Special Commission of Inquiry into Healthcare Funding

Statement of Luke Sloane

Name:	Luke Sloane
Professional address:	1 Reserve Road, St Leonards, New South Wales
Occupation:	Deputy Secretary, Rural and Regional Health, NSW Health

1. This statement 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. I have previously provided a statement to this Inquiry dated 9 April 2024 (**MOH.9999.0979.0001**). This statement should be read in conjunction with my first statement.

A. REGIONAL HEALTH WORKFORCE ATTRACTION AND RETENTION

3. An individual's choice of where to work depends on numerous factors including their own personal arrangements, family arrangements or otherwise. NSW Health cannot force people to train or work somewhere they do not want to. NSW Health continues to implement a variety of different solutions aimed to address some of the factors which influence an employee's decision to train and work in regional areas.

4. Supporting people to train and complete workplace placements in rural and regional areas can positively influence where people choose to live and work in the medium to longer term.

5. Workforce data shows around 30%[1] of people who train in regional and rural areas will stay and continue to work in those areas. Even for those who choose to train in regional areas, if they intend to specialise, it can take up to ten years to complete their training before they return to their place of their origin[2].

[1] Independent Evaluation of the Rural Health Multidisciplinary Training Program Summary of Final Report to the Commonwealth Department of Health. (2020). Available at: https://www.health.gov.au/sites/default/files/2023-03/evaluation-of-the-rural-health-multidisciplinary-training-rhmt-program_1.pdf

[2] McGrail, M.R., O'Sullivan, B.G. & Russell, D.J. Rural training pathways: the return rate of doctors to work in the same region as their basic medical training. *Hum Resour Health* **16**, 56 (2018). https://doi.org/10.1186/s12960-018-0323-7

6. Attracting people to move to regional areas using financial incentives to address a critical need has had limited success. Whilst there may be initial success with financial incentives, it is only one component of successful attraction and retention strategies.

7. Isolation is a factor for those working in rural and remote areas and can affect where people chose to work, particularly for those who are a sole practitioner in the area or region. These sole practitioner roles are not appropriate for new graduates and require the practitioner to be appropriately trained, skilled and experienced.

8. International recruitment is not a guaranteed pipeline to address workforce issues regionally, however this strategy has been utilised and has proved effective due to visa conditions requiring the completion of specific regional postings or periods of work in regional areas.

9. Social and community bonds to an area can increase the prospect of someone choosing to remain in a regional area. Community concierge services and community connect programs are examples of initiatives that can be used to increase an employee's connection to an area and increase the chance they will stay. There is currently a mix of both local health district led programs, and those run by local councils and other organisations within communities.

10. These programs are designed to help attract new staff moving to the region by providing a range of support during their relocation. This can include assistance with travel, accommodation, childcare, work for family members, and social and cultural support.

11. The Welcome Experience, run by the NSW Department of Primary Industries and Regional Development, aims to attract, prepare, and welcome essential workers (which includes government and non-government in the health industry) to regional, rural and remote NSW. The program includes community building, welcome support, and collaboration with local community groups to foster social links.

12. In August 2024, the Welcome Experience program was expanded beyond the eight pilot locations, with the service to now operate in 52 Local Government Areas across regional NSW.

13. All regional local health districts provide a range of additional localised welcome initiatives to support staff relocating to regional areas. Some examples of these programs are outlined below.

a. Medical Settlement Concierge in Hunter New England Local Health District - this position provides support through recruitment and settlement to all medical officers and their families, including overseas trained doctors. The support person is based regionally to assist.

b. The Recruitment and Retention Concierge in Murrumbidgee Local Health District - this program was initially designed to deliver support to new staff relocating to settle into the various locations across the District. This support included regular communication during the recruitment phase, arranging transport, flights and accommodation, handling the arrival and relocation process, including picking candidates up from transport venues (airports/train stations) and transporting to prearranged accommodation. This is combined with local council welcome strategies across Murrumbidgee Local Health District.

c. The Candidate Experience Team Northern NSW Local Health District performs a similar role, focused on both Australian and overseas recruitment.

14. Availability of accommodation is another significant factor influencing an employee's choice to relocate, and it is therefore important that there is suitable accommodation available. Regional local health districts have accommodation allowances for people who are relocating to regional areas to support them to become established in the community. The type of accommodation required is varied, from studio apartments to attract short term individual workers, through to houses that can accommodate whole families on a temporary basis to facilitate relocation and provide them with somewhere to live until they find more permanent dwellings.

15. NSW Health is continuing to roll out the Key Health Worker Accommodation Program. This program aims to increase access to accommodation across rural and regional areas by supplying suitable, and varied, as mentioned above, accommodation for the regional health workforce.

16. Funding of $200.1 million was allocated in the 2024-25 budget and it is anticipated the program will secure a further 120 dwellings during this budget period.

17. Several key health worker accommodation sites have been completed or are underway across five regional local health districts as part of previous investment (Far West, Hunter New England, Murrumbidgee, Southern NSW and Western NSW).

18. Prioritisation is occurring now for future accommodation needs across regional local health districts.

B. OTHER MEASURES TO ATTRACT AND SUPPORT WORKFORCE

Virtual supports

19. There have been some initiatives to address the workload and isolation concerns in rural and remote areas to make them more attractive places to work. This includes availability of virtual support to reduce the burden that on-call commitments place on general practitioners (**GP**s) where the commitments are shared between low numbers of doctors. Virtual supports also assist with coverage for gaps in rosters.

20. In NSW Health's experience, virtual supports are most effective in rural and remote areas when they include an in-person, face-to-face component. An example of this is the Virtual Care Rural Generalist Service (**VRGS**) developed by Western NSW Local Health District. A component of the VRGS recruitment includes a proportion of time spent in the physical clinical environment of the small hospitals VRGS supports. The face-to-face component of the VRGS is advantageous as it provides clinicians with good context of the community and facilities as well as providing an opportunity to build relationships with staff where they are providing support virtually.

21. Another example is the Telestroke Service, which provides rapid virtual access to specialist stroke diagnosis and treatment across NSW. Through the rollout of the service, metropolitan staff have attended sites and developed an understanding and trusted connection with staff supporting the virtual services in the small hospitals. This relationship of trust and understanding improves the provision of the virtual services.

22. Use of these models and the clinical collaboration they provide, has been reported by staff to increase support and provide skills development that would otherwise not exist, and supports the workforce in the smaller health care settings.

23. Collaboration between agencies on initiatives to attract and retain staff is necessary and is something that NSW Health is already undertaking. Regional local health districts work closely with local councils, using community welcome initiatives and accommodation support to attract and improve the experience of those who are considering the move to a regional location.

Community engagement

24. A barrier to introducing new models of care in regional and rural areas is community resistance to the implications of those new models, which can be somewhat mitigated with good engagement and communication. For example, there may be a number of small facilities in a region that are close together, which results in a duplication of services. There is a financial impact in keeping two facilities open with limited benefit to the community, due to the proximity of other facilities that provide the same services. This situation can also mean that the workforce in some of these facilities can face difficulties maintaining their skills due to low presentations and volumes of activity.

25. Robust community engagement and appropriate evidence form the foundations for a conversation about what the future of health care looks like in their area.

26. In moving towards new and improved models of care, it is essential that there is a joint understanding and engagement with community, local groups and local councils and Members of Parliament.

27. As part of the Future Health *Strategic Framework* (**SCI.0001.0011.0001**) Strategic Outcome 2, the Regional Health Division is leading a program of work to better understand and improve how NSW Health consults with communities. This includes consultation for new models of care, new capital builds and delivery of healthcare, and as mentioned above robust conversations about the future of health care, and the best ways to develop gold standard future proof models.

28. Some examples of the areas where NSW Health is working with regional local health districts and other NSW Government agencies include strengthening local health committees, the Shared Understanding Project, and the roll out of Collaborative Care projects.

29. Regarding Local Health Committees, the Ministry of Health, Agency for Clinical Innovation and the Clinical Excellence Commission are continuing work to strengthen local health committees across all regional local health districts, which I have set out in my first statement at [86] to [89].

30. The *Strengthening local health committees in regional NSW* report was published in February 2023 (**MOH.0010.0685.0001**) in response to recommendation 42 of the NSW Parliamentary Inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW (**Rural Health Inquiry**). Recommendation

42 identified the need to review, reinvigorate and promote the role of Local Health Committees to ensure genuine community consultation on local health and hospital services outcomes, and health services planning.

31. Five guiding principles were developed to strengthen community engagement through local health committees. The five guiding principles are: Commitment to community, Collaborative partnerships, Committee led action, Committee members are advocates for healthy communities, a culture of learning and improvement.

32. The Regional Health Division has supported regional local health districts with implementation of the guiding principles since publication of the report, aligned to priority four of the NSW Regional Health Strategic Plan 2022-2032 (**MOH.0001.0372.0001**), *"Keep communities informed, build engagement and seek feedback".*

33. Outlined in this document are considerations for all local health districts on how local health district boards, executives and senior managers, and local health committee coordinators should connect with and develop key relationships with local health committees.

34. The Regional Health Division has worked in partnership with regional local health districts, the Experience team in the Ministry of Health, the Agency of Clinical Innovation and the Clinical Excellence Commission to action three initiatives to enhance and support enhanced engagement with local health committees, including; hosting a Community of Practice and masterclass series to support capability development across regional local health districts, co-design of a best practice toolkit and resource hub to support maturity across regional local health districts, and further support engagement with regional local health districts to advocate for and promote the activities of local health committees in their respective communities.

35. In addition, the Ministry of Health is undertaking a Shared Understanding Project to improve communication with the community, and foster a shared understanding about why healthcare delivery is changing and what safe, appropriate and sustainable healthcare looks like now and in the future.

36. Finally, the success of the Collaborative Care approach highlights the importance of communities and their centrality when finding healthcare improvements and solutions for their own towns. In my first statement, I have detailed several Collaborative Care Programs (see [79] to [85]). Included in this statement I outline the commissioning of the

Sax Institute to complete a Scalability Assessment of Collaborative Care and other place-based planning approaches. The Sax Institute were asked to do two things:

a. Assist in understanding the how the Collaborative Care approach works in the five sites established in NSW and the factors that support its success, and

b. Understand the role of Ministry of Health Regional Health Division in scaling the approach to further sites across the State.

37. Four key themes emerged as the foundations of Collaborative Care and other place-based approaches from the extensive stakeholder consultation and literature as part of this Scalability Assessment. These critical enablers are Stakes/Interest, Trust/Time, Power/Influence and Knowledge/Expertise.

38. The results of the Scalability Assessment demonstrated that the local community plays a pivotal role in all aspects of the collaborative care approach. It found that stakeholders such as the NSW Ministry of Health and external facilitators like the NSW Rural Doctors Network (**RDN**) have an enabling and facilitation role, with the local community stakeholders best suited to identifying the local health needs and opportunities for innovation.

39. Further to this Scalability Assessment, NSW Health has engaged the RDN for the delivery of the statewide Collaborative Care Program (**The Collaborative Care Program**). Under this engagement, the RDN will assist to deliver The Collaborative Care Program in an additional five communities/sub-regions with NSW Health to provide funding to support the delivery.

40. The Collaborative Care Program is a community-centred, place-based approach to mapping and planning solutions to address healthcare challenges in regional communities. It addresses recommendations 10 and 43 from the Rural Health Inquiry. It also supports delivery of 'Priority 5 – Expand integration of primary, community and hospital care' of the NSW Regional Health Strategic Plan 2022-2032.

41. Delivery of this program requires significant engagement and collaboration with local communities, their primary and non-government health related services, NSW Health, local health districts, and Primary Health Networks.

42. It is important that there is flexibility in how community engagement occurs to ensure it best meets the needs of that community.

C. SOLUTIONS

Thin Market General Practitioner Support

43. Thin and failing markets are identified usually through escalation between Primary Health Networks and local health districts.

44. The term thin and failing markets is a term used to describe in this context health service provision that is limited or failing to provide for the consumer needs, manifesting through several factors such as; one or few providers, limited diversity of services or supply of services, little or no incentive for the market to respond, and limited sustainability in the market. This is sourced from the Response to Consultation on Thin Markets in regional and remote Australia by the PHN Cooperative[3].

45. Generalists, GPs or Nurse Practitioners could be used through a salaried model as care leads in areas where there are thin or failing markets. MBS billing is not viable in many of these circumstances. These roles should be funded directly by the Commonwealth. Pilots of this, and other funding models are being explored with the Commonwealth.

46. NSW Health is collaborating with the Commonwealth to trial new funding models focused on thin markets and exploring the use of a small funding pool to test initiatives that could be block funded outside of some of the current legislative, regulatory, funding and policy frameworks.

47. This work will explore the option of turning off the normal funding parameters to funding in order to explore potential funding alternatives and solutions. An example suggested is block funding a primary care service in a small community, where the Medicare Benefits Scheme is not currently being claimed, or where the volume is too low to attract clinical staff. This may also include using alternative clinical leadership such as a nurse practitioner.

48. Early site identification encompasses primary care services that are unstable, failing or at risk.

[3] Primary Health Network (PHN) Cooperative Response to Consultation on Thin Markets in regional and remote Australia Contact. (2023). Available at: https://www.wqphn.com.au/uploads/documents/Thin%20Markets%20in%20Regional-RemoteAustralia_PHN%20Coop.pdf [Accessed 1 Oct. 2024].

Service Configuration and Planning

49. At present, NSW Health needs to reconfigure services for health equity within current workforce limitations. Decisions about reducing or consolidating duplicative services are required to ensure healthcare is delivered in a way that is in the best interest of the patient with the funds and staffing currently available to build on and reshape services into the future. For example, a community hub rather than an Emergency Department, or using virtual care access points in the first instance.

50. Service reconfiguration described above should not limit future workforce strategy and planning required to build on and expand services into the future. There is a longer-term focus including model of care reform, planning and implementation of health services that achieves more equitable access.

51. Further work to centralise NSW Health planning could be undertaken in order to connect more formally with local health districts and communities to plan for, and respond to, regional needs encompassing clinical care delivery, infrastructure and the health profile of each community. This work would support the decisions made by for NSW Health in identifying and implementing the most appropriate model of care and health resources, both locally and system wide.

Single Employer Model

52. The Single Employer Model provides continuity of employment for rural generalist trainees for up to four years during their training in general practices and public health facilities. The overall purpose of the Single Employer Model is to grow a dedicated and sustained local GP workforce to mitigate the risk of compounding workforce shortages within the GP community.

53. The Single Employer Model was initially designed and piloted by Murrumbidgee Local Health District, partnering with the Commonwealth Government, and was referred to as the Murrumbidgee Rural Generalist Training Pathway (**MRGTP**). The MRGTP was initiated for rural generalist trainees to support recruitment and retention of the rural generalist workforce in Murrumbidgee Local Health District.

54. NSW has negotiated a Memorandum of Understanding with the Commonwealth Government, for the expansion of this innovative model.

55. The NSW Rural Generalist Single Employer Pathway collaborative trials offer up to eighty trainee participants employment through the expanded Rural Generalist Single Employer Pathway per year (inclusive of the current exemptions for the cohort of MRGTP trainees). The employment through this pathway includes the Commonwealth S19/2 exemptions, facilitating employment in the NSW Health system, and ability to participate in training and provision of service in private general practice.

56. The NSW Health proposal now in place and accepted by the Commonwealth outlines two groupings of NSW Health local health districts. Each grouping was considered a collaborative trial group.

    a. Collaborative Trial 1 consists of: Illawarra Shoalhaven Local Health District, Far West Local Health District, Murrumbidgee Local Health District, Southern NSW Local Health District, Western NSW Local Health District.

    b. Collaborative Trial 2 consists of: Hunter New England Local Health District, Mid-North Coast Local Health District, and Northern NSW Local Health District.

57. The collaborative trials will be supported to continue for a period of four years by the Commonwealth, evaluation points will occur across that time, and an evaluation will occur at the end of the four-year period.

Luke Sloane	Witness:
3 · 10 · 2024	03/10/2024
Date	Date