Special Commission of Inquiry into Healthcare Funding

Statement of Jill Wong

Name:	Jill Wong
Professional address:	PO Box 126 Port Macquarie NSW 2444
Occupation:	District Director Integrated Care, Allied Health and Community Services, Mid North Coast Local Health District

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding (**Inquiry)** as a witness. The statement is true to the best of my knowledge and belief.

2. This statement is provided in response to topics identified by the Inquiry in a letter to the Crown Solicitor's Office dated 14 August 2024 (**MOH.0010.0542.0001**), to the extent that such topics are relevant to my role, and to the Inquiry's letter to the Crown Solicitor's Office dated 22 August 2024 (**MOH.0010.0541.0001**).

A. INTRODUCTION

3. I am the Director Integrated Care, Allied Health and Community Services, Mid North Coast Local Health District (**MNCLHD**). A copy of my curriculum vita is exhibited to this statement (**MOH.0010.0540.0001**).

4. In this role, I provide strategic and operational leadership and governance, across a complex and diverse portfolio, servicing the entire patient continuum. I am strategically, operationally and professionally responsible for the Allied Health professionals operating across MNCLHD, of which 17 of the 23 Allied Health professions are represented.

5. I am also responsible for the integrated health care services and Community Health Services which comprise a multitude of services that operate outside of the acute hospital setting, including Aged Care, Disability Care, Chronic Care, Cancer Care, BreastScreen, Palliative Care, Brain Injury Spinal Rehab and Movement disorders, Community Nursing Services, Child and Family Health Services, Prevention and Response to Violence Abuse and Neglect, Virtual Care including our Mid North Coast Virtual Urgent Care Services, and Patient Transport Services. I am also responsible for managing our partnerships with healthcare providers which are Commonwealth funded services, including primary care services, Aboriginal Medical Services (**AMS**) and the North Coast Primary Health Network (**the PHN**).

B. INTEGRATED CARE

6. Integrated Care involves the provision of seamless, effective, and efficient care that reflects the whole of a person's health needs: from health promotion, prevention through to end of life, across both physical, psychosocial, and mental health, and in partnership with the individual, carers, family members and healthcare providers outside of MNCLHD.

7. There are significant challenges with respect to Commonwealth-funded services, including aged care services and disability care services provided through the National Disability Insurance Scheme (**NDIS**). The Royal Commission into Aged Care Quality and Safety released their final report in March 2021, with 148 recommendations. The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (**Disability Royal Commission**) released their final report in September 2023 with 222 recommendations. These recommendations have identified significant opportunities for the provision of care for people with disability and those who are aged.

8. The provision of Commonwealth funding of aged care and NDIS services is primarily allocated to providers outside the public health system, including private, not for profit or other Non-Government Organisation (**NGO**) operators. Due to the variety of these services, the misalignment between supply and demand, and nature of services provided by NSW Health, there is often either a gap in available and funded service provision or duplication of service provision between these providers and NSW Health.

9. The impact for NSW Health is that our facilities and services provide care to patients who present to our facilities and services, however cannot recoup funding for those with Aged Care Packages, or NDIS packages. For example, if an aged care resident living in a privately funded residential aged care home (**RACH**) presents to the Emergency Department (**ED**) for treatment of a lower acuity illness, that could otherwise have been provided in their RACH, and remains overnight as is often the case, the RACH may not then accept their return for a period of time resulting in the aged care resident becoming a long stay in an acute bed. Accordingly, the resident is occupying a bed that could have otherwise been used for a patient requiring acute medical attention. The resident is then also at risk of greater exposure to hospital acquired infections and deterioration. Meanwhile, the RACH continues receiving funds for the residential bed, which are not able to be recouped by NSW Health.

10. In the Mid North Coast (**MNC**) Region, there are structural barriers to health care, with the varying costs of healthcare, user fees, and the socioeconomic status of our population. There are also historical and cultural factors that influence access to care in both the state funded and commonwealth funded systems including racism, discrimination, colonisation and the ongoing impact on health and wellbeing of our first nations population which is represented at a rate of 7.5% in MNC compared to 3.4% across the rest of NSW, as well as our refugee population at approximately 13%, and our aging population, with those aged 65 years and older represented at a rate of 29.9% in MNC compared to 17.7% across the rest of NSW per the 2021 ABS census.

11. The need for aged care is becoming greater across the state and nation, with growth in demand and the increase in complexity of patients. With 50% of persons over the age of 85 having a cancer diagnosis, the health care complexity with our aged demographic is significant. This is coupled with increased liquidity of the aging population, and high expectations of care. Additionally, the impact of the NDIS foundational tenet of participant choice and control, similar to the Aged Care commitment to participant choice and control, is that there have been instances where discharges from facilities has been further delayed due to patient choice factors, such as being selective in an already very limited provider market regarding supported independent living options.

12. There is an opportunity to consider the whole of community approach to the provision of healthcare in a more efficient and sustainable manner. This requires a shift in our current models of care to a focus on early intervention, prevention, and maximising out of hospital care. It also requires a health education and marketing strategy to shift community expectations around hospitals being the best place for healthcare, and focus on patient outcomes, and out of hospital care.

13. MNCLHD has a high representation of a range of chronic disease compared to the rest of the state and country which further impacts the experiences within MNCLHD. This includes chronic disease across diagnoses of Cancer, Diabetes, Heart Disease, Lung Conditions such as COPD, and Adverse Childhood Experiences.

14. Within the MNCLHD and NSW Health, there is opportunity to invest or re-direct funding to community-based/out of hospital-based services to focus on prevention and admission avoidance services as well as strengthening early discharge supports. There are a range of service models, for example, programs providing rapid responses (within 24 hours) from community-based allied health and nursing services and the capacity to provide person centred, sometimes intensive time-limited (for example- 2 weeks) home-

based clinical intervention, preventing presentation to our EDs and reducing the likelihood of admission as well as supporting a patient to navigate the whole health system to a more sustainable, care pathway in the community setting.

15. The National Health and Medical Research Council Partnership Centre for Health System Sustainability estimates waste and low value care accounts for 30% of all healthcare. In the absence of any ability to inject new funding, it is critical to ensure a far more assertive and system-wide approach to the identification and de-implementation of low value care. This would enable the reallocation and re-direction of scarce fiscal and human resources to preventive health models of care that are proven to be non-inferior in terms of patient outcomes. Key concepts that could be addressed here are the appropriateness, allocative efficiency and non-inferior or comparative effectiveness of care. In this regard, it is critical that the systems adopt a more robust approach informed by health economics to more thoroughly understand the optimal distribution of the health budget and inform the focus of our key performance indicators (**KPIs)** aligning to the health and wellbeing of our community.

(i) NDIS services

16. There has been a transfer of funding to the private sector, away from state block funding or into the State's budget generally, following the roll out of NDIS in NSW. For disability related services, the transfer of the funding has not necessarily resulted in the movement of associated clinical care because patients will often need to present through the "front door" of NSW Health services. This reliance on NSW Health is for inpatient as well as outpatient services, for example support with assessment and diagnosis (for example, from speech pathology and occupational therapy) to enable eligible participants to access the NDIS or for ongoing therapy due to thin private provider markets in many parts of our District.

17. An example of the increasing stress experienced by Local Health Districts (**LHDs**) related to this, is when existing NDIS participants are presenting to facilities due to a breakdown in supports from the service provider and/or mismanagement by the funded care providers, leading to NSW Health being a default service provider. This creates tensions between health staff, providers, and the National Disability Insurance Agency (**NDIA**), often has negative impacts for the NDIS participant, and contrasts with the very nature of the statement of policy calling for an integrated approach.

18. The impact of this accepted default provider notion results in care being delivered in the wrong setting (NSW Health settings), at a higher cost, and prevents access for people who have acute health needs requiring acute hospital beds, or clinical requirements needing community based or out of hospital services. Furthermore, health staff, particularly Allied Health clinicians, absorb the brunt of this market failure and/or NDIA processing delays. In this scenario, the NSW Health staff become default specialist clinicians being expected to undertake onerous and time intensive assessments and report writing, a pre-requisite to build a new NDIA plan, to facilitate discharge from hospital above and beyond their other core responsibilities.

19. These pressures may heighten the risk of burnout to health staff as a NDIA plan reassessment is dependent on discharge related assessments undertaken by health services. There is an expectation that NSW Health staff prioritise these assessments to support timely discharge, which provides potential inequity of care, or rationing of care to other admitted patients. A key risk to safe discharge is ensuring the availability of an appropriate and skilled workforce to support a participant in a community setting. However, approximately 25% of NDIS participants medically ready for discharge remain in acute facilities for longer than necessary because supports were not immediately able to be sourced. This is one of many examples that occur on a regular basis within MNCLHD, where there are limited to no options that support the participant to be adequately cared for in the community, and the burden of hospital discharge assessments, reporting and case management is significant.

(ii) Supported independent living and RACH

20. There is also substantial market failure in the provision of supported independent living and RACH, resulting in significant access issues. MNCLHD has an aged population, with 29.9% of our population over the age of 65, compared to 17.7% nationally. At any one time, we can have 20 to 30 patients, who are medically cleared (not requiring any active medical intervention) in acute hospitals, waiting for a placement in RACH or a supported independent living home.

21. Across the MNC, there are 35 different private RACHs and one Multi-Purpose Service (**MPS**), which is managed by MNCLHD. Patients of MNCLHD requiring admission into supported independent living accommodation and RACH often remain in our hospital facilities for lengthy periods of time despite being medically cleared for discharge, because they are unable to access a placement. There are a number of patients who have remained in our facilities for in excess of 200 days after they have been medically

cleared for discharge and are no longer requiring hospital based medical treatment. In addition to limited available accommodation, a range of other factors cause delays, including the patient's access to personal funds in order to co-contribute to placements, family support, guardianship issues and transportation issues.

22. In addition to the limited availability of RACHs, there are different admission criteria, bed types and capacities for different cohorts. This is also impacted by geography and demographics. Accordingly, competing cohorts are trying to access these facilities in a supply and demand scenario where demand exceeds supply. Many of our higher acuity patients awaiting discharge from MNCLHD's facilities are overlooked by the residential facilities in favour of lower acuity residents transitioning from independent living. We regularly have conversations with facilities who say they have beds available but are choosing people moving from their own home with manageable health conditions rather than higher acuity patients who require additional resources, such as patients with dementia. Whilst there is a variation in the funding models for RACHs through the Australian National Aged Care Classification (**AN-ACC**) funding scheme, each facility makes decisions based on their business model, bed mix, patient cohort and staffing profile.

23. There are also community expectations to keep our ageing population in their homes and out of hospitals and aged care facilities for longer. The challenge is ongoing because often these patients will suddenly deteriorate and will need urgent admission into an aged care facility, when bed availability is sparse. In order to meet these community expectations, funding models need to better recognise the need to invest in community-based models of care that are align with expectations. These community-based models of care are also often more efficient and avoid the hospital acquired complications and clinical deterioration that often occur once older people are admitted to hospital as inpatients.

24. In my view, it would be desirable if aged care service providers were required, or incentivised via funding model revisions, to prioritise a proportion of their bed capacity to higher acuity patients/patients referred from acute facilities. This would increase the availability of hospital beds for patients whose presenting issues clinically require hospital care.

(iii) Opportunities

25. Management of commonwealth and state funding streams is always going to be a challenge. While aged care and disability reform is currently underway following the respective Royal Commissions at a federal level, there are opportunities to improve clarity on expectations, standardisation and accountability relating to what is expected at a state and federal level, how our services interact, and how we best support our community through their various healthcare journeys.

26. Private services have a large market hold, with seemingly greater capacity in metropolitan areas. However, in more regional locations, there is increasing market failure in relation to the provision of NDIS and aged care services. This comes from a range of factors, limited supply, recruitment and retention barriers, and contextual factors such as limitations in accessible and affordable accommodation and housing, access to childcare, schools, and proximity to work for partners of health care employees.

C. ASSESMENT PLANNING AND DELIVERY OF INTEGRATED CARE

27. MNCLHD has identified a significant gap in the primary care landscape, particularly in Bowraville. Bowraville has higher rates of chronic illness and lower socioeconomic factors compared to the national averages. As such, MNCLHD has funded an accredited General Practice, which has an exemption from the Commonwealth under section 19(2) of the *Health Insurance Act 1973*. The intent is to provide a free and accessible primary health care service in Bowraville, and to reduce the burden on secondary health services through the facilitation of options to create access to care in the right place at the right time.

28. We have established a Chronic Care Program in Kempsey in partnership with the Durri Aboriginal Corporation Medical Service (**Durri AMS**) and the PHN. Kempsey has a high Aboriginal population, and the partnership was established to improve the delivery of healthcare services to Aboriginal people. There has been active partnership with Durri AMS and the PHN to ensure that there is proactive collaboration, engagement in a number of community engagement programs focused on health and wellbeing, as well as regular clinical meetings to coordinate clinical care for shared patients and their families. It has taken time and work to reduce structural and systemic barriers arising through various funding streams across MNCLHD, AMS and PHN to work cohesively for our community.

29. While we have the largest number of GPs in our footprint comparatively, we also have lowest accessibility to GPs. Anecdotally, it appears the lack of accessibility is related to

hours of operation and a low proportion of bulk billing practices impacting affordability for low socio-economic patients. Many of these patients will ultimately present to local EDs for low acuity care that could have been more effectively and efficiently managed in the primary care environment. Since the establishment of MNC Virtual Care, a service that provides clinical care through virtual technology including virtual urgent care early supported discharge, and care navigation, we have seen a significant number of presentations through this service as an alternative for presentation to our EDs.

30. MNC Virtual Care provides prompt access to early assessment and intervention for patients. The service has a focus on hospital prevention (i.e. providing appropriate clinical care through Virtual Urgent Care), care navigation and early supported discharge from hospital. MNC Virtual Care has also established strong novel partnerships with NSW Ambulance with inaugural statewide protocols, to enable Paramedics to provide point of care referrals to the MNC Virtual Care Service, preventing and promoting connection to appropriate care in the appropriate place, at the appropriate time, and reducing the need for unnecessary transfer to EDs by emergency services which enables a more sustainable health care service.

31. In 2023/2024, MNC Virtual Care provided Virtual Care Services to 7204 unique patients, with 4463 avoided ED visits, 959 hospital admissions prevented, 1409 patients being discharged from hospital earlier and 283 direct referrals from NSW Ambulance point of care. This service provision equates to a conservative cost avoidance of $11,401,494.

D. WORKFORCE CHALLENGES

32. The Allied Health workforce in NSW Health is a diverse group of university-trained clinicians who provide patient centred care by assessing, diagnosing and treating a range of conditions across the lifespan. They also contribute to patient well-being by providing psychosocial support, health promotion, advocacy and ensuring safe and enabling environments. NSW Health employs Allied Health staff across 23 different professional groups, and MNCLHD employees 17 of those professional groups.

33. In MNCLHD, Allied Health clinicians work across a range of acute and chronic conditions and in areas such as aged care, palliative care, mental health, drug and alcohol, prevention and response to violence abuse and neglect, child and family health and early developmental services.

34. Presently the Commonwealth Department of Health and Aged Care is undertaking a National Allied Health Workforce Strategy, acknowledging the significant shortage of Allied Health professionals in Australia.

35. Across the Allied Health Workforce in MNCLHD, there has been growth of 22% since 2019, and the total workforce for MNCLHD has grown by 44%. In 2019 Allied Health represented 11.62% of the overall workforce profile, and as of 30 June 2024, Allied Health represents 9.7% of the overall workforce with 409.70 Full-time Equivalent (**FTE**) staff. MNCLHD has observed a different trend to all other Rural Regional LHDs in the last 12 months, with a 3.3% growth in Allied Health compared to an average of 12.6% across Rural Regional LHDs and an average of 9.1% growth across the state. There has been specific and dedicated funding investment into Allied Health over the past couple of years, particularly with the priorities for End of Life Care, Last 1000 Days of life, First 2000 Days of life, and Prevention and Response to Violence Abuse and Neglect, Mental Health and Alcohol and Other Drugs. The focus for Allied Health in many LHDs, including MNCLHD, however, remains on acute services to provide treatment, therapy, rehabilitation and discharge supports, although there has only been limited growth in the inpatient Allied Health workforce.

(i) Recruitment and Retention challenges

36. During COVID, the MNCLHD Allied Health did not experience the same changes in retention rate that was experienced by Nursing FTE roles. Since June 2019 retention rates for Allied Health staff was just under 93% and in June 2024 this retention rate sits at 92%. During the intervening years retention rates for Allied Health professions was greater than 90%.

37. Some of the recruitment challenges that the Allied Health workforce face are related to the diversity of the Allied Health workforce, including the availability of small, but critical professions. There is also limited strength and breadth of the Allied Health workforce pipeline, from students to new graduates, early career opportunities, through to retaining experience senior clinicians.

38. There is significant competition for Allied Health professionals in the local MNC market driven by health demand, primarily from consumers (children and adults) with NDIS packages. This makes it difficult to attract and recruit clinicians, particularly senior clinicians to MNCLHD, where wages are lower, there is less earning potential and less flexibility. Attracting Allied Health professionals to the Mid North Coast is further

compounded by access to affordable housing, access to childcare and access to schooling.

39. The primary professions which are challenging to recruit for in MNCLHD are Occupational Therapy, Speech Pathology, Radiography, Sonography, Radiation Therapy, Social Work and Psychology. Our primary competition for the ongoing employment of graduates is private practice where these professionals have the opportunity to work independently or work in the aged care or NDIS sector. Clinical Psychologists in particular are able to work in far more lucrative private practice arrangements under Medicare arrangements.

40. MNCLHD is also increasingly seeing practitioners with 2-4 years post graduate experience applying for senior roles at our facilities who have minimal clinical skillset or supervisor experience to meet the minimum requirements of the role per the NSW Health Professionals Award. The practitioners are applying for these more senior roles because of the salary gap between entry level clinical roles and their current private practice remuneration. I believe there is an opportunity to better prepare these practitioners in relation to the specific requirements of NSW Health so they may more readily enter our workforce. There are also opportunities to develop new graduate programs across multiple professions to strengthen the Allied Health workforce pipeline and attraction to MNCLHD and NSW Health more broadly. Some of these opportunities include the establishment of Allied Health clinical educators, greater clinical placement rotations, greater access to Continuing Professional Development, and increased commitment to new graduate positions, career opportunities for progression and structures that support the growth and progression to senior Allied Health positions.

(ii) Queensland border challenges

41. The cross-border impacts for MNCLHD exist primarily through the salary variance between NSW Allied Health Awards and the Queensland Health Practitioners and Dental Officers (Queensland Health) Certified Agreement (Award). Compared to NSW Health, the Queensland Health Award has a higher salary for Allied Health of all grades (start at approx. $6,000 higher for graduates). Queensland Health also offers remuneration incentives for Allied Health clinicians to supervise students, undertake further higher education studies and study leave.

42. I understand that the Queensland Government has committed to undertake a review of the Health Professionals (Allied Health) Staffing Model to ensure effectiveness and

efficiency of a service's resource supply against service demand to balance workloads and achieve safe, high quality service delivery. This is an opportunity for NSW to consider, or apply, particularly in the context of a nation-wide shortage of Allied Health Professionals and current cross-border workforce considerations. Additionally, Queensland has a statewide agreement in place for physiotherapy and dietetic professions whereby universities provide payment for placements in order to increase access to student placements within public health services. Through the Enterprise Bargaining agreement, Queensland also has funding for the Clinical Education Workload Management Initiative (**CEWMI**), providing the equivalent of 139 FTE Allied Health professionals to enhance the delivery of clinical education within Queensland Health.

43. Opportunities for NSW Health to support recruitment and retention of the Allied Health profession should focus on developing and strengthening the workforce pipeline from students to experienced clinicians. This includes providing a more coordinated structure for universities to operate in with regards to student clinical placements, similar to the Queensland model. Also, the creation and support for new graduate positions and programs across multiple Allied Health professions (similar to nursing and medicine graduate programs) and resources of Allied Health student supervisor and educator roles.

44. This is built up into the Nursing and Midwifery models, with an average of 1 Clinical Nurse/Midwife educator for every 43 Registered Nursing FTE, however Allied Health have 1 Clinical Allied Health Educator for every 420 Allied Health FTE. This ratio is further impacted by the variation across each Allied Health discipline and the unique requirements for each Allied Health profession, from registration, competencies, professional development, practice endorsement, training pathways, accreditation, clinical placement hours. Consideration also should be given to the unique requirements and supports needed for rural and regional Allied Health clinician attraction and retention as well as building regional student placements. We can see from experience that those who have positive experiences in a rural regional setting are more likely to return to work in a rural regional setting.

E. EDUCATION AND TRAINING

45. MNCLHD hosts a range of different Allied Health students studying a variety of courses across the recognised Allied Health professions in addition to Allied Health Assistants. Those courses have a range of different requirements and placement specifications. For example, some courses might require their students to undertake work experience one

day per week across a semester and others might require intensive work experience over the course of a few weeks. MNCLHD offers placements to students from a number of tertiary organisations, including but not limited to Southern Cross University, Charles Sturt University, TAFE, the University of NSW, and University of Sydney. As stated, each Allied Health discipline has unique requirements across the qualification and clinical placement process.

46. MNCLHD has strong partnerships with all universities within the region and supports clinical placements across Allied Health disciplines to assist with building and supporting a new graduate pipeline in the local area. The current open market for universities engaging in student clinical placements, and competition from private providers to support their workforce pipeline, contributes to local challenges. MNCLHD also does not offer a formalised Allied Health New Graduate program or specific New Graduate positions in Allied Health, which exist in other professions. This can impact the attractiveness of our Allied Health roles which are suitable for graduates and early career clinicians in the current competitive recruitment market.

47. Within the MNCLHD, Allied Health does not have distinct or dedicated representatives to facilitate or coordinate clinical placements as compared to other professional groups, such as nursing and midwifery. Therefore, the delivery of training is locally devolved, and local plans are implemented to ensure they align with university requirements. The Directors of Allied Health across NSW come together to ensure we can share innovation, strategy, and opportunity to collaborate, support, and implement pathways that are applicable to each LHD's unique requirements.

48. Limited funding of placements impacts the ability of MNCLHD to host students, which in turn impacts the ability of our LHD to manage our workforce pipeline and compete with private partners for the employment of this workforce. There is considerable diversity in this area. Some universities fund placements for some professions (for example, physiotherapy), whereas other universities may provide benefits or incentives for the students such as paid accommodation. Private organisations provide different incentives to both the universities and the students.

49. MNCLHD is not able to compete with private practices in relation to certain types of incentives. Some of the private practices incentivise students by employing them in an assistant or administrative capacity while also signing off on their clinical placement requirements. This is attractive to many students as it enables them to earn an income while studying during clinical placements, and many of these providers will offer them

ongoing, guaranteed employment before they graduate which is not available within the MNCLHD.

F. SERVICE CHALLENGES: LANDSCAPE FACTORS RELATING TO ALLIED HEALTH

50. Children and families within the MNC experience significantly higher disadvantage and vulnerabilities compared with most other LHDs. According to the Australia Early Development Census (**AEDC**) scores, MNC has the third lowest proportion of children who are developmentally on track and third highest proportion of children with one and/or two areas of developmental vulnerability. The AEDC scores have deteriorated in MNC and NSW more broadly. They are considered an important measure for understanding areas of disadvantage, and future issues in children and families and need for early intervention services, including Allied Health. This was one of the contributing factors for the significant multi-agency funding commitment and investment in the Brighter Beginnings Services at a NSW State level.

G. OPPORTUNITIES FOR INNOVATION AND REFORM

51. There are many opportunities for innovation and reform, particularly to address workforce shortages that exist in rural and remote areas. There is scope to utilise telehealth and virtual care technologies to better distribute our limited resources and to leverage off our larger workforce in metropolitan areas to provide outreach.

52. There are also opportunities to partner with educators at universities and other LHDs to discuss how we can share resources and enhance student experience by increasing their exposure to virtual care and telehealth during their study. We are in early conversations with other rural LHDs to discuss these opportunities.

53. There is appetite from the community and clinicians for the provision of clinical care virtually and to embed this as part of our normal practice and as a modality of clinical care rather than as additional or supplementary. This would involve the shifting of community expectations and aligning our practice with the provision of remote care. Current funding models are not fully aligned with these strategic aspirations

54. There are opportunities to invest more in hospital admission and presentation avoidance initiatives. There are a range of initiatives that have had success in LHDs across the state, including Allied Health ED models (for example, RAID-ED from Western Sydney LHD) and early discharge community supports such as the Allied Health Quick Access Response Team (**QuART**) which was developed in Illawarra Shoalhaven LHD). Other

successful strategies include expanding Hospital and Rehabilitation in the Home (**HITH** and **RITH**) to support patient discharge.

55. One of our services at MNCLHD that has been able to successfully reduce hospital presentations and admissions is an urgent care service, MNC Virtual Care. MNC Virtual Care, which provides urgent clinical care to our community, accepts referrals from acute care and supports early discharge from acute hospitals, reducing avoidable emergency presentations and admissions. However, It is a balancing act to utilise technology and utilise staff in innovative ways, while also managing the difficulties to the funding of these services as well as manage the rapidly evolving technology outpacing the existing policies procedures and guidelines, to enable us to deliver clinical care in new and novel ways.

56. MNCLHD originally expected uptake of virtual and telehealth services, such as MNC Virtual Care, would be limited to areas where there are limited transport options in rural and regional areas. However, we have seen an even spread in uptake across the LHD, including in major towns such as Port Macquarie and Coffs Harbour. Data collected and analysed by MNCLHD clearly demonstrates that these services are contributing to high quality patient centred care and contributing to avoidance of ED presentations and significant cost avoidance. We have also received positive patient reported outcomes and satisfaction rates, with 96% of our patients reporting their services as good or very good, and 92% of patients stating they would use the service again. Current funding allocation for virtual care is the limiting factor in our ability to expand these services.

57. There are opportunities to shift the focus and understanding on the value of multi-disciplinary clinical care models and structures within NSW Health systems. This would require commitment to marketing and celebrating the value proposition and recognising value of all clinicians contributing to health systems. Presently, the NSW health systems are still reliant on high-cost medical models, and reliance of nursing as 'backbone of care'. This has a direct impact to Allied Health resourcing, ability to fulfil best patient care, and the whole cycle of workforce sustainability.

58. There are new opportunities for Allied Health to further contribute to addressing the MNCLHD's, and the broader NSW Health system's, challenges and become more of the 'backbone of care' together with doctors and nurses by implementing and enhancing Allied Health models of secondary prevention, hospital avoidance, treatment in emergency departments, early discharge supports and enhanced community-based care. This is supported by evidence of the lower cost, high quality care provided by Allied

Health, including multidisciplinary team and transdisciplinary ways of working, particularly in regional and rural health. This is difficult to achieve due to current under-resourcing of Allied Health in many areas and competition for limited resources which is also influenced by the industrial landscape.

59. There are opportunities to consider the reporting obligations, and return on investment (**ROI**) considerations in the devolved system within NSW Health, as when new funding packages are delivered by NSW Health to the LHD, the FTE and funding does not cover the medium-to-longer term ROI, and LHDs are left making value decisions in terms of shuffling small parcels of FTE to fit in with ever changing political cycles, priorities, challenging industrial environment and community expectations. One comes at the expense of others. This comes back to the difficult operational decision making to prioritise inpatient care, where our current metrics and KPIs are aligned, with system and consumer expectations that de-promote integrated, preventative, and outpatient care.

Jill Wong

6 September 2024

Witness: Brooke White

6 September 2024