Special Commission of Inquiry into Healthcare Funding

Statement of Richard Nankervis and Dr Alison Koschel

Name: Richard Nankervis

Occupation: Chief Executive Officer

Name: Dr Alison Koschel

Occupation: Executive Manager Populations, Access and Performance

1. This statement sets out the evidence that we are prepared to give to the Special Commission of Inquiry into Healthcare Funding as a witness.
2. The statement is true to the best of our knowledge and belief

A. Role of Richard Nankervis

3. Richard Nankervis is the Chief Executive Officer **(CEO)** of HNECC Limited (ABN: 51604341362) which operates the Hunter New England Central Coast Primary Health Network **(HNECCPHN).** He has been in this position since 1 July 2015.
4. Richard is CEO lead of the Australian Primary Health Network **(PHN)** Commissioning Review and is the CEO lead for the development of PHN engagement with Allied Health and for the development of the PHN support for ex-service personnel.
5. He is also the founding Director on the Board of the Centre of Innovation in Regional Health and a member of the Commonwealth and NSW Mental Health Bilateral Meeting.
6. Richard has previously worked in a range of clinical, management and divisional roles at the Central Coast Local Heal District **(CCLHD)**. He was also previously the CEO of the Central Coast Medicare Local.
7. Annexed hereto and marked **"A"** is a copy of Richard's current CV.

B. Role of Dr Alison Koschel

8. Dr Koschel is the Executive Manager Populations, Access and Performance at HNECCPHN.
9. Between 2017 and 2022, Dr Koschel was the Senior Manager Population Health Planning and Data at the Murrumbidgee Primary Health Network.
10. Dr Koschel has also worked in a range of clinical roles in Emergency Medicine and Neurosurgery. She has qualifications in epidemiology, biostatistics, nursing and health promotion. Annexed hereto and marked **"B"** is a copy of Dr Koschel's current CV.

C. The HNECCPHN

11. The HNECCPHN is a not-for-profit organisation funded by the Commonwealth Government to improve access to and the efficiency and effectiveness of the primary health system in the Hunter New England Local Health District **(HNELHD)** and CCLHD. The HNECCPHN incorporates 23 Local Government Areas within the HNELHD and CCLHD and covers areas from the Queensland border in the north, to Gosford in the south, to Narrabri, Moree and Gunnedah in the west, and to Taree on the east coast. The HNECCPHN works with the HNELHD and CCLHD as well as various organisations, such as general practices and Aboriginal Community Controlled Health Organisations (**ACCHOS)** to deliver integrated primary healthcare services.

D. Workforce Challenges

12. One of the key challenges in the HNELHD and CCLHD regions is workforce shortages in primary healthcare. For example, one in four general practices have a staff turnover of more than 20% each year and there are insufficient General Practitioners **(GPs)** available to fill vacancies. The GP career pathway is becoming less attractive to younger clinicians as they value a greater work/life balance, and they do not want to work 38 to 40 hours each week in general practice as well as providing services in the local hospital. Further, graduates are not attracted to buying into a general practice and running a business in addition to providing

clinical services. This impacts on succession in general practices as when practice owners retire, there are few GPs who are willing to take over those practices.

13. As a result of workforce shortages in primary healthcare, there has been a decline in the number of sustainable and viable general practices and allied health practices within the HNELHD and CCLHD regions. Through in-depth surveying of 215 general practices as a component of the Sustainability and Viability Initiative (**SAVI**), the HNECCPHN is aware that only one in two general practices are showing signs of financial viability and one in six general practices are operating at a quarterly financial loss.
14. A decline in general practices and allied health practices can adversely impact the wider community. For example, when a general practice in Glen Innes closed, around 600 patients did not have a GP. As a result, patients were required to travel to another town to see a GP. Whilst there, those patients may also attend to other matters, such as shopping, which means that revenue leaks out of Glen Innes. This can lead to a decline of other services in the area and shrinkage of rural towns.
15. These workforce challenges are exacerbated in smaller communities which can sometimes only have between one or a few GPs providing services. In these practices, there are a limited number of GPs to supervise registrars which means that either no registrars train in the area and there is no succession to fill vacancies or if a registrar does train in the area, it is significant burden on the GP supervising. The HNECCPHN is also aware that there are a number of GP registrars who are not willing to live and work in rural areas long-term which impacts on the ability to fill GP vacancies.
16. These workforce challenges also contribute to GP Visiting Medical Officer **(VMO)** issues as well as issues with aged care facility coverage, because local GPs are often providing coverage to these patients and facilities and often out of usual business hours after they have completed patient caseloads in their practices.

17. As a result of these workforce challenges, in the HNELHD, International Medical Graduates **(IMGs)** are heavily relied upon to provide primary healthcare services. From its general practice annual surveying, the HNECCPHN is aware that 60% to 80% of GPs in HNELHD local government areas are IMGs. Although IMGs are a valuable backbone in the provision of primary care, there is additional work required to ensure IMGs can provide effective and efficient primary healthcare services in Australia. Such work may include ensuring IMGs know about the region, the role of the HNELHD and HNECCPHN, how to make referrals and the correct assessment criteria for local acute and primary care services. This information is provided by the partnered work of HNECC PHN and both LHDs through the Health Pathways system and through partnered electronic referral initiatives.

E. Funding Issues

18. The HNECCPHN is aware that there are financial constraints on the NSW Ministry of Health and Commonwealth Governments (Department of Health and Aged Care) due to budgets which have been tightened in recent years, particularly for the NSW Government. As a result, the amount of funding the HNELHD and CCLHD can provide for integrated healthcare is constrained. HNECCPHN and the local health districts **(LHDs)** provide co-resourcing toward integrated acute and primary care services through formal partnership and service agreement processes. The impact of reduced LHD funding, is that there is reduced funding for such services. This includes telehealth-enabled specialist and GP models of care in regional and rural areas, and specialist models of care working in and with GPs and primary care multidisciplinary teams.

19. In our view, Activity Based Funding **(ABF)** does not effectively align with integrated care and other models the HNECCPHN is seeking to test to address workforce shortages. The ABF model impacts the resourcing that LHDs are able to contribute to integrated acute and primary care services. It also acts as a disincentive for some LHD acute services to promote and refer to primary care services options. Examples of this include partnered acute and

primary care services in general practices, telehealth-enabled services close to patient homes, and urgent care services operating in primary care. The reason for this is that the ABF is primarily volume-based.

20. The HNECCPHN believes that effective service and workforce planning would be based on a needs assessment of the community so that the allocation of resources reflects this need. It would also assist if funding allocation from the Commonwealth Department of Health and Aged Care to Primary Health Networks, and from the NSW Ministry of Health to LHDs was more flexible as it would enable the HNECCPHN to commission services where they are most needed.
21. Although there is a lack of resources for primary healthcare services in the HNELHD region, such as access to primary health care services there are some limited opportunities to ensure effective and efficient healthcare is provided to patients in regional and rural areas working with the funding available. For example, the HNECCPHN believes that a greater focus on telehealth would assist in providing greater access to services and support for patients in rural and regional areas at a lower cost. Current funding models are based on historical ways of delivering healthcare, through face-to-face services delivered in general practice or allied health clinics and there needs to be greater innovation to ensure funding available is allocated to where it is needed most and where it can be delivered in a non-traditional way that meets the community needs utilising digital health to assist practitioner delivery.
22. The HNECCPHN believes that resource planning should also be from a ground-up approach as each regional and rural area is unique and has its own specific needs and issues. As such, the HNECCPHN has strengthened its partnership with Local Health Districts to establish a joint needs assessment, this is evidenced by a joint strategic needs assessment (**JSNA**) with The PHN and the Central Coast LHD. The JSNA's purpose is to ensure funding is allocated effectively and services are integrated between primary care and the acute sector.

F. Relationship with the HNELHD and CCLHD

23. The HNECCPHN has a structured and formalised relationship with the HNELHD and CCLHD. For example, the HNECCPHN has formalised agreements with the HNELHD and CCLHD regarding resourcing and workforce planning. The Chief Executives of HNELHD and CCLHD are both on the Board of the HNECCPHN and the Executive Team of the HNELHD, CCLHD and HNECCPHN work closely together to identify issues and potential initiatives to address issues. One example of the positive results of this partnership is the Diabetes Alliance whereby communities and primary care health professionals have benefitted from having improved access to Diabetes Educators and Specialists and the latest treatment modalities through combined education delivered by both the HNELHD and the PHN.

G. Possible Solutions

24. The HNECCPHN believes the Single Employer Model **(the Model)** has been effective. In 2023, the HNECCPHN and the HNELHD recommended to the Ministry of Health that the Model be adopted in this region and provided a business case outlining the benefits. As a result, four to five registrar positions were assigned to the HNELHD under the Model and the HNECCPHN facilitated those registrars to work in various general practices. This Model enables greater workforce flexibility as clinicians and allied health workers can work across various sites, such as in a hospital or in general practice, based on the needs of the community. The model does not currently include allied health or nursing, however HNECCPHN and HNELHD are currently exploring opportunities for it to do so. The Model may also assist in attracting and retaining staff as it not only enables staff to work across multiple sites to develop various skills, but it also enables them to retain their employment entitlements with one employer. This may assist in keeping GP registrars engaged in the GP training program which in turn could assist in addressing GP workforce shortages.

25. It may also be beneficial to establish jointly funded positions to enable clinicians, nurses and allied health workers to work across different sites. For example, a nurse position could be jointly funded by the HNELHD and the HNECCPHN so that the nurse provides services both at the hospital and in general practice which addresses the needs of both the HNELHD and HNECCPHN. We are currently trialling this model with nurse practitioners who work across different aged care facilities, and it appears to be positive in ensuring coverage of services. The HNECCPHN believes it is best placed to facilitate the establishment of such positions as we can enter partnerships with the HNELHD, ACCHOs and general practices.
26. Partnerships between the HNELHD, HNECCPHN and other organisations can also assist in addressing workforce issues. For example, the HNECCPHN is currently leading a partnership with the University of New England and the HNELHD to establish and operate the Glen Innes Health Hub which will offer multidisciplinary services to enhance access to primary health care services to the community.
27. To address succession issues in general practices in regional and rural areas, the HNECCPHN facilitates various initiatives to attract and retain staff. For example, the HNECCPHN provides grants to assist clinicians to relocate to an area and to provide additional support, such as facilitating social engagement, to support clinicians to settle into an area. In our view, if clinicians receive support and have a positive experience in an area, they are more inclined to stay and work in that area. The welcome ambassador initiative of HNECCPHN has demonstrated this. Another example is the small towns engagement model of HNECCPHN, which funds and coordinates co-location of primary care GP, allied health and/or nursing services. One example of this is Spring Ridge where a pharmacist and GP, providing telehealth and regular face to face services every six weeks, are now co-located. This is the first GP service in more than 30 years in this town. Further, the HNECCPHN provides support for GPs during times of disaster, such as bushfires or floods, to ensure they can continue to provide services both during and after the disaster. This includes coordination of GP

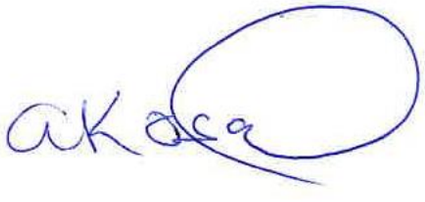
coverage, small grants to practices to rectify urgent issues, and provision of urgent equipment to practices.

28. The HNECCPHN also works with the HNELHD and Rural Doctors Network on effective succession planning in primary healthcare services. We meet monthly to discuss issues such as imminent practice closure and workforce resourcing and collaborate to address issues. For example, six to nine months ago, we established the 'GP Viability Assessment' to obtain a better understanding of general practices' finances and to determine how to address workforce shortages. Our aim is to be more proactive to succession planning. The GP SAVI of HNECCPHN assesses general practice financial, workforce and operational viability, and provides a detailed assessment of viability risk. HNECCPHN's support is including business analytic support, funding for practice manager training, and business and financial coaching.

Signature: 

Name: Richard Nankervis

Date: 16 September 2024



Signature:

Name: Dr Alison Koschel

Date: 16 September 2024