<u>NSW HEALTH HEALTHCARE FUNDING INQUIRY SUBMISSION 2023</u>
<u>Medical Staff Council</u>
<u>Bankstown Lidcombe Hospital</u>

Chair: Dr Lai Heng Foong
Deputy Chair: Dr Fintan O'Rourke, Dr Catherine Turner
Secretary: Dr Katrina Doyle

Thank you for the opportunity to provide a submission for the NSW Health Healthcare Funding Inquiry, which will look at 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. We have provided responses to some, but not all of the questions asked.

Your sincerely,

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Background
Bankstown is one of the high growth areas in Sydney. In 2016 SWSLHD serviced a population of 964,342. Data from the NSW Department of Planning and Environment shows that the South-West Sydney region will experience average annual population growth of 2.1% between 2011 and 2031. By 2031 the SWSLHD is projected to be servicing a population of 1,284,700 people. South West Sydney has a relatively young population profile, with 21% of residents under 15 years of age and a further (14%) in the 15-24 year age range. The region is experiencing rapid population growth which extends across all LGAs, particularly Camden and Liverpool. High fertility rates (2.03) compared to (1.78) for NSW and new urban development are the major sources of population growth. The older population (65+ years) which is currently relatively small with 126,720 people or (13%) of the whole population will grow by (74%) by 2031 with additional 94,000 people. This demographic transition will put more demand on the health system for care. By LHD, the population growth in SWSLHD is second only to that of neighbouring Western Sydney LHD.

Bankstown is also one of the most diverse suburb in Sydney. The 2011 census showed that one in three people in Bankstown were born in a non-English speaking Country and that one in two speak a language other than English at home.

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);*

There is lack of transparency in the distribution of funding received by the LHD for individual hospitals. For example, our hospital- Bankstown Lidcombe Hospital (BLH)- has consistently functioned with less doctor-patient ratio compared to the tertiary hospital, this ranges from specialist down to junior medical officers (see submission by MSC for the Parliamentary Inquiry on the Provision of healthcare for SWSLHD). There is also

inequitable distribution of staff to hospitals in the LHD. This extends to medical, nursing and allied health staff.

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

Bankstown is one of the most multi-cultural communities in Sydney. Bankstown Lidcombe Hospital has a very active Vietnamese community organisation that raises funds to donate to the hospital to help with the functioning of the hospital e.g. purchase equipment for BLH. Our local workers club – Revesby Workers Club also fundraises for the hospital. They are filling a gap that the state government is not funding. However, it is not possible to fundraise for essential staff. This has to be provided for in the healthcare budget and planned for.

We are often not provided with staff to cover for sick leave, which during the COVID-19 pandemic became even more critical due to the high number of staff sick from COVID-19 itself. The COVID-19 Pandemic exposed the vulnerability of BLH in workforce management. It is credit to the healthcare workers at BLH who put in extra hours and their resilience that we managed during the pandemic. However, it underlined the fact that there must be some redundancies in the staffing to allow for covering sick leave, especially during a pandemic, but also during winter season with seasonal flu.

As we are already short staffed compared to other peer hospitals in Metropolitan Sydney and even compared to our LHD, covering sick leave becomes a significant challenge. Please refer to the Bankstown Lidcombe Hospital MSC submission to the Inquiry on healthcare provision for SWSLHD. Link:

https://www.parliament.nsw.gov.au/lcdocs/submissions/67965/0038%20Bankstown%20Lidcombe%20Hospital%20Medical%20Staff%20Council%20.pdf

Staffing shortage is detrimental to patient safety, and also to staff wellbeing. In our exit interviews in the Emergency Department, one factor for competent doctors to leave the hospital is due to the significant unrostered overtime they have to do, especially to cover sick staff members.

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

During COVID-19 pandemic, the state government introduced a "carousel" system for determining where patients should be brought to by ambulance, depending on the degree of work and surge capacity of each hospital, or the infectiousness of patients. This worked very well in distributing the workload. Unfortunately many of the innovative systems that were stood up during the pandemic were rapidly taken down, without consultation with senior medical staff.

iv. *the impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW;*
There are some innovative strategies that have been utilised by the LHD to optimise efficiency using the private system. An example would be using hotels for patients who are undergoing elective surgery who do not need high level nursing care, to free up beds in the public hospital for more complicated patients. Another successful approach was the use of

medihotels during COVID-19 pandemic to isolate and manage patients who were not so unwell, but with a rapid transfer to public referral hospitals if required. Telehealth (whether public or private) has also been utilised to provide specialist health care to rural and remote regions and as an alternative to Emergency Department (ED) presentations when appropriate to avoid EDs that are already stretched and over-capacity.

v. *how governance structures can support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient-cantered care to improve the health of the NSW population;*
A sustainable workforce can only be achieved when we ensure that all the necessary positions are filled, that we have cover for leave, and some redundancy in case of resignations. It also has to be equitable, which NSW health is not at the moment. While some LHD are full staffed all year, some other hospitals have to scramble for staff when there is sick leave or unexpected absences.

When we have a full complement of staff, we can provide quality care to patients. This will create better job satisfaction, which will in turn maintain wellbeing of staff and make it more likely that staff will stay.

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;**

The division of Federal and State funding makes it difficult to ensure that all the unmet needs in public hospitals and community health are addressed. For example, oversight of Aged care is a Federal responsibility, but in each state there are unmet needs in hospital or community care of the Elderly. The separation of care responsibility makes the system less agile for operational and funding purposes, and also leave it open for mutual blaming when things don’t go the right way.

There needs to be more resources dedicated to preventive care. Currently, less than 2% of the health budget is spent on preventive care (Public Health Association Australia data). Many preventive health interventions are cost-effective, as it can avoid complications and diseases that cost much more to treat. At a time of increasing healthcare cost and decreases in health budgets, investing in preventive health makes financial sense.

The fiscal sustainability of health care system

“Governments have the capability of dealing with fiscal positions over medium and long-term time periods (decades or more), and are not in practice forced to react to results over short cycles (such as 1- or 4-year public reporting periods).
In short, the notion that a fiscal gap in a government health system is ‘unsustainable’ is an artificial construct. Any fiscal gap is itself a product of government choices, and the capability to tolerate a fiscal gap of any given size is also a subjective political choice.”

PHAA Report 2018

Social determinants of health

Any healthcare funding model will need to address the social determinants of health, including education, economy, social and cultural aspects of health.

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;**

Demand-driven health sector expenditure growth currently runs at around 7%.[1] Healthcare funding has not kept up with growing cost of living, population aging with more complexity and a population with increasing burden of mental ill-health and cumulative effects of adverse health impacts from a changing climate.

We have more frequent and severe disasters, including extreme heat, floods and bushfires, all of which put pressure on the health system. Disasters are a threat to the public's health. They cause abrupt increase in illness, injury, or death, destruction of health care infrastructure, displacement of populations, psychological stressors and changes in the environment that could further exacerbate health. All this leads to increasing cost of health care, which healthcare funding planning need to take into consideration.

The Ministry of health and LHDs need to invest in preventive health so that we can reduce the spending on acute care presenting to hospitals.

Over-servicing (the provision of costly illness care where it is not needed), and over-investigations are wasteful and do not contribute to better care for patients. In fact, sometimes less is more. In the Choosing wisely campaign, less investigations turn out to be more beneficial to care of the patient and is also more sustainable. It also helps reduce cost of healthcare.

The current funding model for healthcare, which is based on the simplistic 'cost-constraining' approach to health system funding, places perverse incentives on political decision-makers. These include the following:

• By constantly promoting the theme that expenditure totals must be constrained, the current dialogue crowds out sensible discussion of what may be the best overall model of investment and spending in the health of the community. An example would be the indiscriminate cutting of workforce, which does not take into consideration skill mix and experience, because cutting of staff is easy since the pay is a set amount. This has domino effects on the provision of care to patients, as senior workforce contributes so much more than their pay- including quality control, avoidance of clinical incidences, supervision and training.

• By failing to distinguish between preventive health and wellbeing investments and illness spending, current reporting of financial flows, and debate about such flows, are distorted.

• By pressuring state ministers and financial controllers to simply reduce 'costs' in crude terms of financial outflows, and framing this political objective in a short-term timeframe, decisions are directed towards selecting outflows that can be cut to the greatest quantity, as fast as possible, with the least apparent political adverse reaction. It also does not take into

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[1] Average annual rate of growth in total health expenditure for Australia from 2004-05 to 2014-15 was 6.99% - AIHW health expenditure report 2015-16, Table 2.1.

consideration factors that are not easily quantifiable, such as social cohesiveness, belonging at work, and compassionate care

• By not investing in greater preventive health and wellbeing programs because 'new' spending seems to breach current political imperatives, this short term lack of forward planning might have long-term negative consequences for health systems.

Invest in cost effective interventions such as vaccinations, lifestyle modifications for cardiovascular and respiratory diseases, obesity reduction, active lifestyle promotion, exercise and investment in good antenatal care.

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;**

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;*
Workforce is a major issue that any strategy for sustainability of healthcare system must address. Workforce is the greatest asset for any healthcare system. It takes at least 10 to 12 years to train a doctor up to specialist level and 4 to 5 years to train a nurse or allied health practitioner.

We know that there is a shortage of healthcare practitioners in rural and remote areas. This has to be addressed by increasing incentives to retain workforce.

ii. *an examination of existing skills shortages;*
All medical colleges have data of their trainee numbers and need. NSW health and APHRA should have the number of specialists and the hospital they work at, the number of trainees, safe trainee and specialist to patient ratio and workload. This is easily mapped and should be shared to all specialists, which would help with their recruitment and retention of staff.

iii. *evaluating financial and non-financial factors impacting on the retention and attraction of staff;*
Financial-
- pay more in areas that cannot attract staff
- staff specialist model rather than VMO
- permanent staff rather than locums
- think long term rather than short term

Non-financial
- Schools
- child care
- job opportunities for spouse
- less bureaucracy for IMGs to work there
- set up satellite university campuses for those who like research
- have exit interviews with staff to find out why people are leaving

iv. *existing employment standards;*

v. *the role and scope of workforce accreditation and registration;*

vi. *the skill mix, distribution and scope of practice of the health workforce;*
For Emergency Medicine:
https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Sustaining-our-workforce/Workforce-sustainability

https://acem.org.au/getmedia/451cd2ba-f4d9-405f-90f9-2fbc414e3969/2019-Sustainable-Workforce-Survey-Report-R3

vii. *the use of locums, Visiting Medical Officers, agency staff and other temporary staff arrangements;*
The current healthcare delivery and workforce model is not equitable and necessitates the employment of locums, Visiting Medical Officers (VMOs), agency staff and other temporary staff. This usually increases the cost of healthcare provision. However, in order to maintain safe provision and quality of care, this is expense that has to be budgeted for. Any healthcare funding model will have to incorporate sustainability, equitable distribution of staff into the model

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;*

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

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

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

i. *placements;*
Where a trainee goes for their training is definitely a place where there is inequitable spread, with big quaternary hospitals having a monopoly on trainees. This is where government can pull levers to ensure equitable assignment of trainees in all specialties, such as rotations to rural and remote hospitals, and even in Metropolitan areas, to have trainees in smaller hospitals (where they are most needed). State government should work together with professional medical colleges on this.

ii. *the way training is offered and overseen (including for internationally trained specialists);*
See (i)

iii. *how colleges support and respond to escalating community demand for services;*
See answer to (i). The way medical colleges and state government can respond in an agile manner is to look at number of trainees in each speciality, their needs, equitable distribution,

their preference, and incentives to stay (usually in rural and remote areas such as financial incentives, provision of child care and schools and job opportunities for their partners). The patient satisfaction and alleviation of stress from this arrangement more than make up for the cost of these arrangements, and there is large cost savings in not having to set up these very expensive services in the rural and remote areas.

iv. *the engagement between medical colleges and local health districts and speciality health networks;*

This should be a collaborative effort, with a mix of incentives and compulsory rotations, the latter which is not popular, but can be mitigated by factors listed in (iii)

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;*

Telehealth can be a bridge to lack of specialist services, whether public or private. Provision of transport for certain patients that require very specialised care such as medical or radiation oncology treatment of neurosurgical and cardiothoracic surgery and paying for their spouse to stay

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;**

• Telehealth

• Workforce - Most important is that the health workforce is that healthcare workers are one of the biggest ASSETS for the healthcare system, and should not be reduced F.T.E. and pay, and should not be treated as dispensable.

• Expanding scopes of practice for non medical staff such as Nurse Practitioners and Extended Care paramedics

• Fly-in Fly-out specialists where there is demand

• Collaboration with regional and tertiary centre of care e.g. for medical and radiation oncology and obstetric care

• Training of healthcare staff

• Research hubs in regional areas

• Funding of preventive care

• Building community resilience in disasters, rather than a focus of disaster management on response only

References

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Public Health Association of Australia submission on the Inquiry into the future sustainability of health funding in the ACT, February 23, 2018
https://www.phaa.net.au/documents/item/2651

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https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Sustaining-our-workforce/Workforce-sustainability