New South Wales

Special Commission of Inquiry into Healthcare Funding

Submission Number: 10

Name: Southern NSW Local Health District

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Southern NSW Local Health District

SNSWLHD Ref: 23/11538

Mr Richard Beasley SC
Commissioner
The Special Commission of Inquiry into Healthcare Funding

Southern NSW Local Health District response to the Special Commission of Inquiry into Healthcare Funding

Dear Commissioner Beasley,

Thank you for the opportunity to provide a response to the Special Commission of Inquiry into Healthcare Funding. This is a preliminary response from the Southern NSW Local Health District (the District) highlighting key areas of the Terms of Reference that the District considers most significant.

For context, the District's network of hospitals and community services provides for the residents and tourists that populate 44,534 square kilometres of the State's vast south east and tablelands.

The District encompasses seven local government areas (LGAs) spanning the tablelands to the ACT, the Snowy Mountains, and the far south coast to the Victorian border. It encompasses the Upper Lachlan, Goulburn Mulwaree, Yass Valley, Queanbeyan-Palerang, Eurobodalla, Bega Valley and Snowy Monaro LGAs, and incorporates the traditional lands of five Aboriginal nations of the Gundungurra, Ngunnawal, Ngambri, Ngarigo and Yuin peoples.

As the Inquiry progresses, we welcome the opportunity to provide more detailed information through appropriate channels to support this submission and further address the items of the Terms of Reference specifically.

The focus areas of significance include:

Unrecognised Structural Costs of Funding for Rural/Regional Health Services

The Activity Based Funding (ABF) methodology that underpins the National Health Reform Agreement (NHRA) does not adequately or sustainably cover the costs of delivering services in a geographically diverse and expansive rural and regional setting. The primary driver of budget overruns is the reliance on agency and locum clinical staff. This is due to challenges with recruiting and retaining staff, which is more pronounced in rural and regional healthcare settings relative to urban settings.

The District continues to transition to an employed medical model to permanently recruit to and stabilise the workforce. The medical model maps out by site and by speciality the appropriate skill mix and capability to maintain safe clinical services. The District has costed the medical rosters based on the National Weighted Activity Unit (NWAU) average compared to peer facilities and has identified a significant shortfall in funding required to cover the cost of medical rosters. This particularly relates to the community's service expectations and obligations to provide medical services where there is not enough activity to cover the cost of the medical roster. This also relates to other cost areas including nursing and midwifery, patient transport, diagnostic services and other fixed costs. These factors should be considered and funding reform for rural and regional health districts undertaken to ensure funding of services to align with community expectations.

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Other considerations include:

- Prioritisation of funding for Key Health Worker Accommodation in rural and remote areas to recruit and retain staff.
- Appropriate funding to support major redevelopments, new builds, commissioning and recurrent costs. Community service expectations, election commitments and obligations to provide medical services where there is insufficient activity need to support a financially sustainable service. Additionally, due to the long-term nature of the projects, factors such as increased construction costs, housing affordability and a shortage of trades people, particularly in regional locations, continues to impact unfavourably on the cost of new builds and is not being factored into capital budgets.
- Challenges associated with availability of residential facilities close to home and patient transport requirements. Complexities and resource consumption are also not adequately captured in the ABF model, particularly around long stay patients waiting for residential care or National Disability Insurance Scheme.
- The growing disparity between the National Efficient Price and NSW Health State Efficient Price.

National Agreement to agreed Locum and agency nursing rates

Challenges in recruiting and retaining staff in rural and regional areas is contributing to workforce instability in the District. With significant vacant nursing positions and a reliance on medical locum staff continuing to drive unfavourable financial results. Competition between states and internal competition between Local Health Districts continues to drive up fees and conditions paid for agency staff. The high rates agency staff realise has led to casual and part time staff of the District transitioning their employment to agencies enabling them to earn significantly higher level of income. Additional allowances (eg. inclusion of meals) for agency staff also makes their choice to remain on appointments of permanent nature less attractive. This creates a perception of inequity and additionally contributes to unfavourable financial results. The District requests national and statewide negotiations with medical and nursing agencies for consistent terms, conditions and fees to ensure fair competition across and between the states is undertaken.

Addressing Asset (including Information and Communication Technology) backlog and future requirements

Historically the District has received a low level of funding for minor works and equipment. Over time, this has resulted in a significant backlog of assets for replacement and assets reaching the end of useful life over the next four years. This list includes equipment critical to the safe operation of services that is now approaching end of useful life.

The limited capital investment also affects the lifecycle management of our ICT assets, particularly when large scale previous redevelopment assets fall due. Investment is needed to ensure we minimise disruptions to clinical care and operations as well as mitigating cyber security risks. ICT asset refresh funding is required for assets outside eHealth's remit for the upgrade of phone systems and to provide networks with sufficient bandwidth and redundancy. Funding is also required to support our security systems by providing duress systems and to comply with our obligations to staff safety. Critical projects such as the Single Digital Patient Record (SDPR) are expected to result in an increase in resources and therefore cost to the District during implementation and beyond, however the quantum of the increase is not yet known. Technical uplift activities will also be required and requires further scoping and costing.

Notwithstanding a range of significant challenges, the District has so much to be proud of. Most notably we are so grateful for the continued resilience, innovation and commitment of our staff who have provided care throughout a prolonged period of significant adversity including fires, floods, COVID-19 and staff shortages.

Substantial enhancement in service delivery are being enabled through the utilisation of technology and our commitment to a broad range of service partners continues to strengthen service delivery and capability.

The District welcomes the opportunity to continue the conversation to develop a five year forward plan aimed at agreeing a funding program to prioritise and then address the works identified in the recently completed Strategic Asset Management Plan and Asset Management Plan and also look at long term strategies and investment to ensure digital competence and capability in our health system.

For more information, please contact Chief Executive Margaret Bennett at Margaret.bennett1@health.nsw.gov.au

Yours sincerely,

Beth Hoskins
Board Chair
Southern NSW Local Health District

Margaret Bennett
Chief Executive Officer
Southern NSW Local Health District

31 October 2023