New South Wales

Special Commission of Inquiry into Healthcare Funding

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Submission to the Special Commission of Inquiry into Healthcare Funding

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Thank you for the opportunity to contribute to the Special Commission of Inquiry into Healthcare Funding in my capacity as Greens NSW spokesperson for Health including Mental Health and a Member of the NSW Legislative Council, as well as being informed by my own experiences as a general practitioner based on Wiradjuri Country in Albury. I would be happy to discuss any aspect of this submission further. [redacted]

A. The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future.

Australia lags behind similar OECD countries with its spending on preventive health, as recently reported by *The Lancet Public Health*[1]. Health expenditure in Australia is higher per capita than the OECD average (at $7772 compared to $4561) in 2018-19, but preventive health only accounts for 1.34% of that total compared to an average of 2.8% in OECD countries. The Australian Medical Association has referred to the Australian healthcare system as a "sickcare system[2]." A number of Australian public and preventive health bodies, including the Public Health Association Australia have called for a target of 5% of total government health spending to be allocated to prevention[3]. Some preventive health initiatives are extremely low cost and may even be cost-saving, for example restrictions on advertising of junk food, gambling, alcohol and nicotine products on state infrastructure such as public transport.

Similarly, governments currently under-invest in primary care. Economic analysis commissioned by the Royal Australian College of General Practitioners has demonstrated investment in primary care provides significant long term cost savings through reduced need for secondary and tertiary care as well as improved productivity through a healthier workforce[4]. While there is historic precedent and convention for primary care to be the responsibility of the federal government, and hospitals to be the responsibility of state governments, there are countless examples of state-government funded health programs in the community. Notably, there has been a recent focus by the NSW government on programs intended to reduce presentations to emergency departments that include a number of alternatives to holistic primary care - including urgent care centres and increasing services available through pharmacies, but there are a far smaller number of examples of direct state government investment in primary care services.

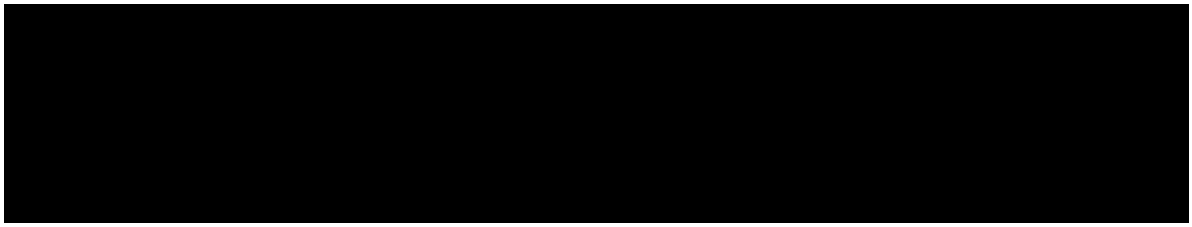
A 2023 review published in the Medical Journal of Australia of financing and policy challenges for Medicare and universal health care in Australia[5] highlighted the successes of Aboriginal community controlled health organisations in providing meaningful improvement in health outcomes for communities through block-funded teams of salaried multi-disciplinary staff. The

review concluded “effective reform that simultaneously reduces fragmentation and improves whole system integration requires that the dominance of fee-for-service payments in the health system be replaced by carefully designed block-funding, capitation, and outcomes-based funding.” The Greens believe that there would be significant benefit, both in health outcomes and long-term cost savings, in providing block-funded primary care services for a number of communities including but not limited to First Nations people, young people, people living with disability, people with chronic complex illness including mental ill-health, people from culturally and linguistically diverse backgrounds, LGBTQIA+ people, and residents of rural and remote areas.

B. The existing governance and accountability structure of NSW Health, including:

i. the balance between central oversight and locally devolved decision making (including the current operating model of Local Health Districts)

The Parliamentary Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales (mental health inquiry), which I am chairing, has heard evidence that critical data necessary to inform workforce planning, such as the number of staff vacancies in community mental health centres, is not centrally aggregated. This raises serious concerns about the effectiveness and efficiency of workforce planning in NSW Health which likely has implications beyond community mental health services.



There is extraordinary inefficiency in Local Health Districts having separate credentialing and onboarding requirements for health workers. In my own experience working between different LHDs I was asked to complete more than 15 hours of unpaid online modules on one occasion for credentialing in workplace basics such as infection control, how to document a patient's allergies, workplace privacy policies and how electronic medical records work. There would be significant benefits for these processes to be centralised, with local updates only required to cover clinically relevant differences in policies or protocols in a different LHD.

ii. the engagement and involvement of local communities in health service development and delivery

The Greens believe that participation by members of the health workforce and the broader community is important to health service planning and decision-making. Mandating the inclusion of local clinicians and community representatives on the governing councils of local health networks is one part of this. Earlier this year, a NSW Parliamentary Inquiry into the NSW government's use and management of consulting services revealed a concerning number of people with links to the "big four" consultancy firms on the boards of Local Health Districts with associated concerns regarding potential conflicts of interest.

iii. how governance structures can support efficient implementation of state-wide reform programs and a balance of system and local level needs and priorities;

Collaborative commissioning between LHDs and federal government-funded Primary Health Networks has the potential to address fragmentation in service provision caused by the state-federal divide in funding.

iv. the impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW

The Greens believe that public funding and management is the most equitable and efficient way to resource and deliver health services, and that providing well-resourced quality public health services is a core government responsibility that should not be outsourced.

The outsourcing of recruitment of locum and temporary medical and nursing staff has resulted in significant additional costs to NSW Health, both directly in terms of the fees paid directly to recruitment agencies [redacted] and indirectly through inefficient placement resulting in higher travel and accommodation costs, deliberate price-gouging by some recruitment agents who are paid commission, and the exacerbation of shortages of permanent staff by agencies who do not permit workers they have placed to accept long-term or subsequent contracts directly with NSW Health. This issue was identified by the 2008 Special Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals which recommended that NSW Health should institute and maintain a centralised register of all doctors available and willing to fill casual shifts or act as locums for specified periods. This recommendation was never implemented. There will always be a need for the mobilisation of locum and temporary health workers even if permanent staffing issues were resolved, for example following disasters.

Presently, different hospitals hire staff through different agencies, so no doctor can see every vacancy and no hospital can see every available doctor. That means that doctor A who lives in region A can be flown to region B, while doctor B who lives in region B is flown

to region A. I have worked at a NSW hospital where two doctors have accidentally been booked to work the same role for the same week and there was no doctor on the following week. Private recruitment agents, some of whom are paid commission, are incentivised to price-gouge hospitals, for example by discouraging staff from accepting placements before the offer of crisis rates.

As examples, I have copies of emails from agents to doctors that include: "I'll let [LHD] know about that date range and we can talk more when there are those crisis rates coming in for those dates" and "I've just gotten the rate approved to go to $3500 [per shift]". I also have a copy of a contract between a recruitment agency and a doctor that states "If within 12 months of your last contact with our Client you are offered further assignments or permanent employment with our Client, its subsidiaries or associated companies, you must negotiate these assignments through us. You acknowledge that if within 12 months of your last contract with our client you enter into a new or extended arrangement with the same client or associated entity of our client otherwise than through [agency] then you shall pay damages to [agency] the fee that [agency] would have received had that new or extended arrangement been arranged through [agency]. Any damages incurred as a result of a breach of this contract [agency] will invoice either you or your incorporated entity payable within 14 days of the days of the date of the invoice."

The mental health inquiry has heard evidence that some LHDs have outsourced their mental health access line to private provider Medibank Services resulting in a poor quality of service.

In addition, outsourcing, even to quality providers, can further fragment services making system navigation more difficult for patients and carers. This risk must be carefully assessed against any benefits of outsourcing, for example to organisations with significant expertise in cultural safety for a particular priority population.

v. how governance structures can support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient-centred care to improve the health of the NSW Population.

As described earlier, the Greens support alternatives to fee-for-service funding of health services and this is particularly urgent for primary care services.

C. The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes for all people across NSW

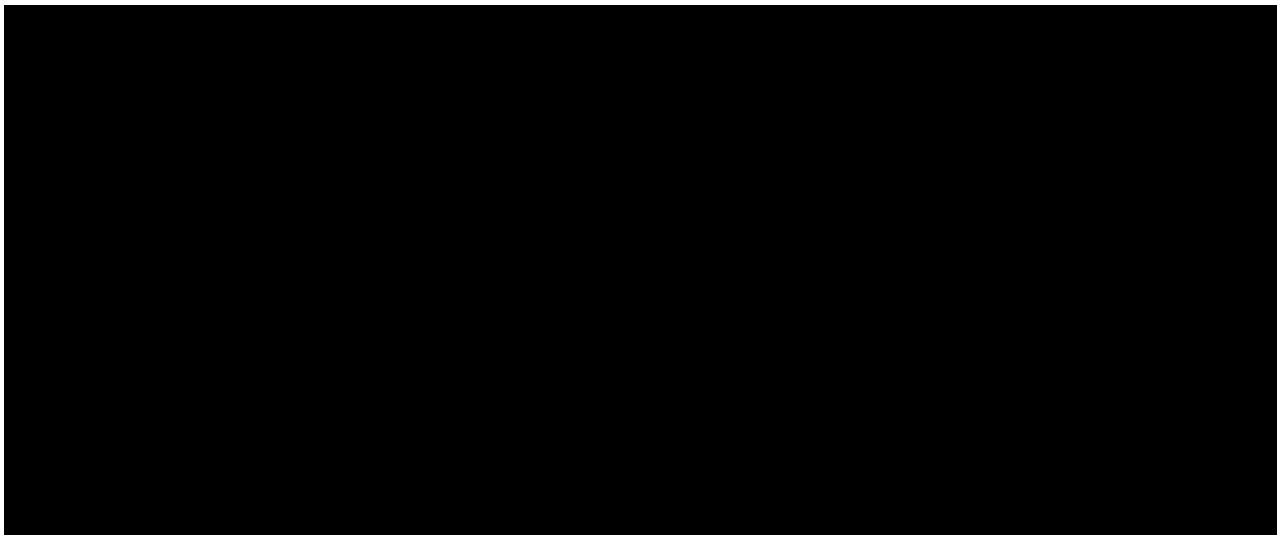
Public dental services in NSW are not adequately resourced to meet community need, with 68,135 people waiting for assessment and treatment in public dental services in NSW as at 30 June 2023[6]. Notably, in Far West LHD only 34% of patients have been waiting less than the maximum recommended waiting time. Untreated dental problems result in patients presenting to emergency departments as well as more serious preventable dental and medical issues.

Evidence submitted to the mental health inquiry has described a system that waits for people to experience a crisis before providing the minimum care required to be able to discharge a person from hospital or community mental health services. This is both detrimental to health outcomes as well as an inefficient use of funding. The inquiry has also heard that people are being placed on restrictive Community Treatment Orders under the *Mental Health Act 2007* for the purpose of enabling access to community services which is a serious concern.

Contraception, abortion and fertility services are essential components of comprehensive reproductive health care. Recent research on the experiences of patients in rural NSW accessing services for unintended pregnancy has recommended mandating publicly funded abortion services to be made available at all public hospitals, including in regional and remote areas[7]. Lack of access to abortion services, whether due to cost, distance or stigma, results in patients seeking abortion at later gestation which may require specialist management in a tertiary setting when medical or surgical abortion may have been able to be safely provided at an earlier gestation in a community or regional setting.

D. Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency;

NSW Health services and programs should be funded and evaluated based on primary outcome measures that are patient and/or community health outcomes. I am aware of a number of instances of NSW Health services or programs being evaluated based on KPIs that are not health outcomes for patients, where the impact of the service or program may actually have a negative impact on health outcomes despite having a positive impact on the outcome being evaluated.



As referred to in part A, the Greens believe that NSW Health should support the provision of primary care services at no out of pocket cost to patients, by exploring health service models including but not limited to block funding models, the Victorian community health centre model and community-controlled health organisations.

While not the responsibility of NSW Health, there is opportunity for the NSW government to improve access to primary care services through a payroll tax exemption for general practitioners in a context where there is largely no public primary care provision in NSW. A majority of medical centres have been set up with a service entity structure where a GP is an independent contractor who collects payment from patients, usually subsidised by Medicare, and then pays a proportion of those fees to the clinic in exchange for services such as IT, reception services and access to shared equipment. Practices were often set up this way so practices could avoid malpractice liabilities. However, clinics have put in place a wide variety of measures to improve patient care, such as shared after-hours rosters and arrangements for doctors to look at incoming test results ordered by their colleagues while they are on holidays. Clinics have also employed other health practitioners, such as nurses, physiotherapists and pharmacists among many others, to work with GPs as part of a multidisciplinary team. This is beneficial for patient care, but measures like this have been assessed in audits as creating employee-like arrangements, and more and more clinics are facing audits that are leaving them with enormous payroll tax bills. As a result, some family medical practices have already been sold to larger corporations, and general practice clinics are receiving advice that they need to restructure their businesses to avoid payroll tax, and that is having disastrous unintended consequences for patients. After-hours rosters, result-checking arrangements and working as part of multidisciplinary teams should be incentivised. The Federal Government's Strengthening Medicare Taskforce is looking to incentivise this kind of teamwork, and penalising employee-like arrangements for GPs by imposing payroll tax is directly at odds with that work.
Skilled paramedics and ambulances are frequently used for patient transport, particularly after hours and in rural and regional areas. This results in decreased availability of paramedics to respond to medical emergencies as well as reduced job satisfaction and burnout for paramedics.

[redacted] Increasing patient transport services to reduce reliance on NSW Ambulance to fill gaps in transport services should be a short-term priority for NSW Health.

E. Opportunities to improve NSW Health procurement process and practice, to enhance support for operational decision-making, service planning and delivery of quality and timely health care, including consideration of supply chain disruptions;

Shortages of essential medicines due to supply chain disruption that were exacerbated by the COVID-19 pandemic have clearly demonstrated the urgent need for domestic manufacturing of essential medicines and vaccines.

F. The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services, including:

i. the distribution of health workers in NSW

The geographical mal-distribution of health workers in NSW is well established. While there have been various worthwhile initiatives for financial incentives for health workers to relocate to rural and regional NSW over the years, it is worth noting that this does not address barriers for health workers to relocate that relate to cultural, family, educational, social, recreational or spiritual needs.

ii. an examination of existing skills shortages

The mental health inquiry has heard evidence regarding skills shortages for psychiatrists as well as nurses with mental health training. In addition, the number of medical practitioners undertaking general practice training is not adequate to meet projected community need (nor current need in many parts of NSW).

The mental health inquiry has heard evidence of extraordinarily inefficient use of the skills of staff employed in community mental health centres who are shouldering unsafe loads of case-management as well as significant administrative responsibilities which limit their ability to provide safe clinical care and use their professional skills to their full scope and therapeutic capacity. The increased use of Clinical Support Officers and peer workers to support and supplement clinicians is one possible urgent solution to address this. It is likely that this would have broader applicability beyond community mental health centres.

iii. evaluating financial and non-financial factors impacting on the retention and attraction of staff

Significant numbers of skilled health professionals, particularly nurses, midwives and paramedics, are leaving NSW Health to work interstate, in other sectors or leaving the profession entirely due to poor pay and conditions in NSW. To improve recruitment and retention of staff, all public sector health care awards in NSW should ensure pay and conditions, at a minimum, with parity with comparable interstate awards.

NSW Health should urgently implement safe shift by shift staffing ratios for nurses and midwives, including guaranteeing appropriate skill mixes, in consultation with the NSW Nurses and Midwives Association. Based on the experiences of other jurisdictions, particularly Victoria and Queensland, this will improve working conditions and retention of nursing and midwifery staff as well as improve patient outcomes and save costs due to shorter length of stay and reduced rates of re-admission[8].

Occupational violence is a significant issue impacting the well-being of NSW Health staff in addition to excessive and unsafe work hours.

iv. existing employment standards

This year, industrial action has been taken by more than one union representing NSW Health employees who clearly feel that they have not been adequately heard or responded to by the NSW government.

v. the role and scope of workforce accreditation and registration
vi. the skill mix, distribution and scope of practice of the health workforce
vii. the use of locums, Visiting Medical Officers, agency staff and other temporary staff arrangements

In addition to the issues addressed earlier regarding the use of private recruitment agencies for temporary and locum health workers, it is common that locum, agency and other temporary staff are offered significantly higher wages than NSW Health staff which is both expensive as well as having a negative impact on morale for permanent staff. I am aware of a number of instances where locum or temporary staff are assigned fewer responsibilities than permanent staff, further exacerbating burnout for permanent staff.

viii. the relationship between NSW Health agencies and medical practitioners

ix. opportunities for an expanded scope of practice for paramedics, community and allied health workers, nurses and/or midwives;

Registered nurses are able to apply for "graduate years" in a number of NSW hospitals that provide a structured pathway to gain experience in a variety of clinical environments, but this is not available in most settings to new enrolled nurses.

Paramedics are not able to train as Intensive Care or Extended Care Paramedics in regional areas, nor retain their advanced skills if they choose to relocate to a rural or regional area.

x. the role of multi-disciplinary community health services in meeting current and future demand and reducing pressure on the hospital system;

This has been discussed earlier.

xi. opportunities and quality of care outcomes in maintaining direct employment arrangements with health workers;

The significant issues caused by the use of recruitment agencies by NSW Health has been discussed earlier.

G. Current education and training programs for specialist clinicians and their sustainability to meet future needs, including:

i. placements;
ii. the way training is offered and overseen (including for internationally trained specialists);
iii. how colleges support and respond to escalating community demand for services;
iv. the engagement between medical colleges and local health districts and speciality health networks;
v. how barriers to workforce expansion can be addressed to increase the supply, accessibility and affordability of specialist clinical services in healthcare workers in NSW;

Medical specialist colleges should provide training that reflects community need, but this is not always the case at present.

A significant number of junior doctors spend years working for NSW Health in unaccredited registrar roles, often in unsafe working conditions particularly with regard to workload, hours and supervision, when some of this time could and should be reasonably accredited by specialist colleges. Where patient load is frequently unsafe this is detrimental to learning as well as an opportunity for NSW Health to employ additional registrars. The extraordinary amount of unpaid overtime being worked by junior doctors has been the subject of recent class action. In addition,

junior doctors frequently face unreasonable barriers to flexible work or job share arrangements which should be supported by NSW Health wherever possible.

The Greens support the work that is being undertaken to provide a single employer model for General Practice registrars with portability of entitlements accrued during hospital-based employment.

The NSW Health staff specialist award has not kept up with equivalent awards in other jurisdictions and as a result many specialist clinicians who train in NSW subsequently take up staff specialist positions interstate.

H. New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation; and

Communication within and between health services in NSW requires urgent improvement. It is a significant risk both to patient safety and patient privacy that a significant amount of information is still being transmitted by fax machine, particularly to and from private general practice clinics. Inadequate communication also frequently results in duplication of services (and subsequent waste of resources), for example repeating investigations because of lack of access to recent results. Despite NSW Health policies and protocols regarding the provision of discharge summaries, it is a common complaint from general practitioners that discharge summaries are not received in a clinically appropriate timeframe and that GPs often see patients for planned follow-up, or because a patient has deteriorated, without access to information about their treatment in hospital.

Emergency responses for mental health in NSW have recently received significant public and media attention, with four fatal interactions between NSW police and a vulnerable person in as many months in 2023. The mental health inquiry has heard evidence from the South Australian Ambulance Service regarding the success of their Mental Health Co-Responder Program, known as MH CORE, which partners specialist mental health clinicians with paramedics to respond to mental health emergencies including risk assessment informed by patient records. This program has been expanded since its initiation to now provide 24/7 coverage in Adelaide due to its success in providing emergency mental health care to patients in the community, reducing transportation to hospital and interactions with police, as well as occupational health and safety for mental health clinicians and paramedics involved with the program. The inquiry has also received evidence regarding the successes of the Mental Health Acute Assessment Team program led by Western Sydney LHD - as of the date of submission it is not clear why this program has not been expanded and replicated in other LHDs.

There has been a significant increase in the provision of digital and telehealth services since the COVID-19 pandemic. There are instances where this is beneficial to support clinicians as well as

offer flexibility for patients who are sometimes able to access care from their own homes - this is particularly beneficial for those with impaired mobility, in rural areas (when internet access is available) or caring responsibilities. However, telehealth and digital services cannot replace face-to-face clinical care and there is a risk that this is done to reduce costs rather than enhance a service. Telehealth and digital services must be used with appropriate protocols in place for patient privacy as well as staff support and not in place of face-to-face clinical care where this would be more appropriate.

Innovation in primary care is limited both by limited research funding compared to tertiary interventions and lack of representative datasets. The Greens support public funding of data collection, data linkage and research to evaluate health interventions and service delivery, particularly for primary care and preventive health.

I. Any other matter reasonably incidental to a matter referred to in paragraphs A to H

Social and environmental determinants of health

Health is affected by physical, mental, cultural and social well-being, as well as the presence of absence of disease or impairment. Individual and population health outcomes are strongly influenced by the social, economic and environmental conditions in which people live and work. Poverty, disadvantage and social inequity must be addressed to improve the health of the whole population.

The climate crisis is an existential threat to global human health and urgent action is required to minimise catastrophic health impacts. Air and water quality must be improved to ensure no adverse impact on human health due to pollution.

Impacts on health should be considered in all decisions at all levels of government across all portfolios. There is a role for local government to be funded for and have an active role in health promotion, education and prevention.

Barriers to health care need to be identified and addressed with specific programs for vulnerable and disadvantaged populations, including: children and the elderly; First Nations peoples; residents of rural and regional areas; people with disability; people with mental illness; culturally and linguistically diverse communities; institutionalised people including people in detention; refugees and asylum seekers; and LGBTQIA+ people.

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