Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025

Hearing – 22/08/2025

Supplementary questions

QUESTION 1

How are resources and funding for health care distributed between the Hunter region and the New England region?

ANSWER

Funding and resource distribution between the Hunter and New England regions is determined by a combination of Activity Based Funding (ABF) and block funding mechanisms. ABF allocates funding based on the volume and complexity of services delivered, measured through National Weighted Activity Units and priced at the State Efficient Price. Facilities that meet ABF thresholds receive funding aligned to their activity levels, while smaller hospitals and Multi-Purpose Services that do not meet these thresholds receive block funding.

QUESTION 2

To what extent do patient outcomes for New England residents differ from those living in the Hunter region?

ANSWER

HealthStats NSW produces statistical information about the health of the NSW population, providing insights into a wide range of health determinants and health outcomes.

Detailed data relating to health outcomes in different populations and geographical regions is also available from the Australian Institute of Health and Welfare (AIHW)..

The District's integrated and collaborative network ensures patients move through the system, supported by structured referral pathways and shared clinical services across emergency care, surgery, maternity, paediatrics, cancer, chronic disease management, Aboriginal health, and mental health.

QUESTION 3

How do economies of scale in the Hunter New England Local Health District function and how would this be disrupted by splitting the district?

ANSWER

Hunter New England Local Health District achieves economies of scale by operating as a single, integrated entity across metropolitan, regional, and rural settings. In 2023–24, the District managed $201 million in operational, governance, and administrative costs (excluding staffing) by distributing these expenses across its entire network. This structure allows the District to streamline executive oversight, corporate services, procurement, ICT, and policy compliance, reducing duplication and improving cost-efficiency.

A split would disrupt shared service models, increase administrative complexity and cost, as well as posing additional barriers to timely, safe patient care. District-wide service streams deliver excellent economies of scale, leveraging shared resources and expertise to ensure they reach regional and rural communities. .

QUESTION 4

Your submissions state that creating a new district would require an additional recurrent amount of around $111 million. How was this amount determined? Does this estimate reflect the ongoing annual cost of running a new district, **not** the cost of setting the district up?

ANSWER

Hunter New England Local Health District incurs approximately $201 million annually in centralised operational, governance, and administrative costs. Creating a new local health district would require duplicating these functions, requiring an estimated additional recurrent $111 million in ongoing operating costs. A new District would also require a new Executive Leadership Team and establishment of a Board of Directors.

QUESTION 5

Hunter New England Local Health District's submission states that splitting the district risks 'compromising cultural safety and access for Aboriginal communities'. Can you provide more information on how Aboriginal patients would be affected if the district split?

ANSWER

Hunter New England LHD has highly developed Aboriginal Health governance and services that aligns to best practice measures outlined in NSW Health's *NSW Aboriginal Health Governance, Shared Decision Making and Accountability Framework.* If the District was split, significant time and resources would be required to build comparable duplicated programs and infrastructure in the new District, as well as rebuilding community trust.

QUESTION 6

We have heard that Aboriginal people do not want to leave their hometowns to receive care in a different town where they do not have any connections, particularly for maternity and birthing. How is culturally safe care provided to Aboriginal patients when they are required to travel off Country to access health services in cities like Newcastle and Tamworth?

ANSWER

The District's recently revised Aboriginal Health Unit provides a networked approach, ensuring Aboriginal communities across the District can access culturally safe care and achieve optimal outcomes by connecting them with the necessary services at the right time, in the right place.

The District supports a well-coordinated care response that respects cultural identity and connection to family, connecting patients with Aboriginal staff in larger hospitals, and may include practical support such as arranging transport, securing family accommodation close to treatment facilities, and assisting with Isolated Patients Travel and Accommodation Assistance (IPTAAS) subsidies for travel to specialised healthcare over 100km away.

Maternity services across the John Hunter tiered perinatal network are planned and provided in line with local needs, current and projected birth numbers, and staff availability to ensure pregnant women, including Aboriginal families, receive the right care as close to home as possible.

QUESTION 7

Your submission expressed concern that the split would delay access to specialist care. Would upgrading service capability at Tamworth Hospital, as suggested by some stakeholders, address this concern?

ANSWER

Expanding service capability at Tamworth Hospital would incur significant costs and would also necessitate coordination across local health districts, as the hospital lacks the same level of access to specialists and support systems within the existing mature networks, clinical

streams, and workflows. It may also create artificial boundaries, disrupting integrated pathways and potentially leading to delays in treatment and fragmentation of care.

The existing networked models of care, including maternity services, stroke networks, Aboriginal health, the menopause hub, and many others, rely on the unified structure for their efficacy.

QUESTION 8

Can you provide some data on emergency department presentations at Wee Waa Hospital before and after its opening hours were reduced?

ANSWER

Services at Wee Waa Health Service were temporarily reduced to ensure ongoing safe patient care. Under these temporary arrangements the Wee Waa Health Service emergency department continues to operate from 8:00am until 5:30pm, 7 days a week. Outside of these times, emergency presentations are redirected to Narrabri Hospital. Patients presenting to Wee Waa Health Service who need admission receive inpatient care at Narrabri Hospital or another facility in the District.

In the 12 months prior to the reduction in service hours at Wee Waa (May 2022 – April 2023), Wee Waa Hospital:

- had a total of 1,494 patients present to the ED (avg 4.1 per day)
- admitted a total of 63 patients (average of 0.17 admissions per day)

In the 12 months following the reduction in service hours at Wee Waa (May 2023 – April 2024), Wee Waa Hospital:

- had a total of 978 patients present to the ED (a decrease of 516, and an average of 2.7 per day)
- admitted 2 patients

QUESTION 9

Could you provide more detail on how the current model for the Hunter New England Local Health District promotes staffing retention?

ANSWER

Medical staff have access to training, secondments, and career development opportunities across the District, supported by established internal mobility processes. The locum management unit provides both non-specialist and specialist locum doctor support across all facilities. The District offers multiple support networks for its Junior Medical Officers (JMO) and continues to increase the number of JMOs providing professional development opportunities to complement their medical education through a two-year rotational placements, in metropolitan and regional areas.

The District-wide nursing and midwifery directorate supports the wellbeing and retention of nurses and midwives through established partnerships with clinical streams, networks, and universities. The District has a study-in-place and grow-your-own nursing and midwifery strategy, partnering with affiliated universities to study in place, while being supported in the workplace. The nursing locums portfolio, including the rural relievers, also plays a vital role in supporting workforce sustainability and staff retention across the District strengthening long-term workforce stability.