals.

94. Australia is facing a significant shortfall in the GP workforce over the coming years. With an ageing and growing population, demand for GP services is projected to increase. In 2021–22, there were around 270 million Medicare-subsidised primary care services in Australia, including, but not limited to: GP attendances (189 million); allied health attendances (25 million); services provided by nurses, midwives and Aboriginal health workers (4.1 million).[6] Despite this significant increase, supply of GPs is anticipated to decrease. The main driver of this trend is workforce renewal. The GP workforce is ageing with the proportion of GPs over the age of 65 increasing. Additionally, not enough medical graduates want to be GPs with the proportion of final-year students listing general practice as their first preference specialty falling.

95. These shortages are magnified by rising demand in emergency care settings, and workforce maldistribution. Lack of exposure to regional settings during training, and concerns about salary and working conditions are driving a shortfall in the GP workforce. Escalating locum costs to address staff shortages increases staffing costs and compounds difficulties in attracting workforce.

96. The reasons for ongoing recruitment and retention challenges in the regional workforce are multi factorial and include working in isolation, lack of available support, spousal employment, reduced career opportunities, schools for children, population decline in small rural towns, onerous on-call requirements, reduced training opportunities and lack of suitable accommodation. It is not simply an issue of more money.

97. Alternate models of care including those provided by non-traditional providers (such as nurse-led initiation of emergency care) or in non-traditional settings (such as day-only acute care admissions or admission at home models) require a review of the way funds are allocated and activities counted. Funding and workforce models are also driving a focus on acute and episodic care and treatment of disease, rather than prevention, integrated care or broader health outcomes.

98. Rigid and restrictive industrial awards are also inhibiting adoption of new models of care, attraction and retention of talent, and attraction of the right people, with the right skills, in the right place. Traditional 9-5 models of care and employment arrangements continue despite 24/7 care needs and infrastructure availability. Generational differences in incentives, and broader future of work changes, are

[6]Allied health and specialist health care across local areas: 2021–22, Australian Institute of Health and Welfare 2022

fundamentally changing service models and working arrangements. This includes through new ways of working and changing employee expectations, such as greater agility, flexibility and work-life balance.

99. Lack of accessible and accurate state-wide health workforce data limits visibility and planning capability and prevents monitoring of credentials and performance. Gaps in workforce, infrastructure and technology continue to exist across NSW, including shortages, poor integration and maldistribution (system-wide but particularly for rural and remote workforces).

100. An emerging issue that further impedes the system's capacity to respond to workforce challenges and increased demand for care relates to the lack of social licence to implement alternate models of service delivery. Community expectations are still for very traditional models of care delivery (e.g., doctors over other professionals, hospital beds over day-only or community-based care, surgical and other invasive interventions over supportive care). Engaging with communities about emerging evidence for these alternate models is required to support a positive discussion with communities about the need to provide care in different ways. This includes support for new models of care that maximise clinicians' scope of practice and care provision in lower acuity settings.

Challenges facing the NSW health system

101. Change is ever present. In addition to the impact of the COVID-19 pandemic and other natural disasters, health systems are facing a range of complex and often intertwined issues impacting the provision of care. These factors include:

a. **rising demand** and **changing demographics**, with demand rising at rates beyond population growth, especially for care to support mental health, diabetes and communicable diseases and the rising number of people over 65 in NSW;

b. **workforce challenges** including attraction and retention of staff which is particularly acute in outer metropolitan and regional, rural and remote areas, award reform to meet the needs of a 24/7 system and respond to innovation and changing models of care;

c. **challenges in accessing primary care** including through residential aged care facilities, resulting in large numbers of lower acuity patients presenting to emergency departments. In addition, chronic conditions become more acute due to lack of continuing community care as GP availability and accessibility declines;

d. **growing complexity of health needs**, with one in four people in NSW anticipated to have two or more chronic conditions by 2031;[7]

e. **increasing consumer and community expectations** in access, quality, safety and patient experience;

f. **new diagnostic or therapeutic interventions** that demonstrate significant potential for health improvement but also high costs and complexity in their implementation;

[7] NSW Health Eating and Active Living Strategy – 2022-2032, Guiding the next decade of overweight and obesity prevention in NSW, 2022

g. **application of new technology** and impact on models of care and consumer experience;

h. **rising operational costs** including but not limited to inflationary pressures, expanding operating base from large infrastructure programs and increased use of premium labour due to workforce shortages/maldistribution;

i. **shared services and procurement** harnessing efficient procurement and shared services to support health care delivery;

j. **travel and cost of care for rural and regional communities** and the impact this has on recruitment in some areas of regional workforce; and

k. **balancing current demands with future prevention** given investments in preventative health have long lead times and results that can be difficult to prove or attribute directly to health.

B. HOW NSW HEALTH IS RESPONDING

102. NSW Health is continually leveraging opportunities to deliver world-class, safe and high-quality care and working collaboratively to harness innovation to position NSW Health as a national healthcare leader.

Future Health Strategic Framework

103. Recognising these challenges, NSW Health *Future Health Strategic Framework 2022-2032* was developed to position the NSW health system to meet the needs of patients, community and workforce over the next decade. This includes investment in preventative health, care in the community, in the home, and through virtual health services which are all driven by a person-centred approach to healthcare, enabling people to have more control over their own health. NSW Health's investment in these areas reflects the future of healthcare delivery.

104. Extensive consultation was undertaken with staff, partners across the sector as well as patients and the community throughout the development of the strategy. These insights have helped shape a plan which outlines a vision for a sustainable health system that delivers outcomes that matter most to patients and the community.

105. A strategic framework has been established to oversee the implementation of Future Health with 10-year roadmaps and 3-year action plans for each strategic outcome. A measurement framework is being developed to monitor key outcomes and provide data-driven insights to explore focus areas and adapt the strategy as required. The need for broad system sustainability underpins this model.

Figure 9: Overarching directions of Future Health Strategic Framework

Source: NSW Ministry of Health 2023

106. NSW Health is working on improving health outcomes and access to health services for people living in regional, rural and remote NSW in collaboration other partners. This work is guided by the *NSW Regional Health Strategic Plan 2022-2032* which has been developed to align with and support the Future Health Strategic Framework, while addressing issues that are specific to regional, rural and remote communities.

107. Governance and engagement have been strengthened in numerous ways for regional, rural and remote NSW. This has included the Regional Health Committee, strengthening of local health committees, the commencement of the Regional Health Ministerial Advisory Panel, and the Regional Health Plan Steering Committee together with the recommencement of the Bilateral Regional Health Forum in December 2022 with the Australian Government.

Supporting the workforce to deliver care

108. Central to provision of care is the health workforce that is required to deliver it.

109. This requires a fit-for-purpose workforce to meet the changing health needs of the population and to service new models of care. The *NSW Health Workforce Plan 2022-2032* has been developed to address long-term trends and the short-term challenges that have emerged due to recent global events, including the COVID-19 pandemic.

110. Supporting the health workforce to deliver high quality care is critical. The experience of the pandemic reinforced the care and commitment NSW Health staff bring to their jobs, day in and day out.

111. Statewide initiatives to attract and retain workforce include nursing and midwifery scholarships and strategies such as mentoring programs, tertiary health study subsidies programs, dedicated allied health new graduate programs and partnering with Investment NSW to focus on overseas recruitment.

112. Enabling the ability to work at full scope of practice for all health professionals where it is needed supports access to high quality multidisciplinary care.

113. Nurse-initiated models of care are well established in NSW emergency departments. They reduce the time a patient waits for treatment, improve the standard of care and reduce the patient's length of stay in the emergency department. However, protocols, education and governance frameworks vary across NSW. This can lead to variations in patient care, nursing practice and the inability for nurses to transfer their skills between hospitals.

114. The Emergency Care Access to Treatment (**ECAT**) is a statewide, co-designed project that aims to standardise nurse-initiated emergency care, improve patient experience and increase staff satisfaction. It supports metropolitan and rural hospitals to provide consistent care across NSW. The program has seen the development of standardised protocols to enable nurse-led emergency care, reflecting a model of enhanced scope of practice to support access to care and better use of medical and non-medical resources.

115. Targeted initiatives to increase the regional medical workforce include the Single Employer Model for GP trainees. This model, first piloted in Murrumbidgee LHD, allows rural generalist trainees to work across hospital and primary care settings, while being paid a consistent salary with entitlements by the LHD. The model relies on an exemption from the Australian Government under section 19(2) of the *Health Insurance Act 1973* (Cth).

116. In 2022, the Australian Government endorsed the expansion of the model in NSW as part of the national Single Employer Model rollout. NSW Health was allocated two pilots with up to 80 trainee places, which will be delivered through a collaborative model spanning all regional LHDs.

117. Some further examples of initiatives to address workforce concerns in regional and rural areas include:

    a. Rural Preferential Recruitment Program which supports junior doctors undertaking their first two years of work in a rural location;

    b. Extensive training networks linking metropolitan and rural hospitals in speciality clinical areas;

    c. Clinical placement grants for allied health and nursing and midwifery students to subsidise rural clinical placements;

    d. Rural Allied Health Locum Program to provide locum coverage to sole allied health practitioners so they can access professional development and leave;

    e. Aboriginal Medical Pathways Program for Aboriginal doctors in rural areas;

    f. Key Worker Accommodation Program which will drive construction in the regions and deliver critical health accommodation improvements. The program is being delivered in Far West, Murrumbidgee and Southern NSW LHDs in partnership with Health Infrastructure. Hunter New England and Western NSW LHDs are also delivering key worker accommodation projects through the NSW Regional Housing Package; and

    g. Virtual Rural Generalist Service which supports rural medical and nursing staff to deliver safe and high-quality care to rural and remote communities 24/7. Work is currently underway to consider how this model could be scaled to a statewide model to support smaller facilities to remain open when there is no doctor present on site as well as providing workforce relief for doctors in rural areas.

Engaging clinicians, patients, carers and families in health system design and delivery

118. The experience of the pandemic also demonstrated the value of engaging clinicians in the design and delivery of frontline healthcare. To facilitate this ongoing engagement and ensure the voice of clinicians is heard at the centre, a Health System Advisory Council (**HSAC**) has been established by the NSW Health Secretary. The HSAC consists of a multidisciplinary group of 24 doctors, nurses, midwives, oral health and allied health professionals together with the Ministry of Health Executive Management group.

119. Membership includes representation from the Aboriginal clinical community and primary healthcare. The HSAC will provide independent and impartial strategic clinical advice, which reflects the views of clinicians in the health system, on key statewide and system priorities. This includes involving the clinical workforce in informing specific components of work. Clinical advice provided by the HSAC will inform the operational arms of NSW Health and will guide the planning, preparation and execution of measures related to the delivery of healthcare.

120. Ensuring the frontline workforce can focus on activities that support delivery of patient care, NSW Health has initiated the Time for Care project. This project is focusing on identifying any areas of activity that take staff away from their core responsibilities and do not add value to patient care delivery. Key strategies will address core drivers of administrative burden such as recruitment, rostering, onboarding and education, clinical guidelines and equipment management.

121. Engaging patients, their carers and families in the design, improvement and governance of health services and health programs is essential for creating patient-centred, effective, and equitable healthcare systems. It not only improves the consumer experience but also leads to better health outcomes, increased accountability, and greater innovation in healthcare delivery.

122. Elevating the Human Experience is NSW Health's first state-wide strategy to deliver an exceptional patient experience and make that experience empowering for everyone involved in receiving and providing care. Over 200 consumers, staff, and representatives from peak agencies such as Health Consumers NSW were involved in the co-design and co-development of All of Us – A guide to engaging consumers, carers, and communities across NSW Health.

123. A new consumer voice is being established within the Ministry of Health, to complement the HSAC. The group has two key functions, firstly to provide advice on specific statewide strategies and secondly to provide advice on methods and extent of engagement required on strategic priorities. This group will ensure the consumer voice is heard at the most senior levels at the Ministry of Health.

124. NSW Health is also implementing the Health Outcomes and Patient Experience (**HOPE**) patient reported measures platform to enable patients to provide direct and timely feedback about their health experiences and outcomes that matter to them at the point of care. More than 56,000 patient reported outcome measures have been completed in the HOPE platform to give clinicians real-time insight into health experiences and outcomes. Clinicians are using this data to inform care and sharing patient reported measure results with other care providers to support appropriate and timely follow up.

125. NSW Health also has a long history of collecting experience measures from Mental Health consumers to improve the care received by this vulnerable cohort. This includes the national Your Experience of Service (**YES**) survey and electronic YES survey to measure consumer experience in mental health services. The YES questionnaire was developed in partnership with mental health consumers. In addition, the national Mental Health Carer Experience Survey) is undertaken to ask carers about their experience of mental health services.

Providing the care communities need when and where they need it

126. Hospitals will continue to be a cornerstone in healthcare for patients who cannot be supported in the community or the home and virtual settings. Future health needs, technological advances and healthcare sustainability will necessitate new models of care.

127. NSW Health is already working towards more people accessing care outside hospital settings and providing more options for care in the community and the home, facilitated through strong partnerships with general practitioners and non-government organisations.

128. Models of community-based care and initiatives to support community care include:

    a. A **GP deputising pilot trial** in partnership with Healthdirect, providing virtual GP appointments for all after-hours NSW calls to the Healthdirect Information and Advisory Service. This is part of the **Single Front Door** initiative, which is a partnership between NSW Health, the Commonwealth and Healthdirect to help patients navigate their care;

    b. **Collaborative Care** – a community-centred approach to place-based planning to address health care challenges in remote and rural NSW. Involves partnering with key stakeholders in a community to understand health needs and identify fit-for purpose solutions;

    c. **Hospital in the Home** – provision of hospital-level care in a patient's home or in the community. Various models of this service delivery are operating in several LHDs and SHNs with further enhancements enabled by virtual care;

    d. **Virtual Care** – also known as telehealth and safely connects patients with health professionals complementing face-to-face care. An example is the VirtualKIDS Urgent Care Service which provides experienced clinical nurse review, with referral to an expert paediatrician where needed, to determine the best care pathway and care provider based on the child's needs. The service which is accessed via the **Single Front Door** is currently available in 6 LHDs and will be rolled out statewide by the end of 2023.

    e. **Extended Care Paramedics** – expanded scope of practice for paramedics enabling the provision of a broad range of low acuity care interventions in the community setting following a triple zero call, where hospitalisation is not the best pathway;

    f. Exploring options to provide **community pharmacies with phone access to GPs** to support cases presenting for medication re-supply without a prescription;

    g. **Rapid Access Clinics** – outpatient clinics established to target specific, high prevalence health concerns in local communities and reduce hospitalisation;

h. The roll-out of **Urgent Care Services** in partnership with LHDs, PHNs and GPs, will provide a range of services for people who need care for an illness or injury that can be managed through alternative pathways without requiring a trip to the emergency department. Services may include information and access lines (digital and telephone); Urgent Care Clinics that are able to treat mild infections, fractures and burns; rapid response hospital teams that provide urgent care in the patient's home; and virtual (telehealth) specialist and GP services. Urgent Care Services are in addition to the 13 Urgent Care Clinics in NSW that the Australian Government is establishing;

i. An **expansion of the range of services provided by appropriately trained pharmacists** such as prescribing for urinary tract infections and medications for a range of minor conditions (such as skin ailments and ear infections, and hormonal contraception), in consultation with pharmacy regulators and through a clinical trial to assess safety and sustainability of the model;

j. **Lumos Program** – Australia's first state-wide linked acute care – primary care data asset that links records to map patient journey through the NSW Health System in collaboration with 10 PHNs and over 600 participating general practices;

k. **Caring for People in the Community** - 15 LHDs to be transitioned to the Emergency Department to Community model, providing case management to clients with complex/chronic health needs, reducing unplanned hospitalisation and emergency department use;

l. **Residential Aged Care** – Secondary triage provides an alternate pathway for low acuity RACF residents calls to NSW Ambulance via MyEmergencyDoctor Service;

m. The **Integrated Care Residential Aged Care** supports facility staff to care for unwell residents by providing training, and virtual care support and triage;

n. **Collaborative Commissioning** to accelerate value-based healthcare in NSW. Patient centred co-commissioning groups identify and prioritise local health needs and develop care pathways to help address the gaps in patient care. This initiative includes the Frail and Older People Pathway which aims to deliver proactive and timely care in the community to people who are at high-risk of an unplanned hospital admission in Northern Sydney LHD. The pathway addresses gaps and enablers across the primary and acute care settings through a flexible model of support for frail and older people at greatest risk of hospitalisation. There are several outcomes and benefits that the pathway will deliver including an aim to reduce emergency department presentations, unplanned hospital admissions and ambulance transfers;

o. **Specialist Outreach to Primary Care** which links GPs with medical specialists to support and upskill primary care clinicians to manage conditions such as early onset dementia, heart disease and diabetes;

p. **Formal partnerships** between NSW Health, PHNs, LHDs and Aboriginal Controlled Community Health Organisations (**ACCHO**), Diabetes NSW & ACT and other partners on a **statewide initiative to improve the coordination of diabetes care** across NSW and keep people well and out of hospital; and

q. **Sustaining NSW Families** - a sustained health home visiting service that aims to strengthen relationships between children, parents and/or carers, build parenting capacity, and enhance child development, wellbeing and health,

with evaluation supported by linked data that brings together health, education and justice service and outcomes data.

Working in partnership

129. NSW Health recognises the importance of working closely with PHNs in the delivery of health care. The *NSW Health and NSW Primary Health Networks: Joint Statement* signed by the Commonwealth, NSW Health and PHNs outlines principles for working together that supports collaboration on cohort specific projects with the objective of brings these two systems together in the delivery of more coordinated care.

130. This has underpinned collaboration across a range of initiatives, including the expansion of aftercare services across NSW. This initiative provides psychosocial support services to those who have attempted suicide. The Commonwealth, NSW, PHNs and LHDs are working together to identify where services are required and how to better embed them across the health system including through expanded referral pathways.

131. NSW Health is also trialling approaches to patient registration to support coordinated care. For example, My Care Partners voluntary patient GP registration is jointly funded by Western Sydney LHD and PHN and provides payments for each enrolled patient on top of eligible MBS items, as well as payments linked to patient outcomes.

132. Multidisciplinary care should extend beyond the health system to provide truly integrated, whole of person care to address the social determinants of health including for those vulnerable groups.

133. There is transformational cross-agency work already underway to support all NSW families to access high-quality health, education and community services in the first 2000 days (pregnancy through to the first five years) of a child's life. The early years are critical and are a predictor of school performance, adolescent pregnancy and involvement with the criminal justice system in the adolescent years as well as being related to obesity, elevated blood pressure and depression in adulthood and a predictor of coronary heart disease and diabetes in later life.

134. Many children and families have not had the support or information they need during the critical early years – when most of a child's brain development occurs. The 2021 Australian Early Development Census found that over 44% of NSW children are not developmentally on track when they start primary school.

135. In NSW, $376.5 million has been committed over four years to support cross-government programs targeting early childhood development in the first 2000 days of life. Initiatives include health and development checks in preschools, maternal home visiting programs and expanding Aboriginal Child and Family Centres across the state. This work brings together government agencies and sector professionals to improve outcomes for NSW children and their families.

136. There are 63 Multi-Purpose Services (**MPS**) in regional and remote locations across NSW that provide integrated health and aged care services for older people. The funding for MPS comes from the Australian and NSW Governments. NSW Health is working collaboratively with the Australian Department of Health and Aged Care to support the adequate provision of aged care beds in rural and remote locations, including expansion of MPS where there are thin markets.

137. Patients who live in communities that border the state can experience additional challenges to accessing health care. NSW Health partners with counterparts in neighbouring states and territories to reduce barriers for patients living in border communities. One example of this is Albury-Wodonga Health, a unique cross-border health service established in 2009, that is jointly funded by both NSW and Victoria but is managed by Victoria.

Preventive health

138. Preventive services and early interventions, as well as care aimed at maintaining people out of hospital, should be strong pillars of Australia's healthcare system to support people to be healthy and well. People living in Australia are experiencing increasingly complex health care needs. Low proportional investment in preventive health, the wider determinants of health and increasing burden of chronic disease has led to increased spending on treatments to manage conditions that could be prevented, detected earlier or managed more effectively in a comprehensive primary care setting reducing the need for hospitalisation.

139. NSW Health undertakes a range of prevention activities. Examples include:

    a. strategies to address HIV, Hepatitis B and C and sexually transmitted infections. These strategies cover a range of initiatives from access to clean injecting equipment, immunisation, increasing access to testing through innovative testing technologies and priority settings and supporting linkage to care and treatment;

    b. screening programs including for cancer (e.g., bowel, breast and cervical) newborn hearing and a range of conditions through newborn blood spot screening;

    c. strategies to reduce tobacco use including campaigns and social marketing, embedding tobacco cessation advice and support in routine clinical care, and QUIT line and other cessation support services;

    d. strategies to promote healthy eating and active living through the *NSW Healthy Eating and Active Life Strategy 2022-2032* which is a whole-of-government strategy to support healthy eating and active living. The approach is comprehensive and delivers prevention programs and services, embedding routine advice as part of good clinical care, leveraging best practice social marketing to support behaviour change, and improving physical activity environments to make healthier choices easier; and

    e. support for local council in their regulatory activities and the provision of safe drinking water.

140. NSW Health prevention activities have a particular focus on priority populations such as Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities.

141. NSW Health continues to deliver mental health services and care to support the wellbeing of people across the State. This includes driving government priorities related to mental health and suicide prevention through cross agency collaboration and engagement. Key cross agency actions underway to improve mental health outcomes include:

    a. maintaining and strengthening student mental health and wellbeing;

b. improving service collaboration and outcomes for shared client groups at the interface of mental health, homelessness, and social housing services;

c. improving Aboriginal social and emotional wellbeing; and

d. better meeting the health needs of people with a mental health issue in forensic mental health services and custody.

142. NSW is signatory to a $383 million bilateral schedule with the Australian Government under the National Mental Health and Suicide Prevention Agreement. The national agreement provides a framework for all jurisdictions to work together to deliver mental health and suicide prevention reform. The development of this agreement and associated bilateral schedule was informed by advice from the National Suicide Prevention Adviser and relevant matters from the Royal Commission into Victoria's Mental Health System. There are seven key co-funded initiatives under the bilateral schedule.

143. NSW Health has also developed new models of care that deliver rapid access to specialist mental health services together with alternatives to emergency departments for those experiencing mental ill health. This includes the establishment of 19 Safe Havens across NSW which provide an alternative pathway to presenting to an emergency department for people experiencing suicidal distress. Safe Havens have been co-designed with and are led by people with lived experience of suicide and recovery. Visitors have access to a safe, quiet and welcoming space with opportunity to use music, sensory equipment and conversations with suicide prevention peer workers who are uniquely placed to understand their experience.

144. Another example is the Police, Ambulance and Clinical Early Response (**PACER**) program, which is a mental health co-responder model that places mental health clinicians in police stations to support first responder responses to mental health emergencies by providing an immediate, compassionate response and connection to appropriate services for ongoing care, without always needing to go to the emergency department.

Enabling the future health system – technology, new models of care, sustainability

145. NSW Health has prepared a 20 Year Health Infrastructure Strategy that has identified significant trends that are transforming how patients and clinicians interact, the services that people want, and the skills and infrastructure needed to deliver them.

146. This includes focusing capital investment on providing a range of care options. These extend from the home to local centres and hospital precincts as well as virtual care settings. This means investing in the next wave of future healthcare facilities and shifting activity away from traditional hospital settings, accelerating virtual and digitally enabled care, and advancing whole of system digitisation.

147. As part of this whole of system digitisation, the introduction of the Single Digital Patient Record (**SDPR**) will provide a secure, holistic and integrated view of the care a patient receives across the NSW Health system. Clinicians will have fast, secure and easy statewide access to an integrated record of an individual's medical history in real-time.

148. The SDPR will replace the current nine electronic Medical Record systems, 10 Patient Administration Systems and five Pathology Laboratory Information

Management Systems in use across NSW Health into one platform. This will reduce duplication of costs and efforts required to support and maintain these systems.

149. It will also enable patients to have greater access to their own health information which will in turn help GPs have a better level of information about their patients who interact with the public health system.

150. Other statewide initiatives such as the electronic medication management system have delivered significant results that contribute to improved clinical safety and quality of care. Implementation of the electronic medication management system has led to more patients having a completed medication history compared to the paper-based system delivering savings across the system.

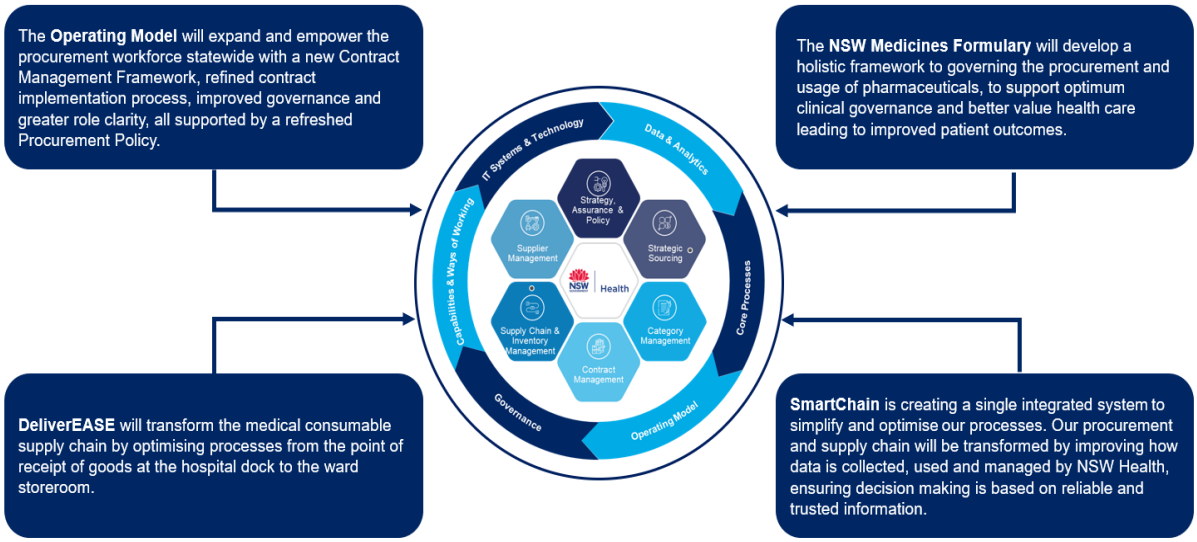
151. The statewide telestroke model of care has also been a successful initiative which provides guidance to implement world-class hyperacute stroke care (care delivered in the initial 24 hours after the onset of stroke symptoms) for patients with suspected stroke in NSW, regardless of their location. This program has enabled the delivery of life saving treatment across NSW with 23 telestroke sites established since 2019. This program has seen an increase of adjusted life years (survival weighted for disability/quality of life) of 4.2 years per patient.

152. NSW Health is also focused on the sustainability of the health system, including environmental sustainability. Recognising the substantial carbon footprint of the public health system, NSW Health is on track to halve emissions by 2030 (based on 2005 levels), primarily through its world leading Solar for Hospitals campaign. Energy efficiency upgrades, creating an electric fleet, and the incremental phasing-out of natural gas are also underway, helping to drive down energy costs and reduce emissions. NSW Health is actively engaging with clinicians to change models of care that are identified as high polluters. Further work is underway to guide transition to a modern high quality, net zero carbon and climate-resilient health system, focused on value, innovation, and equity.

Shared services and procurement reform

153. NSW Health is undertaking a system wide Procurement Reform Program to deliver an integrated end-to-end procurement and supply chain system. This program has four key workstreams which are driving greater efficiency and savings across NSW Health. This includes the DeliverEASE program which is improving the availability and visibility of medical consumables across NSW hospitals. The program has resulted in faster and more efficient delivery of stock, with users being alerted if items are already on backorder, reducing the risk of over ordering and saving money. The SmartChain program is digitally transforming supply chain and procurement processes across NSW Health creating a single integrated system resulting in an easier and a more efficient process.

Figure 10: NSW Health Procurement Reform Program



Source: NSW Health 2023

154. Procurement activity is supported by an effective policy framework which sets out stringent thresholds and approval requirements for NSW Health agencies undertaking procurement. This provides a strong focus on effective contract management to ensure that operational and financial performance is maximised, benefits are delivered, and risks are adequately managed so that value for money is achieved.

ICT and digital services

155. NSW Health has a federated model for the delivery of ICT and digital services across the public health system. The model is based on a combination of statewide planning, coordination and delivery of many ICT services through eHealth NSW, and local planning and delivery of other ICT services by LHDs, SHNs and other health entities. eHealth NSW currently runs approximately 70% of all ICT and digital services across NSW Health.

156. To date, eHealth NSW has been successful in standardising and consolidating a range of key platforms and services, including:

- Data centre and cloud hosting, as well as wide area networking services;
- Finance, payroll and procurement systems;
- Staff recruitment, rostering and performance management systems;
- Safety and quality incident management platform;
- Cybersecurity services (partial consolidation); and
- Hospital pharmacy system and several other clinical platforms (partial consolidation).

157. eHealth NSW has already delivered significant procurement savings by standardising, creating economies of scale and strategically managing key ICT vendors.

Innovation, medical research and advanced therapeutics

158. NSW is investing in physical infrastructure to support novel technologies, both in terms of supporting research and development activities in the biotech and clinical trial areas, but also in terms of manufacturing capability and developing the workforce required for the future provision of precision and personalised medicine. NSW is leading nationally in investments in infrastructure around advanced therapeutics such as bacteriophages, gene and cell therapies, viral-vector and CAR-T-cell therapies and in the development of novel gene therapies and vaccines targeting genetic disorders, cancers and chronic conditions.

159. The **ACI** bring patients, clinicians and managers together to support the design and implementation of innovation in healthcare. This includes clinical evidence generation, clinical guidelines, development of models of care, patient engagement and clinician engagement through over 40 clinical networks, institutes and taskforces reaching thousands of clinicians, managers and consumers across NSW.

160. NSW Health has a range of research partnerships with universities, Australian Research and Translation Centres and Medical Research Institutes. NSW Health manages significant programs to fund research in cardiovascular diseases, spinal cord injury, organoids and other technologies to support reduction in use of animals in research as well as an extensive program of translational research grants aiming at applying the knowledge of research into real clinical settings.

161. Additionally, NSW Health is leading the Health Precincts Program, as part of a whole-of-government agenda, to deliver a coordinated approach to medical research, and leverage health and medical research activity and assets. Precincts and place-based collaboration also support economic activity, develop our workforce, attract industry, and improve the health system and patient outcomes.

162. NSW Health also works closely with Investment NSW to promote the state's health and medical research sector to a global audience to attract investment, collaborations and partnerships.

163. A key initiative is the Viral Vector Manufacturing Facility (**VMMF**) within the Westmead Health Precinct with the ability to manufacture high quality clinical grade viral vectors at the scale required to support projected demand for research and clinical outcomes and service delivery. The VMMF establishes a globally competitive capability in advanced gene-based therapeutics in NSW, creating high value and advanced manufacturing jobs in emerging industries by leveraging existing capabilities and high global market demand for viral vector technologies and products.

164. Finally, NSW Health has invested in an ongoing way to support the design and implementation of clinical innovations that combine information technology, new diagnostics and treatments as well as changing knowledge about appropriate clinical delivery through the work of its pillar organisations and various Ministry branches. Few systems internationally have developed such a strong ecosystem of support organisations, working collaboratively to continuously innovate and address clinical variation in care.

C. OPPORTUNITIES

165. NSW Health sees a significant reform agenda to drive the changes needed to deliver a public health system that is well placed to respond to challenges and harness opportunities. Building on delivery of existing programs and strategies, there is the opportunity to ensure structure and systems support and enable the workforce to deliver contemporary models of care that meet the health needs of NSW communities.

Workforce

166. Ensuring the right skill mix and distribution of workforce is critical. Current arrangements are geared towards increased specialisation, rather than supporting general practitioners or generalists more broadly. The needs of the population should be reflected in the training delivered and workforce pipeline, recognising the changing disease burden and ageing population.

167. The distribution of the workforce also needs to be considered and issues such as housing availability and affordability needs to be addressed at a cross-agency level to ensure options are available for those who are willing to relocate to rural and regional areas to work within the NSW public health system.

Industrial relations framework

168. The workforce needs to be able to effectively deliver new models of care as they are developed. This will require new capabilities and new skills, which the workforce will need to be supported in gaining. Consideration of a range of factors is required including location of work, work hours and patterns together with skill mix and accountability and importantly, career path, remuneration and industrial arrangements.

169. Without changes to the current arrangements, NSW Health will not be able to effectively deliver health care that meets the changing needs of communities. NSW Health industrial instruments must be modernised and should be consolidated to remove all industrial barriers to productivity and flexibility in the workforce.

170. NSW Health notes the Review of the NSW Industrial Relations System and how its findings will inform the future negotiation and arbitration of more modern and contemporary awards.

171. NSW Health is actively engaged in identifying reform opportunities, noting the significant impact of the NSW Government's removal of the wages cap that operated for 12 years. The impact of this policy has led to NSW Health less competitive than other states. There is now clear evidence of less competitive market positioning on salaries in key clinical roles.

Workforce supply

172. Challenges in workforce supply have meant Australia has relied for many years on the attraction and recruitment of health professionals outside of NSW. The pandemic and associated border closures exacerbated shortages and increased

the reliance on more temporary solutions including locums. This is particularly apparent in specialities for example in psychiatry.

173. NSW Health supports work underway at the national level to examine opportunities to standardise the price of non-specialist medical locums, noting the impact of high locum costs across Australia, but particularly in regional and rural areas. Support to progress this work is critical, recognising that where very thin markets exist, there may need to be some flexibility in approach.

174. An independent review, led by Robyn Kruk AO to examine regulatory settings relating to overseas trained health professionals and international students who have studied in Australia is underway. Recommendations in the Interim Report have been supported by National Cabinet and are being implemented. NSW Health supports this work.

175. The role of medical colleges in specialist training has a significant impact on the numbers of trainees. There is not good alignment between the future workforce needs and current practices of the medical colleges. Further, this limitation of trainees has a flow on effect to economic supply and demand.

176. At the Health Ministers' Meeting (**HMM**) the current challenges with the Australian Medical Council and colleges were discussed, regarding specialist recognition, specialist numbers and accreditation for training sites, with the expectation of improved collaboration to improve these processes.

177. This has been reinforced through a Policy Direction to Australian Health Practitioners Regulation Agency (**Ahpra**) and the Medical Board of Australia on behalf on the Ministerial Council. The Policy Direction notes that accreditation decisions, including withdrawal of accreditation, have a significant impact on the availability of medical workforce at sites/locations, which in turn, has a significant impact on patients through reduced service. NSW Health supports this national collaborative approach to tackling this issue.

Scope of practice

178. Both the employment and funding models should enable the workforce to deliver care across settings, regardless of jurisdictional responsibilities. Care delivery should be multidisciplinary, incorporating nursing, medical and allied health professionals This includes facilitating expanded scope of practice, particularly for nursing and allied health, to deliver this care. This should include expansion of prescribing rights for nurse practitioners, registered nurses and allied health professionals where appropriate.

179. As an example, enabling patients access to prescribed medicines from endorsed podiatrists (the only prescribing profession currently without access to the PBS) could significantly benefit rural patients where there is limited access to GPs. Patients with untreated high risk foot infections can quickly develop cellulitis which is one of the most potentially preventable hospitalisation conditions in NSW.

180. Enabling pharmacists to undertake a range of vaccinations and prescribe medications for agreed conditions will support communities in accessing the health care they need. NSW Health is also running a pharmacy trial enabling pharmacists to prescribe medication for urinary tract infections and for the oral contraceptive pill. Once evaluated, this could be expanded both in terms of location and the range of conditions eligible for pharmacist prescribing.

181. Broader investment in nurse practitioners and allied health professionals including the Aboriginal Health Worker and Aboriginal Health Practitioner workforce is required. This will assist in developing and supporting a more sophisticated workforce to respond more effectively to the changing needs of communities.

Funding

182. Given the challenges facing the NSW public health system, a review of the long-term NSW and national funding model is required to respond to the challenges outlined including workforce maldistribution and changes in operating costs. This includes review of the long-term funding envelope and growth rates for the NSW Health budget. Work is also required to better align operating costs with the rate of capital expenditure to ensure LHDs and SHNs are funded adequately to engage the workforce for new facilities.

183. The introduction of ABF has brought considerable national transparency to the funding of public hospital services, but at the expense of supporting innovation and care outside the hospital.

184. ABF focuses on throughput (activity) and not on outcomes. This focus on technical efficiency is at the expense of allocative efficiency. An increased focus on outcome-based funding and preventive health would improve access and equity particularly for vulnerable cohorts and those in regional and rural communities.

185. The definition of public hospital services and hospital avoidance measures should be broadened to enable provision of a Commonwealth funding contribution under the NHRA to better reflect how care is now delivered. ABF should also reflect the need to provide a broader range of services in some settings if the patients accessing the service have barriers to accessing care in other settings. This approach is important to address health inequalities. Examples of such settings may include drug and alcohol, mental health and sexual health services.

186. The NHRA Addendum restricts growth funding under this agreement in any one year to a national 6.5% growth cap. When the cap is breached, the Commonwealth effectively shifts funding risk to the States irrespective of whether cost growth is within States' control, with the impact being the Commonwealth's contribution rate is effectively reduced. This cap should be removed to ensure more equitable sharing of risk and to enable a timelier movement of the Commonwealth share of public hospital funding to 45%. The NEP should also accurately reflect the increased cost of delivering care in hospitals.

187. Integrated funding models to support care in the community need to be fast-tracked, with a more blended funding model moving away from a reliance on ABF in dominating decisions on budget allocations at the state level. This would assist in enabling the delivery of different models of care and provide more scope for innovation. However, implementation of any new funding model would need to consider underlying equity and the responsibility to maintain the safe operation of the public health system.

188. An integrated funding model could also enable greater collaboration and improve patient experience and outcomes. For example, residential aged care facilities and general practitioners working under the same model in small communities reduces fragmentation of funding and enables sharing of information to ensure shared and a more holistic approach to patient care.

189. Innovative models of care, including virtual care need to be scaled and embedded. While the NHRA does provide for the trialling of innovative funding for new models of care, in practice, this process has been complex and slow.

190. Governance and funding models should be designed to support the adoption of evidence based new models of care and not require 'work arounds' to ensure communities can access the care they need where they need it.

Governance

191. Ensuring the right governance settings to support local decision making while enabling effective oversight and management of the public health system is crucial.

192. The broad governance settings for the NSW Health System, including the role of the State as the system manager and the governance of the LHDs, including their Boards, are set under Appendix E of the NHRA.

193. While the requirements are quite prescriptive, there is an opportunity to reform and improve current arrangements. This could include, at the LHD level, strengthening and focusing the role of Boards on local engagement with their local communities, their clinicians and their workforce both to listen to concerns as well as communicate LHD and statewide initiatives. This would be particularly valuable to improve the voice for communities in regional and remote NSW. In line with the review of NSW Government Boards that will be undertaken by The Cabinet Office, the size of LHD Boards will be reconsidered. Reviewing employment arrangements for Chief Executives to ensure a single line of accountability to the Secretary NSW Health could also be undertaken.

194. There is an opportunity to re-assess current governance options of statewide health support services to ensure appropriate oversight while maintaining an agile structure responsive to health system needs. A stronger reporting link to the Ministry of Health executive for the functions of education and training could also be considered.

195. More needs to be done to ensure governance arrangements across NSW Health support formal partnerships with Aboriginal organisations, including Aboriginal Medical Services and ACCHOs to embed shared decision making and improve cultural safety. This includes embedding Aboriginal voices on LHD/SHN Boards and providing support and training for Aboriginal people in executive roles across NSW Health.

196. Current governance arrangements across primary and community health make the provision of integrated, multidisciplinary care challenging. Options could include development of health hubs to integrate care provision to respond more effectively to local health care needs and better harness digital solutions. Any proposed model would need to evaluate both service delivery and patient experience.

Innovation in health care delivery

197. NSW Health is consistently harnessing evidence and research to inform health care that responds to the changing health needs of communities. Development is also informed by context, clinician experience and patient perspectives.

198. NSW Health harnesses innovation informed by evidence and research. This ranges from biomedical research through to clinical and health system research right through to population health research. NSW is at the cutting edge of health and medical research, focusing on translating this research into practice and through to commercialisation.

199. There are processes and systems in place to support this development, which is an iterative process and occurs at all levels from within health facilities and LHDs through to statewide models and programs. This allows continuous improvement, the testing and piloting of innovations prior to scaling innovation as needed by the system.

Digital/AI and Personalised care

200. Technology, research and innovation provide significant opportunities that can be leveraged to improve the delivery of safe and effective health care across NSW. This includes harnessing technology to support personalised and predictive care, such as the use of genomics and Artificial Intelligence (**AI**).

201. AI will provide a host of challenges and opportunities. For example, AI could be introduced to improve the efficiency and accuracy of breast screening – of which there are currently in the region of 600,000 undertaken annually.

202. There are processes and systems in place to support this development, which is an iterative process and occurs at all levels from within health facilities and LHDs through to statewide models and programs. NSW Health supports the future development of these new technologies to inform health care delivery and improve patient experience.

Virtual care

203. To improve the patient experience and outcomes, NSW Health has embraced technology to provide virtual care where clinically appropriate, together with hospital avoidance and hospital length of stay minimisation models and are increasingly networking and integrating services to improve equity of access to patients.

204. NSW Health supports the expansion of virtual care models across the continuum of care delivery. Virtual care should not be seen as a substitute, but as an integrated part of health care and the location where virtual care is received does not impact availability of safe care.

Community expectations and health system navigation

205. Community expectations of health care has been influenced by traditional hierarchies of care that almost always lead a patient to seeking healthcare from a

doctor. There are a range of highly skilled professions within the healthcare sector that can provide intervention and care.

206. Continuing to engage the workforce together with patients and consumers in the design and delivery of care is critical. Improving the health literacy of communities is needed so individuals can more effectively manage their own care journey and understand the benefits that new models of care bring.

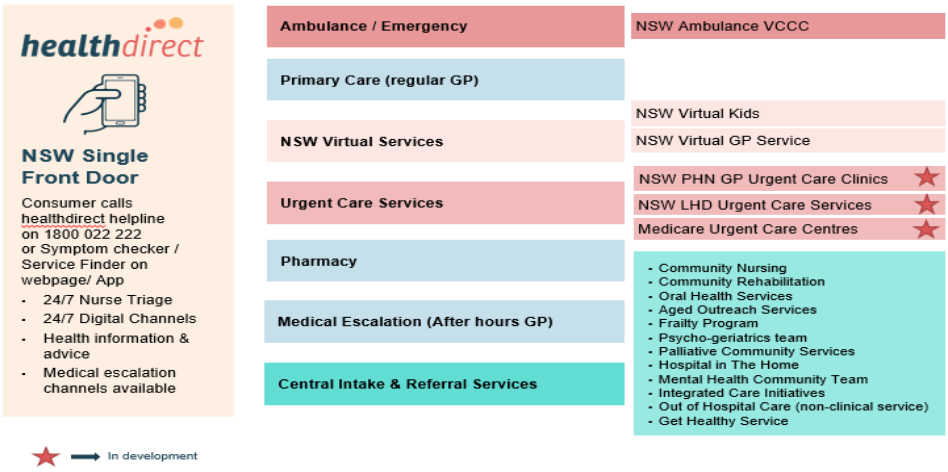
207. There will also need to be more done to support and increase community understanding, navigation and acceptance of digital and virtual services. Work will also be required to support vulnerable cohorts in accessing these services to ensure any inequity is not exacerbated. There should also be an increased focus on securely sharing information across specialities, settings and services to reduce the need for consumers to continually repeat their information and story.

208. There needs to be a greater focus on digital channels of communication between healthcare consumers and the NSW Health system. This includes a particular focus on patient portals and apps aimed at enhanced engagement and empowering patients/consumers to make informed choices about accessing healthcare services in the community.

209. The Single Front Door is a transformational strategy and should be embedded across health services and expanded to capture additional referral pathways. This could include leveraging virtual adult care services which provide statewide virtual emergency department specialist services to the broader community, such as the current virtual rural generalist service model which sees RPAvirtual support Far West LHD.

210. Another area for expansion is the virtual medical specialist pathway, which could see GPs and urgent care networks receiving support for specific specialist conditions such as cardiology, respiratory, geriatrics and women's health.

Figure 11: NSW Health's Single Front Door



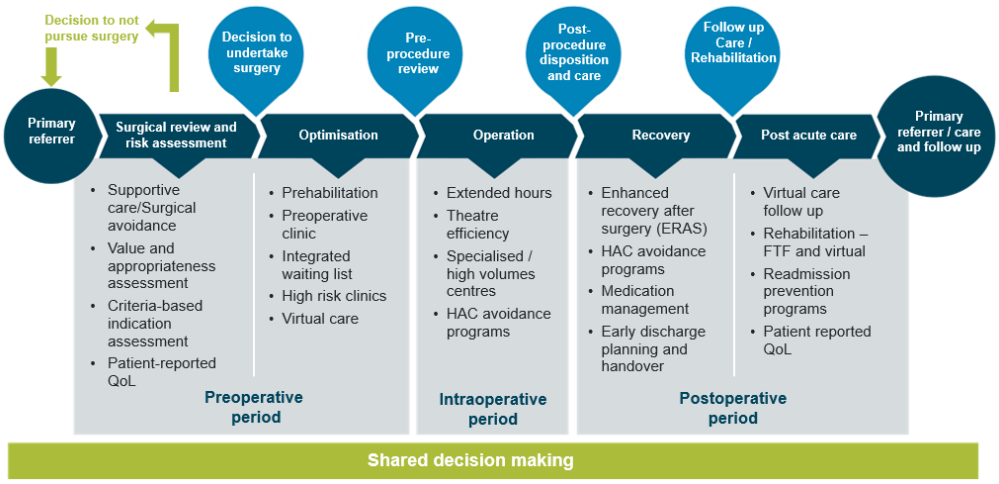
Source: NSW Health, 2023

211. These services must be well integrated with broader health services, including primary care and have agreed assessment and risk stratification tools to ensure acceptance into referred services. These integrated digital systems will also allow embedded pathways for clinicians to ensure patients are referred to the supportive prevention programs they most need to be healthy and well.

Improving surgical care

212. NSW Health is working to integrate care delivery and leverage virtual care to improve efficiency and health outcomes, including greater focus on prevention. For example, surgical care can be improved through changes such as increasing day-only models of care for a broader range of surgical procedures. Shared decision making from the pre-operative through to the post operative period supports better decisions and delivery of high quality care. An application of virtual care for post operative care will also improve efficiency and patient experience, reducing travel times for care and length of stay.

Figure 12: Surgical care opportunities



Source: NSW Health, 2023

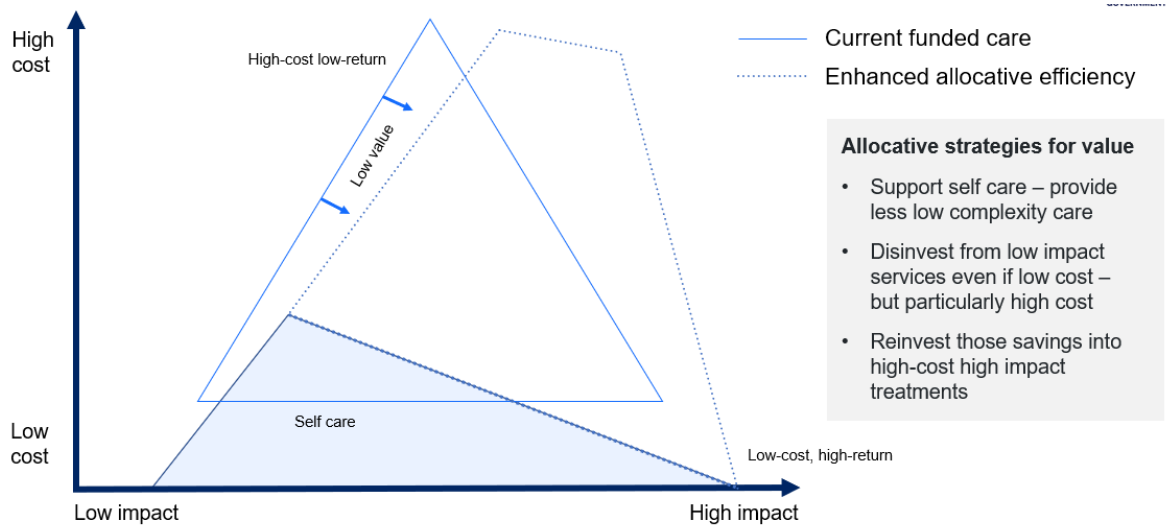
Value based care

213. There needs to be a far greater focus on prioritisation and disinvestment from low value care and further work to reduce futile care. What is meant by value based care is as follows:

- health outcomes that matter to patients;
- experiences of receiving care;
- experiences of providing care; and
- effectiveness and efficiency of care.

214. This approach is supported by a focused effort on ensuring the health system is pursing allocative strategies for value. It requires a more purposeful discussion with the community by all levels of the health system.

Figure 13: Allocative strategies for value



Source: NSW Health, 2023

Aged care and disability care

215. NSW Health has developed 'workarounds' to care for those in RACFs to prevent unnecessary admissions to hospital. These include virtual care and aged care outreach services. These outreach services provide timely access to multi-disciplinary care when a person experiences an acute deterioration in their health. These services provide valuable support to RACFs in supporting the clinical care of residents, however these services should not be used as a substitute for GP and primary care services.

216. A collaborative approach between the state public health system, PHNs and RACFs is needed to successfully implement and deliver these services. There is an opportunity to further scale and embed this model across NSW, however as aged care is the responsibility of the Australian Government, an appropriate funding model needs to be developed.

217. Appropriate disability supports in the community are key to enabling safe timely discharge and reduce likelihood of re-admission. In September 2023, the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability handed down 222 recommendations that will need to be considered.

Single Digital Patient Record Program

218. NSW Health has committed to implementing the SDPR program, which will require a significant whole of system effort to ensure successful delivery and system transformation.

219. This program will transform the digital systems and workflows that NSW public healthcare workers use every day to deliver care. It is a next-generation, integrated patient administration system, electronic medical record and laboratory information management system.

220. The SDPR will provide improved integration with medical devices and other clinical systems, such as NSW Health's Radiology Information System and Picture

Archiving System (RIS-PACS), and the statewide Enterprise Imaging Repository (EIR). The SDPR will also have capability to send electronic discharge summaries and integration with primary care providers

221. The SDPR will provide an opportunity to establish more consistent clinical workflows across the state, supporting more holistic, streamlined care across NSW Health services and care settings. Once implemented, clinicians will be able to securely access the same comprehensive information when and where they need it so patients will have a more seamless care experience.

222. Holistic and integrated data sets from the SDPR will also provide greater information to guide clinical care, service-delivery decisions and efficiencies and inform health policy and resource allocation.

Modernising and standardising shared services

223. At a statewide level, further work should be undertaken to progress standardisation across key shared services such as procurement to improve efficiencies and free up resources to focus on providing direct, value-based health care.

224. There are also opportunities for eHealth NSW to deliver further savings through modernising legacy systems by standardising, consolidating and decommissioning across the current operating model. Additional procurement savings could also be realised through further centralisation of ICT and digital procurement with a focus on core strategic vendors and state-wide platform development strategies.

Linked data and analytics

225. Given the ageing population, increasing comorbidities and workforce challenges, it will be increasingly important to work as one system, engaging effectively with partners, both across governments and with non-government organisations, the private sector and communities. Ensuring equitable access to health care and supporting a healthy and well community requires considerable action outside of Health. To facilitate this, shared accountability and outcomes driven by data and analytics is critical.

226. Improved data requires investment and commitment by both the Commonwealth and the states and territories. NSW has already invested in Lumos to bring together data sets and provide the evidence to evaluate reforms, support joint accountability and inform the development of capitated, blended and other outcome-based payment models. Collaborative investment with the Commonwealth and ideally other states is needed to support Lumos expansion.

227. There are also opportunities to further strengthen linked data with data sources outside of health to better inform funding models and support evaluation of models of care. NSW is supporting the development of the Australian National Data Integration Infrastructure and the National Disability Data Asset, to streamline access to and use of linked Commonwealth and State data to support better health outcomes for people with disability.