Special Commission of Inquiry into Healthcare Funding

Outline of Evidence of Josh Carey

Name: Josh Carey

Occupation: Executive Director of Service Delivery, Western New South Wales Local Health District

1. This is an outline of evidence that it is anticipated that the witness will give to the Special Commission of Inquiry into Healthcare Funding.

My role

2. I am the Executive Director of Service Delivery at Western New South Wales Local Health District (**WNSWLHD**). I have been in this role since February 2023.

3. Prior to that, I was a member of the Executive Leadership Team at WNSWLHD as the Director of Finance, starting with WNSWLHD in January 2014.

4. The Service Delivery portfolio includes the following direct reports:

   a. General Managers of Dubbo Health Service, Orange Health Service, and Bathurst Health Service;

   b. Director of Rural Health Services that manages the remaining hospital and health services within WNSWLHD;

   c. Director of Mental Health, Drug and Alcohol;

   d. Director of Child, Youth and Family Services;

   e. Director of Western Virtual;

   f. Director of Aged, Palliative and Disability services;

   g. Director of District Wide Services; and

   h. Director of Service Improvement.

5. My role provides leadership, direction and management for health service delivery across a wide range of services and settings, focused on the delivery of high quality and safe health services, in line with NSW Health Future Health, and WNSWLHD strategic directions and operational plans. My role has significant input into the development and oversight of strategic and business plans, policy development, business and clinical service strategies and relationship management.

6. The Service Delivery portfolio was established with my appointment to the role in February 2023, bringing together the frontline health services including acute and community across the region. A focus over the last 12 months has been establishing the new leadership structure and associated portfolios across the Service Delivery Directorate (**Service Delivery**), aligning appropriate governance structures to complement and work with the broader Executive Leadership Team of WNSWLHD.

7. Individual accountability structures are in place with my direct reports via Monthly Accountability Meetings along with a combined monthly Service Delivery Committee to guide the integrated workplan for Service Delivery. It should be noted that this is a work in progress as we continue to work through the new structure. Key principles that have guided the evolution of the Service Delivery structure are:

    a. Service Delivery should operate as a united entity,

    b. Service Delivery's natural referral networks should support its operational delivery model,

    c. Specialised and Clinical Services should be functionally aligned,

    d. Clinical Streams should evolve to Clinical Networks, focusing on clinical standardisation, a multi-disciplinary approach, peer networking, information sharing and innovation.

    e. District-wide services should be prioritised and optimised where they provide benefit.

8. District-wide Clinical Networks support Service Delivery by enabling greater cohesion amongst speciality groups. The Networks, albeit in their infancy, are designed to improve clinician engagement and clinical leadership between our hospital services. The seven Clinical Networks once established will be Cancer and Haematology, Cardiology, Emergency Medicine, Intensive Care, Maternity and Paediatrics, Medicine, and Surgery and Anaesthesia.

9. The Service Delivery portfolio is large and complex. While I am aware of the various programs which are carried out under my portfolio, I do not necessarily know the specifics of each service, program or project.

Mobile CT Service

10. As a rural and regional LHD, WNSWLHD is quite innovative with its approach to combat its vast geography and desire to provide services as close to the community as is appropriate and safe. An example of an innovative project in my portfolio is the mobile CT Service. In 2023, WNSWLHD established a mobile CT service using a CT scanner mounted on a semi-rigid truck to travel between Bourke, Cobar and Walgett on a rotation basis. The solution provides access to CT services to multiple communities through investment in a single scanner. This is an innovative solution, operating successfully overseas, but not implemented elsewhere in Australia (as I understand).

11. The CT targets elective procedures and provides increased access to acute and post-acute services in the community by bringing the service to the patient. The main goals of the project were to reduce travel time, avoid unnecessary transfers to Dubbo Health Service, and improve access to remote communities. As of the end of December 2023, the mobile CT Service had provided approximately 800 scans, and saved:

    a. patients travelling 425,000km,

    b. 42 inpatient transfers,

    c. 49 Emergency Department (b) transfers, and

d. $170,000 in Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) mileage.

12. A formal evaluation project is currently being designed to further capture and consider the costs benefits of the mobile CT Service.

13. The service is eligible for Medicare billing for outpatient procedures, however it is important to highlight while WNSWLHD received capital support from NSW Health (along with a significant contribution by WNSWLHD Staff Specialist Radiologist Trust funds) to purchase the truck, scanner and associated equipment, the ongoing operating expenses are not easily considered as part of the current funding models. Of course, the service is offset by Medicare revenue however the service by nature (remote, mobile and largely non-inpatient) does not attract a discrete funding source from NSW Health.

Remote X-Ray Operator Program

14. Another example of an improvement project lead by WNSWLHD Imaging Unit is the Remote X-Ray Operator Program. Essentially, WNSWLHD uses nurses and medical officers who have undertaken further training to take simple x-rays in the absence of a qualified radiographer. While WNSWLHD has been using remote x-ray operators for over 20 years in various locations, in more recent times it has collaborated with the Health Education and Training Institute (**HETI**) to redevelop the training program that was ceased by the University of Newcastle in December 2021.

15. In WNSWLHD, remote x-ray operators support the timely delivery of x-ray services in small communities, which often don't have access to 24x7 x-ray services delivered by a radiographer. Successful use of remote operators can aid in avoiding unnecessary transfers, expedite timely access to definitive care, and support the remote radiography workforce in managing fatigue from excessive on-call.

16. Historically the training was conducted by the University of Newcastle, but they ceased their program in December 2021. WNSWLHD, in collaboration with HETI, gained agreement with University of Newcastle to redevelop their course content for delivery under the NSW Health banner. This has been developed and initial pilot cohorts conducted. Sustainable delivery of this program is still being developed with the Ministry of Health, and it is hoped this will able to be delivered locally in WNSWLHD moving forward to ensure we can continually train new remote x-ray operators reliably into the future.

17. The first cohort of remote x-ray operators completed their training in early 2024 with a second cohort completing the program in March 2024. Currently, WNSWLHD has approximately 23 registered remote x-ray operators in the following locations: Coolah, Walgett, Brewarrina, Lightning Ridge, Canowindra, Warren, Condobolin, Nyngan and Collarenebri.

Virtual ADHD and Behaviour Management Service

18. Another example is the Virtual ADHD and Behaviour Management Service. WNSWLHD offers Specialist Paediatric Outpatient Clinics in Bathurst, Dubbo and Orange and associated referral communities. Extended waitlist pressures exist for all 3 services. Waitlists are triaged according to acuity which unfortunately presents an issue for families struggling to access diagnosis and management of behavioural issues in children. WNSWLHD has been successful in designing a pilot multi-disciplinary (**MDT**) model to support virtual clinics, and to assist with waitlist demand and access via

centralised management across the region. Temporary funding to support the service was supported by NSW Health over 3 years. The service's aims and goals are to:

a. Improve the healthcare journey and outcomes for families and children aged 5-12 years, with ADHD and/or behaviour management concerns in WNSWLHD.

b. Improve access to General Practitioner (GP) shared care management.

c. Facilitate access to specialist MDT care for the management of ADHD and/or behaviour concerns.

d. Expedite the provision of services for eligible children/families currently on local paediatric waitlist.

19. The initiative and funding to support is welcomed however the ability for WNSWLHD to recruit against temporary positions such as Specialist Paediatrician and Clinical Psychologist as part of the MDT is limited. The LHD has been proactive in establishing a partnership with Sydney Children's Hospitals Network (**SCHN**) to access a specialist paediatrician and also a clinical psychologist (who are employed by SCHN and funded by WNSWLHD), supported by WNSWLHD's local coordination of service and waitlist management. The initiative has taken some time to begin, however the service is now underway. The ongoing funding to support it sustainability is of concern, as it is unclear how the program/pilot funding could become recurrent, and the investment versus activity capture (specialist outpatient) would not easily suit the current activity based funding model.

Challenges to WNSWLHD

20. In my view there are a number of key challenges which WNSWLHD faces.

21. First, there are **population and demographic changes** within WNSWLHD. Generally speaking, the overall population of WNSWLHD has not increased materially however there is an obvious and growing internal migration occurring, with a significant increase occurring from Dubbo and in our LHD's south. This change in population, with some of our more remote communities becoming smaller, does not diminish their need to access health services. The demographics for all our communities, and even more so in our smaller communities, is ageing creating significant demand for services over the medium term, however in contrast we are also experiencing a growing child and youth population particularly in our Aboriginal communities. The larger regional cities of Bathurst, Dubbo, Mudgee and Orange populations are growing, creating an uneven distribution of general acute demand across our health service network.

22. In addition to the challenge of matching services to community needs, is the challenge of **matching the funding streams to those service**s. For example, the NSW Health funding streams are based predominantly on activity-based funding principles. Drivers of this funding model are population and demand weighted, and in theory are appropriate when considering the factors described in the paragraph above. However, the existing funding model:

a. is based on a LHD or regional basis, not individual communities, which immediately creates a misalignment for a LHD such as WNSWLHD with internal population movement; and

b. assumes costs will follow patients, however costs in healthcare are predominantly fixed, with variable costs immaterial outside significant volumes. Over 70% of

health care costs are employee or people related, further constrained by industrial awards (appropriate to ensure patient and staff safety) adding to the challenge.

23. For example, regarding fixed costs, ED presentations or acute inpatient demand for a small rural hospital may be declining however patient and staff safety requires a minimum staffing profile. The existing funding models do not adequately acknowledge the fixed cost of service, particularly if the workforce is challenged to retain resident staff. To the same example, WNSWLHD runs 38 EDs across the region with significantly different volumes however, by definition, require medical input. The traditional staffing model would have been to employ the local GP as a Visiting Medical Officer (VMO) for acute on-call work on a fee-for-service basis (demand driven). The reality is these arrangements are now somewhat limited with many GPs (if the community is lucky to still have a GP) unable to provide regular VMO services due to their own demand for primary care service. This unfortunately requires short-term locum services to provide acute on-call support to the ED or acute inpatient, usually at a high daily rate plus on-costs, regardless of the volumes. Funding models do not acknowledge this increased fixed cost despite a growing national impact.

24. Secondly, to the point above, the **primary care system is either failing or is non-existent** in many locations within WNSWLHD. As a result, WNSWLHD has had to step in to support the primary care system, which is described in a number of examples below. However, if we consider the example above in relation to the limited number of GPs available to support acute on-call, WNSWLHD has successfully introduced a virtual Rural Generalist Service (**vRGS**). The vRGS was in response to the ongoing impact of short-term locums required to service our many small hospital EDs, acute inpatients and in some cases our Residential Aged Care residents in our Multipurpose Service (**MPS**) sites. The vRGS, albeit virtual, has been successful in:

    a. attracting and retaining an appropriately skilled workforce, and

    b. creating a sustainable demand based model creating consistency of access for rural and remote health services.

25. There is concern however for the ongoing funding sustainability. As mentioned, vRGS provides a service to the Residential Aged Care residents in our MPSs. Previously, this activity would have been billable to Medicare by GPs however the LHD is unable to access this funding stream. The fixed nature of the small hospital of block funded models do not address the demand based service model offered on a LHD basis.

26. Another example is the 4Ts project which sits within my portfolio is transitioning from trial to business as usual and is expected to operate on a continuing basis. The project is a joint collaboration between WNSWLHD, the Western NSW Primary Health Network, and the NSW Rural Doctors Network.

27. The project is an innovative model of care which aims to meet the health needs of the local community, improve service delivery and address workforce shortages. The 4Ts program involves employing doctors, as well as clinic and administrative staff, under a single employer model to collaboratively deliver primary, acute and emergency care. Those workers are supported by virtual health models of care where necessary.

28. The model has been reviewed recently by the Sax Institute. The review found that the project had a generally positive impact on patient care outcomes. However, it may not be economically viable to expand this project across the whole of WNSWLHD.

29. Another example is WNSWLHD has a contract with a third party Medical Group to support its acute medical needs in our far remote communities. Under a formal procurement process the third party was engaged by WNSWLHD to provide acute medical services for on-site cover to six of our facilities (Bourke, Brewarrina, Collarenebri, Coonamble, Lightning Ridge and Walgett). The third party provides primary care in the community through its General Practices, the contract with WNSWLHD effectively supplements the cost of running the General Practice. The difficulty with this model is that it has become necessary because of the failings of the primary health system. It therefore represents a significant cost to WNSWLHD due to the limitations of the Commonwealth funding system. Existing remuneration arrangements such as Fee-For-Service VMO has proven to not be sustainable.

30. Finally, the WNSWLHD faces a significant **workforce challenge for all disciplines**. Large parts of WNSWLHD are regional or remote. This has made it difficult to attract staff, and has meant that WNSWLHD has had to rely significantly on premium labour at an increased cost. This has been exacerbated in the post pandemic time. WNSWLHD has taken steps to reconsider its recruitment initiatives particularly for nursing and allied health, sponsoring increased graduate programs and establishing shared pathways amongst our broader hospital network. For example, rotations of graduate nurses from our larger regional cities to surrounding smaller communities, supporting a greater skill mix and or liveability options for individuals. Further opportunity does exist for our medical officers, and WNSW LHD is exploring improved pipelining and training pathways that may complement our workforce gaps in our smaller communities to facilitate training outside of our regional referral hospitals.

Opportunities

31. In my view, it is important to have the present review of the funding model and how services are delivered. The current model of care in small communities is through a MPS, which provides aged care, an ED, acute or sub-acute beds, and in some instances a co-located GP. While I consider that the MPS model works, it may be more efficient for the mix of services provided to be less focused on an emergency and acute care, and more directed towards aged and primary care. If the MPSs become more focused on primary care, this may pose challenges such as who pays for it. Currently the MPS funding model is on a fixed grant basis, commensurate with static Residential Aged Care beds or Community Care packages. However, given the shortfall of General Practice and therefore growing medical costs along with NSW Health award based nursing conditions, the current fixed grant basis is no longer covering the cost of delivering residential aged care services and the State is effectively subsidising responsibilities of the Commonwealth.

32. Furthermore, WNSWLHD's existing Service Agreement includes a key metric associated with overall budget variance. This metric is informed by multiple funding streams, some quarantined and managed on a program basis, therefore limiting LHD's ability to reallocate, versus some that are considered demand or service capacity based. The outcome is that in order to balance the budget, in most instances each of the funding streams offsets the other and limits the opportunity for WNSWLHD to target short, medium and longer-term strategies aligned to service needs, and clinical service planning.