New South Wales

Special Commission of Inquiry into Healthcare Funding

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Name: Mid North Coast Local Health District

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Mid North Coast Local Health District Submission

The Special Commission of Inquiry into Healthcare Funding

NSW GOVERNMENT

Health
Mid North Coast
Local Health District

Introduction

1. This is the Mid North Coast Local Health District (MNCLHD) submission to the NSW Special Commission of Inquiry into Healthcare Funding **(Inquiry).** The MNCLHD submission is intended to provide further context into system wide matters that impact on the financial sustainability and delivery of healthcare in a rural local health district.

2. The MNCLHD submission addresses the following:

   a. MNCLHD – background and context including population, health outcomes, research, partnering and performance

   b. Healthcare workforce

   c. Financial stability and funding cycle

   d. Funding model for population needs

   e. Delayed discharges

   f. Capital infrastructure funding certainty

   g. Regional governance to support innovative healthcare across the care continuum.

A. MNCLHD – background and context including population, health outcomes, research, partnering and performance

3. MNCLHD is located in a beautiful part of Australia, surrounded by rivers, bushland and beaches, 395km north of Sydney and 390km south of Brisbane. The district incorporates five Local Government Areas (LGAs): Port Macquarie-Hastings, Kempsey, Nambucca, Bellingen and Coffs Harbour.

4. MNCLHD acknowledges the traditional custodians of the lands across our District, the Gumbaynggirr, Dunghutti, Birpai and Nganyaywana nations. There are just over 15,000 Aboriginal people living on the Mid North Coast, representing 6.9 per cent of the total population compared to 2.9 per cent for NSW.

5. MNCLHD is committed to improving health outcomes for all Aboriginal people and creating culturally safe healthcare services. Our Aboriginal workforce is at the core of our commitment and represents 5.5 per cent of our total workforce, well above the NSW Aboriginal workforce participation rate of 2.9 per cent.

6. There are a broad range of public health services provided to the community through seven public hospitals and 12 community health centres. There are two major referral hospitals in Mid North Coast, located at Coffs Harbour in the north and at Port Macquarie in the south.

7. MNCLHD provides supra-regional services at our major referral hospitals in Port Macquarie and Coffs Harbour, with these services accessible for residents in the west to Armidale, north to Grafton and to Taree and surrounds in the south. The services include comprehensive Cancer care with both radiation and chemotherapy, interventional cardiology, brain injury services and 24-hour access to surgical care. Public Health services are provided across MNCLHD and Northern NSW Local Health District (NNSWLHD), ensuring a consistent approach for population health in the region.

8. The district has established a Sustainable Healthcare Framework Towards 2030 with a vision to achieve best practice low carbon, low waste, and a climate resilient health system which continues to focus on excellence in people-centred healthcare. This builds on our existing environment sustainability initiatives and will guide the district with achieving less waste and moving towards a net zero healthcare environment.

Population

9. According to the 2021 Census data by Local Government Area (LGA), the MNCLHD population is estimated to be 229,888, with a growth of eight per cent or 17,656 people since the 2016 Census. This represents an average annual growth rate of 1.6 per cent during this period.

10. The largest growth has been in the major regional centres. Port Macquarie has grown by 8,237 people or 10 per cent, with an average annual growth rate of two per cent from 2016 to 2021, above the NSW rate of growth. For Coffs Harbour, there was a growth of 5,818 people or eight percent, with an average annual growth rate of 1.5 per cent. For NSW over the same period, there was an eight per cent growth, with an annual growth rate of 1.5 per cent.

11. The Department of Planning and Environment (DPE) population projections estimate that the MNCLHD population will grow by 0.6 per cent each year from 2018/19 through to 2041. This projected annual population growth rate is slower than that of NSW at 0.9 per cent and well below the rate of growth that the district has experienced between 2016 and 2021.

12. Projected growth is highest for Port Macquarie with an average annual growth rate of 0.8 per cent and Coffs Harbour growing at an average of 0.6 per cent each year from 2018/19 to 2041.

13. While there is higher growth in our larger regional centres, in other communities across the district there is minimal growth projected, with Nambucca estimated to grow at just 0.1 per cent annually from 2018/19 to 2041, Bellingen by 0.2 per cent and Kempsey by 0.3 per cent.

14. Like NSW, the fastest growth is in the 70 years and older age group. The 70 years and older population for MNCLHD, represents the highest proportion of the total population than in any other LHD, with 18 per cent of the MNCLHD population being 70+ in 2019 and climbing to 26 per cent by 2041. By comparison, in 2019 the NSW 70+ population represented 11 per cent of the total population and is expected to be 17 per cent by 2041, the same as MNCLHD 2019 proportion.

15. MNCLHD is also home to a growing culturally diverse population with an estimated 13 per cent of residents born overseas. Coffs Harbour has an increasing number of refugees settling in the area, with the main refugee communities being Afghani, Sudanese, Burmese, Congolese, Togolese, Sierra Leone, Ethiopian, Eritrean and Somali.

Health outcomes

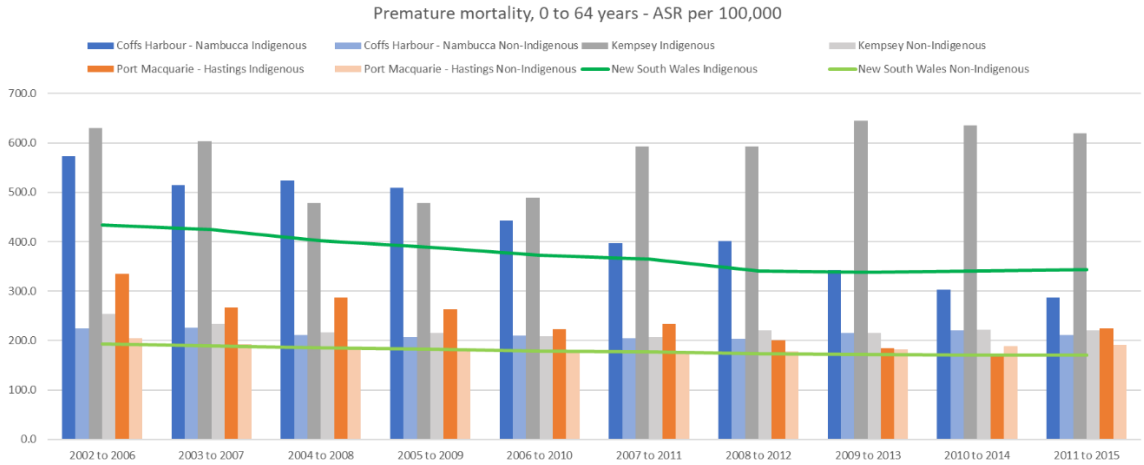
16. MNCLHD residents are living longer, with a life expectancy of 83.1 years for a baby born in 2020 up from 81.3 years in 2010. This is longer than both the UK (81 years) and the USA (76.4 years). Life expectancy for MNCLHD residents is however lower than the 2020 NSW rate of 84.5. MNCLHD residents' life expectancy is also lower than most metropolitan areas.

17. 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. Data is not available for life expectancy for Aboriginal people at the local health district level.

18. Figure 1 below shows the rate of premature mortality in the Mid North Coast, broken up by Indigenous Areas, comparing Indigenous and non-Indigenous population in each of the three local Indigenous areas, and for NSW as a whole. Premature mortality in this case is deaths in people aged 0-64 years, calculated per 100,000 population and can be considered a proxy for life expectancy.

19. The information highlights the challenges in Kempsey Local Government Area, where there is a much higher rate of premature mortality, especially for Aboriginal people, but also for non-Indigenous residents. The rates in this area have not reduced over time and remain well above the NSW rates, which points to the need to rethink and consider a different approach to how we address health needs in this region, where there is considerable disadvantage. The current funding and governance approaches are not supporting the outcomes needed to make a real difference.

Figure 1 – Premature Mortality by Indigenous Areas, MNCLHD



Source: PHIDU - Closing the Gap, Time Series Atlas, Data by Indigenous Area, Published June 2021 release, PHIDU.

20. MNCLHD is home to some of the most disadvantaged communities, as measured by the Socio-Economic Indexes for Areas (SEIFA), Australia. According to the 2021 SEIFA indices, Kempsey is the sixth most disadvantaged community in NSW and Nambucca is the eleventh with all MNCLHD Local Government Areas scoring well below most advantaged communities in NSW. The indices highlight the considerable disadvantage in rural and remote communities compared to those located in major cities.

21. The SEIFA information highlights the decline in Education and Occupation scores for all MNCLHD LGAs. A lower score means that more people in the community are without qualifications, in low skilled occupations, or more people are unemployed, and that there are fewer people with a high level of qualifications or in highly skilled occupations.

22. Lower socioeconomic outcomes and lower educational and occupation levels are linked to poorer health outcomes as is often reflected in the burden of disease and hospitalisation rates. For MNCLHD in 2021/22 the rate of hospitalisation per 100,000

was 11 per cent higher than the NSW rate, with MNCLHD hospitalisation rate being 37,117 compared to 33,422 for NSW.

Table 1. SEIFA Indices by Local Government Area, MNCLHD, 2016 and 2021

Local Government Area	Index of Relative Socio-economic Disadvantage		Index of Relative Socio-economic Advantage and Disadvantage		Index of Economic Resources		Index of Education and Occupation	
Year	2016	2021	2016	2021	2016	2021	2016	2021
Bellingen	966	981	954	960	975	983	990	985
Coffs Harbour	967	972	954	954	974	982	960	953
Nambucca	907	920	896	898	938	946	919	906
Kempsey	888	903	877	881	935	943	891	882
Port Macquarie-Hastings	976	985	958	958	985	991	965	954
Most disadvantaged in NSW (Fairfield)	856	814	896	885	943	937	882	919
2nd most disadvantaged (Brewarrina)	757	818	818	866	768	789	943	917
Most advantaged in NSW (Woollahra)	1115	1110	1165	1176	1056	1043	1191	1193

Research

23. Building evidence of what works to improve outcomes for rural populations is critical and can only be achieved through a comprehensive research program. MNCLHD is an active partner for research across NSW and nationally and is involved in more than $9 million total research funding through the National Health and Research Medical Council, Medical Research Futures Fund and NSW Translational Research Grant Scheme.

24. MNCLHD has active and successful relationships with the four (4) universities: University of New South Wales (UNSW), University of Newcastle (UoN), Southern Cross University (SCU) and Charles Stuart University (CSU), through collaborations in MNCLHD-led research projects and supporting student research such as the UNSW Medical Student's Year 4 Independent Learning Projects and CSU Medical Generalist Student projects. MNCLHD is also involved in collaborations with University of Sydney, along with a range of national research centres.

25. MNCLHD is the only rural LHD in NSW that is a partner of one of the National Health and Medical Research Council (NHMRC) Advanced Health Research Translation Centres. Through this collaboration with NSW Regional Health Partners we are part of a pilot application of health economic analysis seeking to improve investment decisions relating to healthcare expenditure.

26. There is generally a significant underrepresentation of rurally based researchers on Australia's major research advisory and funding bodies, and this tends to be reflected in research funding allocations as outlined below for example:

    a. In 2018 basic science received 45 per cent of NHMRC expenditure, clinical research 31 per cent, public health 13 per cent and health services research 4.4 per cent. Although 30 per cent of the population lives rurally, only 2.4 per cent of NHMRC funding was allocated to research that specifically aimed to deliver health benefits to people in rural Australia.

    b. The Commonwealth Research Support Program (RSP) – bulk of institutions awarded funding are in metropolitan areas.

    c. The NSW Health Medical Research Support Program (MRSP) provides funding to support independent Medical Research Institutes - none of these MRIS are based in rural, regional, remote (with the partial exception of Hunter Medical Research Institute which is located in Newcastle).

d. The NSW Health Prevention Research Support Scheme (PRSP) – bulk of institutions awarded funding are based in metropolitan areas.

e. The NSW Health Translational Research Grants Program commenced in 2015 with the first funding round awarded in 2016. There have been six rounds of funding. Of the 80 grants funded over six rounds, 16 (20%) applications have been awarded to rural, regional and remote LHDs (FW, MNC, M, NNSW, SNSW and WNSW LHDs), equating to just over six million of the $40.6 million awarded in total.

Partnerships

27. As outlined above, MNCLHD has strong partnership with all tertiary education providers in the region in terms of building research capacity to address local health needs. Tertiary partnerships have also evolved with increasing student placements throughout the MNCLHD, supporting real life workforce preparation of the next generation of doctors, nurses, allied health professionals and other health care workers within a regional setting.

28. There were 2,192 student placements at MNCLHD in 2023, which is an increase from 1,993 in 2018 or a seven per cent increase. The largest increase has been for medical students, which is up by 37 per cent. Student placements for nursing have remained stable throughout this period and there continues to be more than 1,000 student nursing placements at MNCLHD each year.

29. MNCLHD has a long-standing formal partnership with Aboriginal Community Controlled Health Organisations (ACCHO) in the Mid North Coast region. The MNC Aboriginal Health Accord partnership agreement was established to achieve optimal health and wellbeing for Aboriginal people on the Mid North Coast with MNCLHD, Durri Aboriginal Corporation Medical Service, Galambila Aboriginal Health Service, Werin Aboriginal Corporation Medical Service and the Healthy North Coast (Primary Health Network) being parties to that formal agreement. A review of the partnership agreement was undertaken in 2023, with all parties confirming the importance of the partnering arrangements and quarterly meetings continuing.

30. A key example of the collaborative work that has been undertaken with one of our Aboriginal Community Controlled Health Organisation partners, is the opening of the Chronic Care Centre in Kempsey that operates from the Kempsey District Hospital. Both MNCLHD and Durri Aboriginal Corporation Medical Service have invested jointly in delivering chronic care to Aboriginal residents in Kempsey and surrounds through this new centre.

31. Partnership with Private Hospitals in the area have continued to strengthen with collaborative care models in place. The Private Hospitals have been an important partner in addressing surgical back-log as a result of COVID. Private Hospitals account for 29 per cent of the market share of healthcare for MNCLHD residents.

32. MNCLHD has partnered with Tresillian to provide a Residential centre at Macksville Hospital, bringing a service for rural families needing a more intensive level of support in their parenting journey.

33. MNCLHD is working to strengthen partnership with local Aged Care Providers in the region and our teams are engaging regularly in discussions on approaches to improve transfer of patient from hospital to aged care facilities.

34. Healthy North Coast (Primary Health Network) and MNCLHD have formal partnering arrangements in place with a joint Board meeting providing a forum for strategic

discussions. The MNCLHD is working with the Primary Health Network to expand primary care alternative pathways to our services. This includes supporting the "Health Connect" and "Urgency Care" models that are funded by the Commonwealth.

MNCLHD Performance

35. MNCLHD had a strong performance history based on the NSW Performance Framework, achieving and maintaining the highest rating of zero from 2011 through to the middle of 2022. MNCLHD has been the only rural local health district to sustain such a positive performance rating for that duration.

36. Historically, the LHD has operated within funding allocation, exceeded service growth targets and compared well to the State efficient price. Over the past two years, matters such as premium labour costs and structural workforce issues have impacted these results.

37. Another key challenge for MNCLHD is the changing demographics with an increasing older population and demand for health services rising above the rate of population growth in the district.

38. MNCLHD emergency departments are among the busiest in the state, with the rate of presentations per 100,000 population being well above the rate for NSW. In 2020/21 the rate for MNCLHD was 56,642 per 100,000 compared to 35,576 in NSW. The rate for MNCLHD has been trending upwards from 2014/15 where the rate was 48,756 which is a 14 per cent increase, well above the population growth.

39. Emergency department presentations across the MNCLHD have increased overall by eight per cent from 2018/19 to 2022/23, with an average annual growth rate of two per cent, once again, above the population growth rate for the district. The biggest increase has been in Port Macquarie, which has experienced a 26 per cent increase for the same period or annual average growth rate of six per cent. For the same period, the total NSW emergency department presentations increased by three per cent.

40. The LHD continues to make progress towards reducing our overdue surgical numbers.

41. Importantly, 92 per cent of consumers of the MNCLHD have recently rated their experience of receiving care at MNCLHD as good or very good.

B. Healthcare workforce

42. MNCLHD is the largest employer on the Mid North Coast, employing just over 4,000 full time equivalents (FTE) in 2023. Total FTE has grown by 18 per cent or 608 FTE since 2018.

43. Pre COVID-19 MNCLHD operated sustainably, experienced growth and over time experienced less difficulty attracting health care workers, as a result of partnerships with local universities in nursing and allied health and partnership with a Go8 university (UNSW) for medical students.

44. MNCLHD has experienced unprecedented challenges in attracting and recruiting nursing staff post the COVID pandemic. The district at present has more than 300 nursing vacancies. This has led to MNCLHD having to for the first time, undertake an overseas recruitment drive targeting nurses, which at the time of this submission, received more than 150 acceptances.

45. To fill the present gaps in nursing, there has been an increase in utilisation of agency nursing staff, which due to demand across the nation, is at a premium cost. In addition, there is also an increase in overtime, as our existing and dedicated nurses rise to the challenge of covering the shortfalls, which is both costly for the local health district and unsustainable for our nursing staff.

46. Structural workforce issues have contributed to a considerable increase in workforce costs. When comparing workforce costs from 2022/23 to 2018/19, the following has occurred:

    a. Nursing agency costs have increased by $5.3 million

    b. Medical agency costs have increased by $1.7 million

    c. Overtime has increased by $7.9 million

    d. Sick leave has increased by $4.4 million

    e. The district is paying $1.5 million more for staff accommodation

    f. All up, workforce structural costs, have increased by an estimated $28 million from $35 million in 2018/19 to $63 million in 2022/23.

47. Another workforce challenge for MNCLHD is the retention of staff, with retention rates declining since 2019. Below are the retention rates for the month ending October for the past six years:

    i. 2019, 92.4%
    ii. 2020, 93%
    iii. 2021, 91.1%
    iv. 2022, 89.1%
    v. 2023, 90.3%
    vi. 2024, 90%

48. Retention rates for nursing staff across MNCLHD has seen a considerable decline from 93 per cent recorded in June 2020 to 89 per cent in June 2023.

49. The district has the second highest assignment of roles classified as hard to fill/critical under the new retention and recruitment funding. Currently the LHD has 27 per cent of its FTE roles defined within these categories. Only Far West Local Health District is higher at 28 per cent. This allowance has been assigned to a range of hard to fill clinical roles. MNCLHD has welcomed the important incentives program.

50. There are many broader social and financial factors that impact on a person's choice to relocate and work in a rural local health district and also to stay. There are concerns around access to schools for children, spouse employment opportunities, isolation and access to services, sports and other entertainment available in metropolitan centres.

51. A particular challenge for MNCLHD is the rising costs of houses in terms of buying and renting. The average median house price in Port Macquarie was $787,000 for the March 2023 quarter and in Coffs Harbour it was $785,000 which is rivalling capital city costs in some parts of Australia. There are challenges with access to short term and long-term housing accommodation for healthcare staff, compounded by low rental vacancy rate, growth in population and competing government projects in the region that increases competition for accommodation.

52. There needs to be state-wide strategies that attract staff to the regions and better negotiation for sustainable financial arrangements with agencies and the contingent labour force.

53. The increasing demand for locums to provide medical coverage not just in NSW but across the nation has directly impacted on the market for these services, with increasing locum rates placing considerable pressure on the healthcare budget. This highlights a need for a national approach and agreement on locum rates to ensure the rural health system can remain sustainable and continue to provide high quality care to the community.

C. Financial stability and funding cycle

54. The MNCLHD is now facing a year-on-year funding cycle that has no capacity for growth.

55. As a result of the current budget cycle, local health districts have limited discretionary funding, which impacts on the ability to fund innovation and restricts ability to expand successful services such as virtual care that have proven to make a difference in addressing local challenges.

56. Having a three-year funding cycle would enable effective planning and partnering, with local health districts having certainty of their funding contributions and flexibility to invest in models of care or programs over a longer timeframe. A three-year funding cycle has been in place in the past and had proven effective in supporting local health districts to respond to local needs.

57. Outlined below are examples of services that have been effective in addressing local needs and without further growth funding, will be challenging to expand:

    a. MNCLHD Virtual Care provides prompt access to early assessment and intervention for patients. The service has a focus on Hospital Prevention (through Virtual Urgent Care), Early Supported Discharge from Hospital, and strong partnerships with NSW Ambulance, who provide Point of Care referrals to the service to prevent the need for hospital transfer which enables a more sustainable health care service.

    b. In 2022/2023, Mid North Coast Virtual Care provided 56,000 occasions of service to more than 10,800 individual patients. This has prevented 6,394 emergency department presentations and has supported 586 patients being discharged home earlier.

    c. The Emergency Mental Health and Acute Addictions Response Team (EMHAART) model provides a multidisciplinary team that aims to see all people who present to the emergency department with a Mental Health and/or Alcohol and other Drugs condition within 30 minutes of arrival, providing culturally led, trauma informed and just restorative care.

    d. Since the commencement of EMHAART in February 2023, more than 2,796 people have accessed the services, resulting in a reduction in the number of people with a mental health and/or alcohol and other drug condition staying in the emergency department for more than 12 hours, with a 50 per cent reduction in October 2023 compared to February 2023 and fewer people staying more than 24 hours in an emergency department. This means, more people are receiving care more promptly in a more appropriate environment. The bed occupancy of our inpatient mental health units has also reduced from around 85-90 per cent down to 70 per cent since the commencement of this service.

58. Another specific challenge for the LHD is the present revenue targets set by NSW Health, which are difficult to achieve given the demographic profile of the MNCLHD population. The LHD has a degree of relative disadvantage, lower than the State average, and has a low level of collection of revenue associated with private patients in our public facilities.

59. Although MNCLHD, although has a population with lower private health insurance coverage, it relies on the private sector to be sustainable and accessible. Increasing gap payments, on top of other cost of living pressures, impacts on affordability of private services, and in particular, access to private outpatient specialists, such as cardiologists often resulting in people not accessing follow-up specialist care. There are increasing calls for the MNCLHD to provide/expand public specialist clinics.

D. Funding model for population needs

60. Activity Based Funding (ABF) has been in place since 2011/12 in NSW and has provided a lot of benefits to the system such as more transparency around funding, reduction in clinical variation and improved service efficiencies. Information and data available is much richer and more useable in the context of understanding complex healthcare inputs, cost structures and clinical outcomes. The introduction of ABF and the evolution of the model has been a good platform, from which the system can build.

61. The ABF model, as a mechanism for funding local health districts based on type and volumes of services provided, is primarily a hospital acute service model and does not effectively consider the broader socio-economic factors impacting healthcare and importantly health outcomes, and perhaps now is the time to build on and strengthen the ABF and broader funding models so that the system can strengthen the alignment between outcomes and throughput.

62. The application of ABF in NSW Health needs some consideration to ensure that LHDs are funded adequately to support innovation, meet community needs and that those LHDs, such as MNCLHD with considerable population disadvantage, receive a fair share of state health budget.

63. The current application of ABF does not adequately align funding with activity with year-on-year budget increases more so aligned with expenditure growth and not true activity growth due to the modelled nature of the application.

64. Now is the time to consider a funding model that supports preventive health, early intervention, more care in the community and changes over the longer term that improve health outcomes.

E. Delayed discharges

65. One of the biggest challenges for MNCLHD is high levels of occupancy in major hospitals at Coffs Harbour and Port Macquarie, impacting on patient flow, timely transfer of patient from the emergency department into a hospital bed, delays in ambulance handovers and delays in access to planned surgical care. The main contributing factor is delayed discharges from the acute facility.

66. Delayed discharges are becoming a considerable issue around the world, with the United Kingdom, Germany, Ireland, Scotland and New Zealand all reporting increasing numbers of delayed discharges, with policy narrative pointing to limited capacity in social care, primary care and aged care as the root cause of delays.

67. A delayed discharge occurs when a patient who is clinically ready for discharge, cannot leave hospital. MNCLHD is experiencing challenges with increasing delayed discharges particularly for aged care patients, patients waiting for support through the National Disability Insurance Scheme (NDIS) and patients who require additional support and primary care access.

68. Present information from the Primary Health Network (PHN) indicates that most of the region has a lower number of General Practitioners than the state average and a bulk billing rate lower than the state average, which leads to poor primary care access.

69. MNCLHD major hospitals have been experiencing bed occupancy rates of 100 per cent or more on a regular basis. Patient flow is most effective when hospitals are at around 85 per cent occupancy. Staying at around 85 per cent occupancy provides a 'surge capacity' that allows emergency departments to transfer patients in busy times and capacity for emergency surgery, without impacting on planned surgery.

70. Contributing population characteristics that impact on delayed discharges include increasing older population, increasing number of people with chronic and complex care needs and several pockets within the community with lower socioeconomic outcomes, along with more people living alone.

71. People living alone, with no support and challenges accessing primary care is a growing concern for MNCLHD. The number of people living alone across MNCLHD has increased by 19 per cent over the 10-year period from 2011 to 2021, with more than 4,000 more people living alone in 2021. There were close to 26,000 lone person households recorded in the 2021 Census, representing around 11 per cent of the MNCLHD population.

72. In terms of Residential Aged Care Facility access, there are currently 34 aged care facilities across the MNCLHD, with 2,902 aged care beds. Of the total beds, 121 or four per cent are offline due to issues relating to workforce shortages, refurbishment or Commission imposed sanctions. At the time of writing this submission, there were 44 aged care beds available for new referrals across the district.

73. The challenge for the district is the lack of information about the type of beds and the inability to plan and match patient needs to the type of beds and capacity available in the Aged Care Facilities. For example, knowing the capacity to accept a resident with dementia or behavioural challenges which is a cohort that tends to stay longer in hospital. Improving this level of information sharing between the sectors would be beneficial for both patients and service providers.

74. Another key issue that impacts on delayed discharges or people re-presenting to hospital, is long waiting times to access the Commonwealth Home Support Program, once client access has been issued. People are not able to access services and support they have been funded for. This is due to limited service providers or workforce challenges for existing providers that impact on the ability to meet the local demand for services.

75. There are also other factors such as hospital-based processes and access to local health district community health services that can impact on delayed discharges. MNCLHD Virtual Care and the Emergency Mental Health and Acute Addictions Response Team (EMHAART) are good examples of programs introduced to alleviate some of the challenges from the local health district perspective.

76. There needs to be more consideration and financial negotiations and contributions from both levels of government on matters that are related to shortfalls in Commonwealth funded Aged Care and NDIS, that flow through to local health districts. There also needs to be financial considerations that acknowledge shortfalls in primary care that impact on Local Health Districts.

F. Capital infrastructure funding certainty

77. MNCLHD has submitted major infrastructure projects as part of the NSW Capital Investment Proposal process for projects that will address critical infrastructure needs for the district. These projects have been assessed as meeting the NSW prioritisation requirements and are included in the 10 Year NSW Capital Infrastructure Plan.

78. Despite projects being included in this NSW 10-year Plan, there is no certainty of funding for these critical projects and no timeline for funding being made available, which limits the district's ability to engage with key stakeholders, particularly our clinical team members on when projects will come online and limits our engagement with our local communities.

79. Although the MNCLHD has a very good volunteer network and considerable community support with donations to our services, such as cancer and maternity units, there are limited opportunities for partnering with large donors to address major infrastructure requirements. Major redevelopment of MNCLHD facilities relies on public monies and therefore more transparency on priorities across the state would be beneficial for planning and engaging with our local communities.

80. MNCLHD has an ageing building profile that will require significant investment in maintenance and in some cases investment in new builds to deliver clinical services required by the community and reflect standard models of care. For MNCLHD, there are 26 buildings over 40 years old. Of these, 10 are over 70 years old and two are over 100 years old. These buildings have significant functional suitability and performance issues which need to be addressed. Many of these buildings are utilised for community health and health support services.

81. Wauchope District Memorial Hospital has several sections that over 30 years old, some areas that are 70 years old, Bellinger River District Hospital (sections that are over 40 years old), Kempsey District Hospital (eight areas that are over 40 years old including one area over 100 years old) and Dorrigo Multi-Purpose Service (two areas over 60 years old) also have significant portions of buildings over 30 years that are not suitable to deliver modern health services and would require significant investment to refurbish them to a suitable standard.

82. The small community hospitals across the MNCLHD play a key role in delivering networked surgical services, sub-acute services and emergency department care, with the exception to Wauchope, which transitioned to an Urgent Care Centre in place of the emergency department. The role of the small community hospital is crucial for communities and supports the MNCLHD with ensuring residents of the district can access their care closer to home and in a more timely manner, while easing the pressure on the major centres.

83. Noting the age of these small community hospitals, infrastructure issues are reaching a critical point, and while throughput is not comparative to the larger regional hospitals, or those in a metropolitan setting, their role is important in a rural setting. Targeted capital investment is needed for small rural hospitals if they are

to continue providing contemporary and safe healthcare for the community and become more digitally enabled and environmentally sustainable facilities.

84. There are sections of the Port Macquarie and Coffs Harbour Base Hospitals that are over 20 years old and require considerable investment to refurbish them to a suitable standard to deliver modern health services into the future. There has been some upgrades at both these sites to address priorities, but further investment is needed, particularly at Port Macquarie.

85. Major Medical Equipment considers individual equipment that is > $250k. Ten per cent of MNCLHD Major Medical Equipment is between 10-15 years old. MNCLHD submitted capital investment proposals for priority replacement of major medical equipment, which was estimated to cost just over $19 million. There has been zero funds allocated for the past two years to this, and likely the same result in this financial year, costing the LHD revenue and leaving the district with unsupported equipment.

86. Maintenance funding levels are typically based on an historical allocation of funding, with adjustments applied each year as appropriate. Further work is required to better quantify maintenance priorities and understand the impacts of current funding on whole of life asset costs and asset performance outcomes. Market rate being approximately 2-3 per cent of total asset value, with MNCLHD operating at just one per cent.

87. MNCLHD has undertaken several projects as part of the NSW Health Asset Renewal Program, but with this coming to an end, with considerable shortfalls, there are considerable risks for MNCLHD with no other funding sources and uncertainty around future funding.

88. MNCLHD Asset Management Plan and the Strategic Asset Management Plan have highlighted the considerable investment required to upgrade and maintain current assets. The district's allocation this financial year was $400,000 for District Minor Works and $1.2 million to be spent on projects deemed important by NSW Health.

89. There are increasing fees and charges from state-wide services such as eHealth and Health Infrastructure taking further investment dollars from local health districts.

90. Having contemporary and safe health care environments supports better therapeutic outcomes for our healthcare consumers and assist with attracting and retaining our health workforce. Having more surety of funding for capital investments to address critical priorities, major medical equipment replacements and ongoing maintenance of facilities and equipment is crucial for rural local health districts particularly as there is limited opportunity to raise substantial funds through community and individual philanthropy.

G. Regional governance to support innovative healthcare across the care continuum

91. MNCLHD recognises the needs for greater collaboration and integration of primary and secondary healthcare and strong links through to tertiary level services to support better outcomes and experiences for our healthcare consumers and their families.

92. The Local Health District and Area Health Service model has been in place for more than 20 years. Likewise, the approach for primary care has not shifted far from the Division of General Practice model. Any structural changes that have occurred in either domain, have continued to result in duplication in some areas, gaps in others and a broader system that remains difficult for consumers to navigate.

93. Responsibility for delivering high quality care and support across the full patient journey as well as keeping people healthy in the community through prevention and early intervention is often blurred and results in considerable overlap, particularly in a regional community.

94. Decisions in the primary care sector have considerable impact on our hospitals, particularly emergency departments, which have traditionally been the doorway to healthcare especially when there are no other affordable options available in the community.

95. When general practitioners close their services over the holiday period, immense pressure is placed on the public hospital emergency departments. In MNCLHD this has for many years been the situation in peak tourism periods where the population is significantly increased.

96. The next phase of healthcare governance and administration would benefit from a different approach that is based on accountability across the continuum of care. This could offer a health care model, where consumers are truly at the centre of decisions throughout their episode of care and not left seeking services funded at different levels of government. An effective governance and accountability model to create, support and maintain the delivery of quality care involving multiple providers across the social and health sectors is critical.

97. There are examples around the world where nations have acknowledged the importance of single source funding which can align both primary and secondary care through strengthened governance and accountability.

98. Perhaps now is the time to consider a governance model that ensures both local health districts and primary health networks are accountable to one authority within the geographical boundaries aligned with natural patient flow and clinical networks.

99. Such a model of governance would support better operational and strategic planning, strategic risk management, workforce planning, along with shared vision and values across organisations, with decision making in the best interest of the whole system.

100. Although goodwill and focus on patient-centric care gets stakeholders to the table, once they have to make decisions about how integration of services will be achieved and commit to funding, challenges arise, often due to different funding authorities and competing priorities.

101. We should be leading the discussion in how the healthcare dollar can be better used to deliver outcomes for communities.

102. We should be engaged across all levels of government to ensure best use of funding and remove duplication and waste.

103. We should be working through these challenges today to ensure the vulnerable communities, people with complex healthcare needs and our future communities have confidence in the health system.

104. We, in collaboration with our communities, need to consider the true value of care and, where appropriate, facilitate the use of lower cost, safe alternatives such as virtual care services.