Special Commission of Inquiry into Healthcare Funding

Statement of Mark Spittal

Name: Mark Spittal

Professional address: 7 Commercial Avenue, Dubbo, NSW 2830

Occupation: Chief Executive, Western NSW Local Health District

1. My name is Mark Spittal. I am the Chief Executive of Western NSW Local Health District (**WNSWLHD**).

2. This is a supplementary statement to my statement dated 6 February 2024, and accurately sets out the evidence that I would be prepared, if necessary to give to the Special Commission of Inquiry into Healthcare Funding as a witness. The supplementary statement is true to the best of my knowledge and belief.

3. My statement dated 6 February 2024 related to section E of the Inquiry's Terms of Reference (Procurement). It can be summarised as saying that the current procurement and logistics systems overseen by NSW Health is generally effective, and that the WNSWLHD is actively participating with HealthShare, the Ministry of Health and other parts of NSW Health to take advantage of the opportunities available to it to improve the efficiency and effectiveness of them. The primary area of deficiency, from a WNSWLHD perspective, is that the current model of healthcare financing does not adequately compensate rural LHDs for the additional costs they incur due to supply chain logistics and rurality. This deficit in NSW Health's current healthcare financing model is generic for all rural LHDs and increases with remoteness.

4. This statement is also supplementary to the Submission to the Inquiry made by the WNSWLHD dated October 2023 which, to the best of my knowledge and belief, accurately provides an overview of the LHD and provides a reliable perspective, which as Chief Executive I endorse, across a range of issues of relevance to the Inquiry.

A. SUMMARY OF KEY POINTS

5. In making this supplementary statement the key points that I wish to draw to the attention of the Inquiry are that:

   a) the NSW Health system has produced generally good results for the people of NSW across both a range of key health indicators relative to the health outcomes achieved in other jurisdictions, particularly internationally, as well as hospital process measures (such as ambulance turnaround), and has done so with relative efficiency in terms of the cost of as a percentage of GDP;

   b) notwithstanding these historic successes, a range of current public policy settings, at both the Commonwealth and State level, are increasingly misaligned to ensuring that the health outcomes experienced by people living in remote, rural and regional New South Wales generally, and in the WNSWLHD catchment in particular, are equitable compared to those who live elsewhere in NSW;

   c) the case for legislative reform to provide greater clarity as to who is responsible for improving the healthcare outcomes experienced by Australians, so as to better clarify the overall system objectives and accountabilities at all levels of government, including NSW and the Commonwealth, is strong;

   d) well designed and well executed public policy interventions that draw together all parts of government to address the determinants of health for the people of NSW

who reside in communities with comparatively poorer health and social outcomes are likely to have highly beneficial impact on the root causes of both ill-health and less productive social participation. Currently such interventions are comparatively rare and small scale;

e) the case for targeted investment in illness prevention through a public health and social determinants approach that is designed to improve the health and wellbeing of those living in remote and rural communities, is supported by a strong evidence base;

f) the case for the reform of the current healthcare financing mechanisms to better serve the needs of residents who live in remote, rural and regional settings is supported by a strong evidence base;

g) there is a strong case for healthcare financing reform to better address the distribution of resources to better achieve social equity, noting the differential disadvantage in health and social outcomes experienced by some parts of NSW society (especially, but not exclusively, in remote and rural settings);

h) there is good evidence to suggest that significant reform of the healthcare financing model for small towns across remote and rural NSW is warranted, and that a pooled approach to healthcare funding in these "thin markets", between Commonwealth and State health agencies, is likely to produce better health outcomes for the people living in those communities. In my opinion there is generally strong support for such common-sense reform across the rural and remote communities covered by the WNSWLHD. Furthermore the WNSWLHD has the willingness and capability to actively participate as a test bed for such reforms;

i) there is good evidence to suggest that the previous collaboration between the Commonwealth and State governments that led to the Multi-Purpose Service (**MPS**) programme being established in 1993 was highly beneficial for rural and remote communities. However, this historic process of reform, (which focussed primarily on emergency departments and aged care in small towns), is no longer fit for purpose. It is my opinion that the emphasis of current and future MPS reform should be refocussed on integrating the primary care, aged care and community service sector within the MPS setting in particular;

j) there is an urgent need for the NSW Health system to design and implement a meaningful and robust model of healthcare financing that better reflects the true costs of delivering state-funded health services in rural and remote settings. Such a model needs to be capable of accommodating the rapidly changing environment that is profoundly shifting both the costs of labour and the stand-by costs associated with providing high service availability with low service utilisation (especially for emergency and acute inpatient care) in these particular settings; and finally

k) decision making regarding investment in the delivery mechanisms for health care services, and the infrastructure that supports that delivery, needs to urgently shift from paradigms that are based on historical patterns and models of service delivery (and advocacy to retain those facilities and services at all costs) to decision making that is based in an assessment of population needs, is evidence based, and has considerations of social equity, improved health outcomes, and economic efficiency at its core.

6. In summary, and in support of these key points, there is ample evidence across the WNSWLHD catchment that the people who live here:

   a) have generally shorter life expectancy, a higher mortality rate and poorer health compared with the rest of NSW;

   b) have exposure to a greater level of societal and other risk factors that have a long-term impact on their health and social outcomes;

   c) have generally lower levels of access to primary care compared with the rest of NSW, and declining access in some areas;

   d) have inequitable and inadequate access to specialist outpatient services that is generally more pronounced than in many metropolitan settings;

   e) live in communities that are described by the Commonwealth as being "thin markets" for primary, community and specialist care;

   f) are more likely to experience the negative effects of a transient and insufficient healthcare workforce across a range of healthcare settings;

   g) make up a population with a higher proportion of older people than the average for NSW;

   h) are demonstrating significant population change, with a decline in many small communities and an increase in regional centres over the last 20 years;

   i) and are more likely to identify as being of First Nations descent than the NSW population overall.

B. WNSWLHD – GEOGRAPHY AND POPULATION

(i) Geography

7. The geographic area of WNSWLHD is 246,676 square kilometres, covering approximately one-third of the NSW land mass which is an area larger than the state of Victoria. It includes 22 local government areas (**LGA**s), of which 7 are classified as remote or very remote.

8. The WNSWLHD catchment includes the lands of a number of First Nations communities including those of the Barindji, Barrinbinja, Barundji, Gunu, Kamilaroi, Muruwari, Wailwan, Wiradjuri and Wongaibon peoples. I acknowledge and respect the elders, past, present and emerging of these nations who have been the custodians of their lands on which we reside for millennia.

(ii) Population

9. The WNSWLHD population is geographically dispersed across a large region, with regional centres, medium and small rural towns, and remote communities. There are approximately 284,285 people living in WNSWLHD, which is larger than the population of the Northern Territory. 14.5% of the population identify as First Nations people.

10. The population of WNSWLHD is projected to increase by 10% over the next 20 years, to 312,544 in 2041. This is lower rate of projected increase for NSW as a whole (21%), but

the aggregate statistics mask profound differences in the sub-population projections within the LHD's catchment as a whole. Some communities are projected to see population numbers decline, for example Cobar, Bourke, and Brewarrina. Others are projected to see their populations increase markedly, for example, Bathurst, Dubbo, Forbes, Mudgee, Orange and Parkes. The demand for health care services in the more remote northern communities is therefore likely to dramatically reduce over the next 15-20 years, but increasing demand for services in the south of the District is expected to be a sustained trend.

11. The 70 years of age and over group of the population is projected to increase by 44% in 2041 compared to 2021.

12. The present infrastructure owned and operated by the LHD reflects a historical distribution of the population and the maldistribution of that infrastructure relative to population need is expected to continue to increase.

(iii) Health Profile of the WNSWLHD population

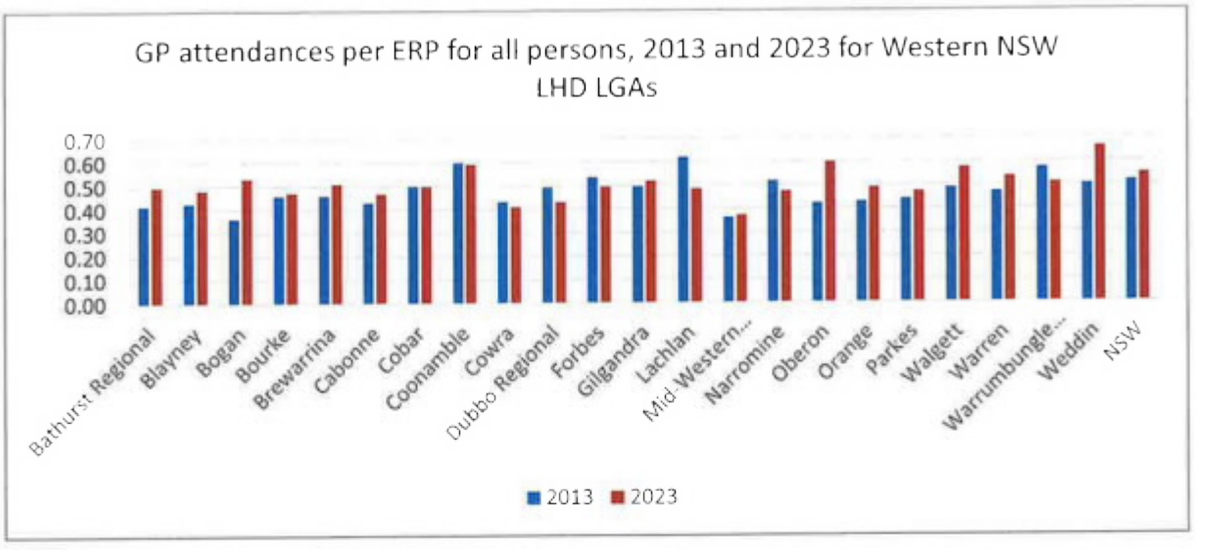
13. People living in WNSWLHD generally have a shorter life expectancy, a higher mortality rate and poorer health than other people living in NSW, when comparing WNSWLHD rates to the NSW average. Many First Nations people living in WNSWLHD have poorer health than non-First Nations people.

14. In my view, the health of WNSWLHD people, compared to people elsewhere in NSW, is an indicator of the greater vulnerability across multiple social determinants of health outcomes, the higher prevalence of biomedical risk factors (for example overweight/obesity, blood glucose levels, blood cholesterol levels, blood pressure), riskier health behaviours, the prevalence of riskier types of employment (for example, primary industries / transport), the inequality of access to affordable health care services at all levels (from primary to specialist care) and the highly dispersed nature of the communities which makes health interventions more difficult and more costly to mount and sustain.

(iv) Reduced access to primary care and public funded specialist outpatient care

15. Reduced access to affordable primary care and publicly funded specialist outpatient care are particularly worthy of note in the context of this Inquiry.

16. Our analysis of Australian Institute of Health and Welfare (AIHW) Medical Benefits Scheme (**MBS**) data indicates that in 2023, people residing in 18 of 22 (82%) LGAs in WNSWLHD had lower GP attendances per estimated residential population (ERP) than the NSW average. Over the ten-year period, 7 LGAs had a decrease in GP attendances in 2023 compared with 2013 - Coonamble, Cowra, Forbes, Narromine, Warrumbungle, Dubbo and Lachlan. Dubbo LGA has experienced a notable decrease, with people living in that LGA experiencing 4% less GP attendances per ERP than the NSW average in 2013, which declined to 21% less than the NSW average in 2023.

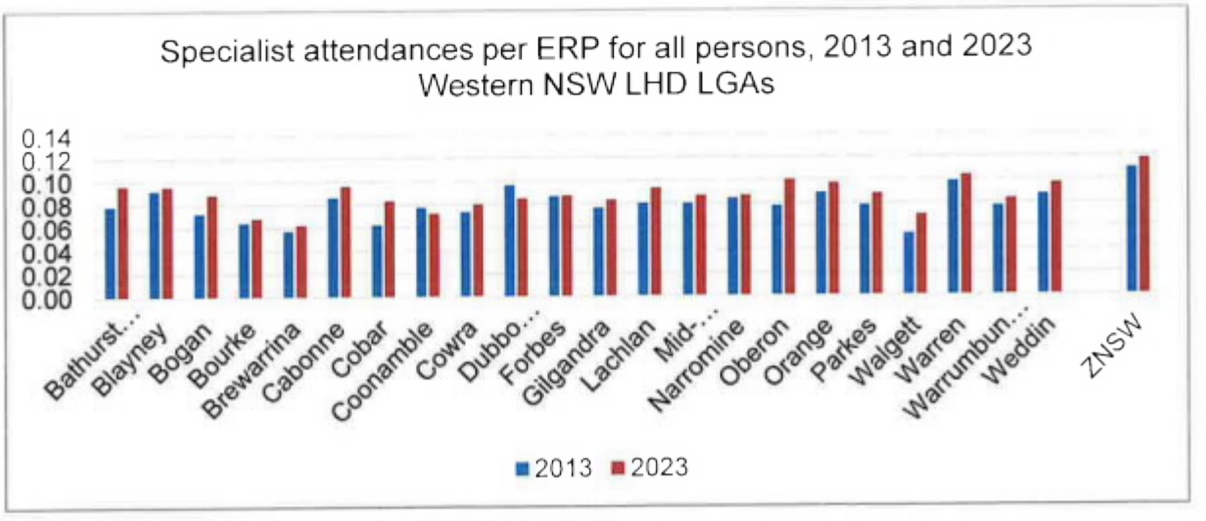


17. In 2023, people residing in every LGA in the WNSWLHD had a lower rate of GP attendance for children aged 0-15 years than the NSW average. In 2023, people aged 65 years and over in 20 of 22 (91%) of the LGAs in WNSWLHD had lower rates of GP attendance than the average for NSW.

18. Timely access to affordable primary care is a critical to improved health outcomes, and is a key element of all high performing health systems. While this is not the province of NSW Health, the reality is that reduced access to affordable and effective primary care is a key driver of demand for NSW Health funded services. In remote, rural and regional settings this impact is especially profound and amplifies a number of other risk factors.

19. International studies show that the strength of a country's primary care system is associated with improved population health outcomes for all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from major respiratory and cardiovascular diseases. Increased availability of primary health care is associated with higher patient satisfaction and reduced aggregate health care spending.

20. The LHD's analysis of AIHW MBS data over that ten-year period (2013-2023) suggests that in 2023 the people who live in every LGA anywhere in the WNSWLHD catchment had lower rates of specialist attendance than the average across all of NSW. In some LGAs, such as Dubbo Regional, MBS funded specialist attendances declined between 2023 and 2013 by 12%.



ERP = estimated resident population

21. Internal analysis of the LHD medical specialist outpatient clinics across Bathurst, Orange and Dubbo also found there are a number of specialist outpatient medical services where demand far exceeds capacity.

22. Disease prevalence and health outcome data for the WSNWLHD strongly suggest that these lower rates of attendance are not due to the population being healthier than the average for the state. Rather the evidence strongly suggests that there is a systemic, longstanding, structural problem in the access to specialist services for people who reside in Western NSW compared to people who reside elsewhere in NSW, on average.

23. It is logical to conclude, given the lower GP and specialist attendance rates, that there is a corresponding significantly lower spend per person by the Commonwealth Government on MBS related services in WNSWLHD catchment than is the average for Australia as a whole. The data suggest the magnitude of that gap is multi-million in nature. Other organisations have also modelled expenditure and usage based on geographical remoteness, which shows a decline in MBS per-capita age-standardised spending with increasing remoteness.

24. The evidence strongly suggests that:
    a) the current mechanisms for funding access to primary care at the Commonwealth level; and
    b) for planning and funding access to specialist outpatient care at both the Commonwealth and State levels;

    both differentially disadvantage people who live in remote, rural and regional areas.

(v) Social risk factors

25. Social risk factors are pronounced in remote, rural and regional settings. As one example, available epidemiological evidence suggests that most (8/13) of the LGAs across NSW that have the highest social risk factors relevant to the health of mothers and babies are found in regional and rural LHD settings. Within the WNSWLHD catchment the Dubbo Regional LGA is a location of particular vulnerability. A quarter of all births (First Nation and non-First Nation) in the Dubbo Regional LGA are associated with a significantly elevated social risk score. This is the second highest percentage of any LGA in the state (the highest is in a LGA in a neighbouring rural LHD).

26. In lay terms this means that, on average, some infants have a greater risk of long-term health and social harm. This is more likely to be true for infants born in particular rural and remote settings. These social risk factors are multifactorial, although factors such as the risk of domestic violence are particularly high in specific locations. These social risk factors profoundly matter. They are strongly correlated with significantly poorer health and social outcomes over an individual's entire lifetime.

27. The Australian Child Maltreatment study (www.acms.au) reports, for example, that family adversity increases the risk of child maltreatment in multiple forms, and that 48% of people who experience maltreatment as a child report having a mental health disorder of some kind. There is a clear correlation between childhood maltreatment and intergenerational harm, that is, the propensity is for the cycle of harm to repeat across generations.

28. While the health system needs to be highly responsive to treating those who have experienced such harm, it also needs to work closely with other parts of government and community-based services to support parents and families to reduce the likelihood of

exposure to multiple types of maltreatment. To reduce child maltreatment, for example, multiple government services, including health services, need to be targeted to the needs of parents experiencing different kinds of vulnerabilities (such as poverty, addiction or mental illness) or at times of greater vulnerability (such as recent separation). Many of these interventions fall well beyond a hospital-centric conception of what a health system needs to deliver.

29. Between 2018 and 2022, the average annual perinatal death rate in WNSWLHD was 32% higher than that in NSW. The number of children living in WNSWLHD considered developmentally vulnerable on two or more domains, was 30% higher than for NSW. These disparities in the health outcomes for children are more pronounced for First Nations communities.

30. These specific examples of the risks faced by newborns and children are one of many examples of the significant risk factors evident across WNSWLHD that have an influence on the health of the population overall. Most of the social risk factors will be more efficiently addressed through a range of interventions across multiple layers and parts of government, including Federal and State, well upstream of the hospital system and downstream from it. These risk factors point to profound differences in social equity.

31. These differences will have a profound bearing on the cost of health and social services over the long-term. For example, the average future cost to NSW Government for vulnerable young children aged 0 to 5 who live in Western NSW is forecast to be the second highest across all parts of NSW. Similarly the average future cost to the NSW Government for children aged under 15 who are affected by mental illness will be second highest, and the average future cost to NSW Government for children and young people aged 15 to 18 who are affected by mental illness is forecast to be the highest of any part of NSW.

32. There is a strong social and economic case for investing heavily upstream in order to reduce these long term costs to the NSW Government while also improving the lives of children, young people, their families and the community as a whole. See for example the Their Futures Matter Family Investment model regarding the Western New South Wales FACS District at **Exhibit A**. **(MOH.9999.1209.0001)**

33. Behavioural risk factors present in the WNSWLHD population include:

    a) smoking – in 2022,18% of the WNSWLHD population smoke daily, compared to 11% of NSW on average;

    b) harmful use of alcohol – in 2022, 35% partake in risky alcohol behaviour, compared to 32% of NSW. Between 2016-2017 and 2020-2021, rates of alcohol attributed deaths were 33% higher for WNSWLHD than the NSW average;

    c) between 2017 and 2021 the percentage of adults overweight or obese in WNSWLHD was 17% higher than NSW, and had increased by 23% in 2021 compared with 2017.

34. Cardiovascular disease, diabetes mellitus, chronic obstructive pulmonary disease, and cancer contribute significantly to the burden of disease in WNSWLHD people.

35. There have been some improvements over the last 10 years in some areas, for example there has been a decline in the death rates from cardiovascular disease, injury and poisoning, and rates of smoking and an increase in vaccination rates.

36. The WNSWLHD population experiences higher rates of substance abuse and domestic violence than NSW overall.

(vi) mental health

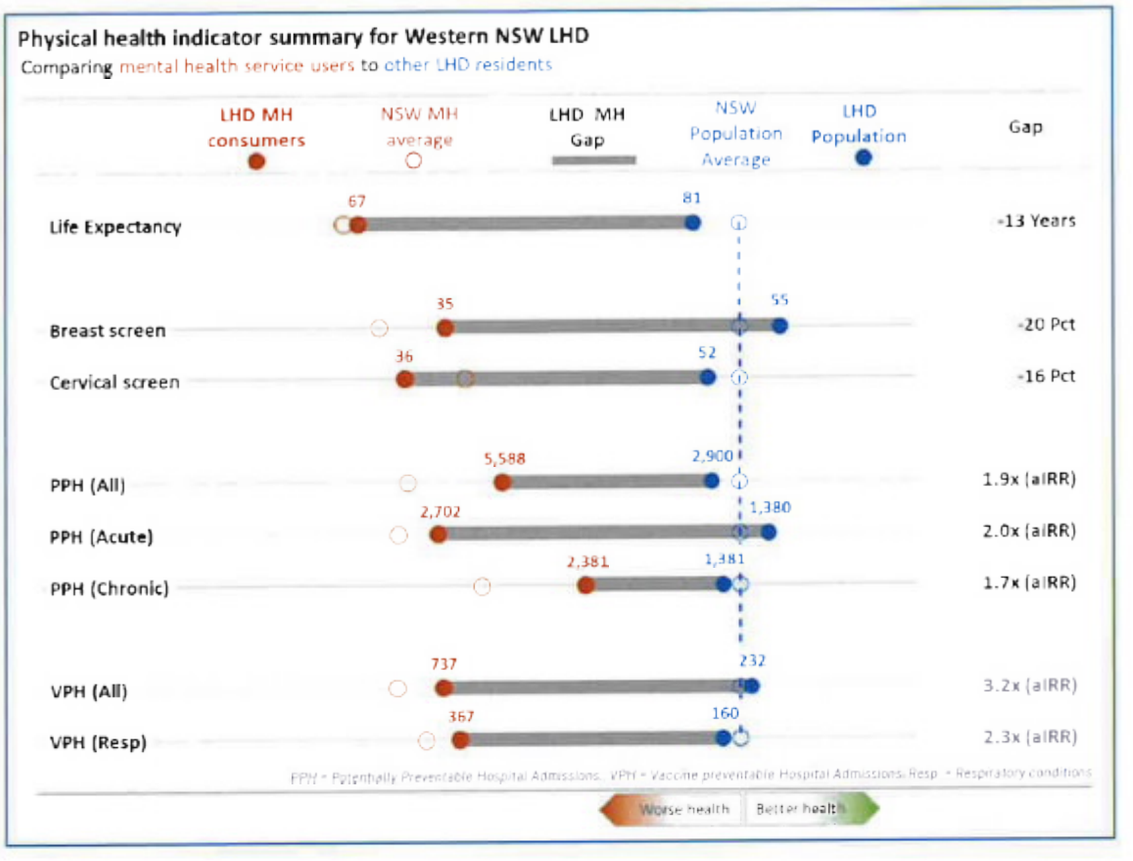
37. Some groups of people within the WNSWLHD population experience heightened risks. For example, presentations to WNSWLHD Emergency Departments (**ED**s) because of mental health disorders is 58% higher than the average for NSW.

38. The disproportionately high rate of mental health and drug and alcohol presentations increases the further north in the District the ED is located.

39. In all NSW LHDs, mental health service users have reduced life expectancy, reduced cancer screening and higher rates of avoidable hospital admission for non-mental health conditions compared to other LHD residents. Social and economic factors cause some of these gaps.

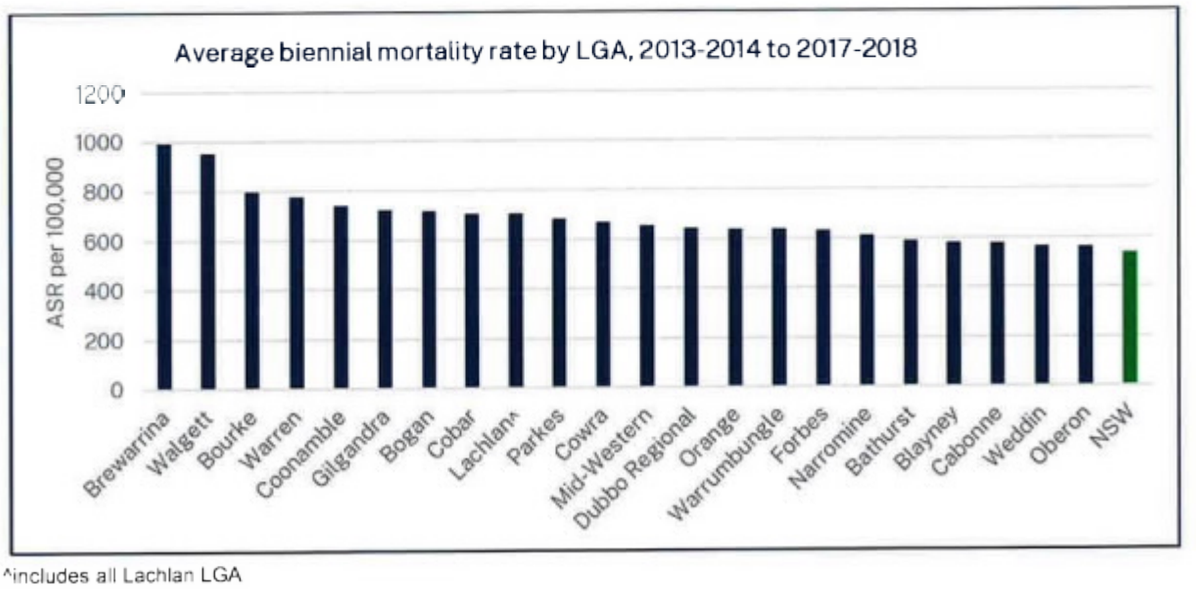
40. There are opportunities for primary, specialist and mental health services to work together to understand local health system barriers and to improve prevention and care. For example in WNSWLHD the people who use mental health services will, on average, die thirteen years earlier than the LHD's general population. They are 1.9 times more likely to be admitted to hospital for a non-mental health condition for which hospitalisation is potentially avoidable. This group of people is 3.2 times more likely to be admitted for a vaccine preventable reason. Rates of breast and cervical screening amongst women with a mental health condition are 20% lower than for other women living in the LHD. (The LHD's Mental Health Drug & Alcohol Service are in the early stages working with the LHD's Planned Care for Better Health team and the Screening services to tackle some of these issues.)

41. Many of these factors suggest that people with a mental health condition face disproportionate disadvantage due to challenges they face in accessing affordable primary care. It also suggests that people are being exposed to harm because of the deeply ingrained silos that exist between mental health services and other types of clinical care within the health system generally.



Source: Mental Health Living Longer (MHLL) project, NSW Health, April 2024.

42. Potentially avoidable deaths are 48% higher in WNSWLHD than for NSW as a whole. Suicide rates are higher in WNSWLHD than NSW overall and are increasing. Annual average death rates (age-standardised) from all causes by LGA compared to NSW from 2013-2014 to 2017-2018 are shown below:



^includes all Lachlan LGA

C. WNSWLHD – HEALTHCARE SERVICES

(i) Healthcare facilities

43. WNSWLHD has 38 inpatient facilities including 3 rural referral hospitals, 4 procedural hospitals, 6 community hospitals, and 25 MPS, in addition to 50 community health centres, 23 community mental health services and 14 inpatient mental health, drug and alcohol units.

44. The WNSWLHD facility map is at **EXHIBIT B**. **(MOH.9999.1210.0001)**

45. The hospitals are as follows:

    a) Regional referral hospitals: Dubbo, Bathurst, and Orange;

    b) Procedural hospitals: Cowra, Parkes, Forbes, Mudgee;

    c) Community hospitals: Canowindra, Cobar, Condobolin, Coonabarabran, Narromine, Wellington;

    d) MPS: Baradine, Blayney, Bourke, Brewarrina, Collarenebri, Coolah, Coonamble, Dunedoo, Eugowra, Gilgandra, Grenfell, Gulargambone, Gulgong, Lightning Ridge, Molong, Nyngan, Oberon, Peak Hill, Rylstone, Tottenham, Trangie, Trundle, Tullamore, Walgett, and Warren.

46. The WNSWLHD has long recognised the limitations of a facility-centric view to its planning and operation. Formal regional referral networks exist between smaller facilities and procedural or regional hospitals. The flow of acutely unwell patients across these networks is managed by an in-house division, Western Virtual, which specialises in providing virtual care, oversees patient flow and provides resources to undertake patient transport across the District.

47. There are well-formed links to metropolitan facilities for highly specialised (tertiary-level) healthcare services. These referral pathways between LHDs are formally governed by NSW Health policy and procedures. For example, the "Inter-facility Transfer Process for Adult Patients Requiring Specialist Care" at **EXHIBIT C**. **(MOH.9999.1211.0001)**

48. The LHD is gradually piloting the introduction of local networks through which clusters of the smaller and more remote facilities can be managed to achieve better economies of scale. One example is the Castlereagh Network through which the MPS facilities and community services at Coonamble, Gulargambone and Gilgandra are managed as a single cluster.

49. Major capital works either underway or in development are:

    a) Bathurst Health Service: this is a $200 million redevelopment of the hospital's ED, inpatient, outpatient, mental health and support service infrastructure to meet a range of community needs that have been identified through a local Clinical Service Planning process. This project is at facility design stage;

    b) Blayney MPS: this is the last redevelopment within NSW to be funded from the current round of the joint Commonwealth/State MPS programme. It is at design phase with the outcome of construction tenders expected to be notified in the next month;

c) Canowindra HealthOne: this is an approximately $8 million development to create a HealthOne facility co-located on the campus of Canowindra community hospital. The HealthOne will accommodate local GP services along with a range of community services provided by the LHD in one location in order to better support multidisciplinary primary and community care. It is at design phase, with demolition of several old buildings on the site underway;

d) Cowra Health Service: this is a $110.2 million rebuild of the procedural hospital at Cowra to meet a range of community needs that have been identified through a local Clinical Service Planning process. It is at the early works / finalisation of the detailed design phase;

e) Dubbo Health Service: NSW Pathology are currently renovating a part of Dubbo Health Service to accommodate a significantly improved pathology laboratory. This is at the construction phase;

f) Dubbo Alcohol & Other Drug (**AoD**) Residential Rehabilitation Centre: this is a multi-million dollar project to develop a residential AoD rehabilitation facility in Dubbo. It is in the community consultation and facility concept design phase;

g) Orange Health Service: the LHD is currently installing the second largest solar panel array on any public building in NSW. The solar project is at construction phase. In addition the redevelopment of cold shell capacity in the inpatient area to accommodate an expanded palliative care unit is at design phase.

h) Key Health Worker Accommodation: the LHD is currently procuring, installing or purchasing key health worker accommodation at the following locations; Baradine, Condobolin, Collarenebri, Dubbo (motel complex), Mudgee, Narromine, Orange, Tullamore, Trundle, Walgett, Warren and Wellington. With the exception of Orange all of these projects are fully committed and are at varying stages of execution.

*(ii) **Healthcare** services*

50. The WSNWLHD is currently realigning its internal operational structures to facilitate greater cohesion between services across the District. These changes are also being mirrored by changes being made to the District's clinical governance architecture with the same objective in mind. For example, the WNSWLHD Clinical Governance Framework has been recently revised and clinical streams, which have been in place for many years with variable effectiveness, are currently transitioning to District Clinical Networks. These networks will aim to increase clinical engagement, improve the adoption of evidence base practice, provide oversight of workforce development, and provide a vehicle for input into strategy, planning and clinical governance.

51. There are a number of District-wide services with a central operational governance and staffing model that spans the entire district rather than a single facility, including: Medical Imaging, Oral Health (dental) services, Radiation Oncology, and Pharmacy services; Aged Care, Disability and Specialist Palliative Care services; Mental Health Drug and Alcohol services (which operate as an integrated model); Women's & Children's services including maternity, First 2000 days services, sexual assault and integrated Prevention and Response to Violence, Abuse and Neglect (PARVAN) services; Public Health and HARP (HIV and Related programmes); Aboriginal Health & Wellness including Health Promotion; and Western Virtual (including vCare, remote monitoring, the Virtual Rural Generalist Service, Virtual Allied Health, Virtual Pharmacy, and Planned Care for Better Health).

52. Interventional Cardiology and Radiation Oncology are currently operated under a 'one service two-site' model across both the Dubbo and Orange Health Services.

53. Community and primary health services operate across 50 centres, the majority of which are co-located with hospital or MPS services. The services provided include nursing and allied health, maternal and child and family health services, liver/hepatitis services, violence prevention and response services and programmes aimed at meeting the needs of priority populations including Aboriginal health, those with chronic disease, children and older people.

54. The WNSWLHD provides the largest rural mental health service in Australia. This includes a broad range of community and inpatient mental health services, including some state-wide, highly specialised mental health services. Specialist alcohol and drug services are also delivered by the LHD and its non-government organisation (**NGO**) partners. There are 23 community mental health centres and two community Safe Havens (in Parkes and Dubbo).

55. In the 2022/23 financial year, there were:
    a) 203,195 ED presentations – this involved an average of 557 people each day, a 1.2% increase of the previous year). Of these, 48% occurred at Dubbo, Orange and Bathurst;
    b) 84,709 admitted patient separations, with 74% of these occurring at the regional referral hospitals;
    c) 25,759 surgeries;
    d) 3,420 births;
    e) 909,173 outpatient occasions of service (17% of which were virtual);
    f) 65 visits to dental clinic visits, on average per day;
    g) 421 MPS residential aged care beds. Currently there are 381 residents occupying these beds.

(iii) Anticipated trends

56. Anticipated trends, based on modelled base case projections without any changes to models of care, suggest that by 2036:

    a) ED activity will increase by 15%. This comprises a projected 29% increase at the regional referral facilities, a 9% increase at procedural sites and a 3% decrease at community hospitals and multipurpose services. Triage 1 and 2 presentations are projected to remain at around 11% of all ED presentations, and triage 4 and 5 presentations around 57% of all ED presentations.

    b) Even with a small shift of inpatient care to out-of-hospital settings, the demand on inpatient acute services will increase by 27%. This projected growth equates to an additional 84 acute beds within WNSWLHD. The highest growth is projected in the rural referral facilities (33%). By 2036 it is projected that 79% of the District's acute inpatient activity will occur in these facilities (Bathurst, Dubbo and Orange), reflecting the increasing specialisation of medicine as well as demographic change.

57. These projections are likely to underestimate the activity and service impact associated with an increasing length of stay for older people. The impact of ageing on the consumption of health services, and the complexity of care is profound, as shown in the table below.

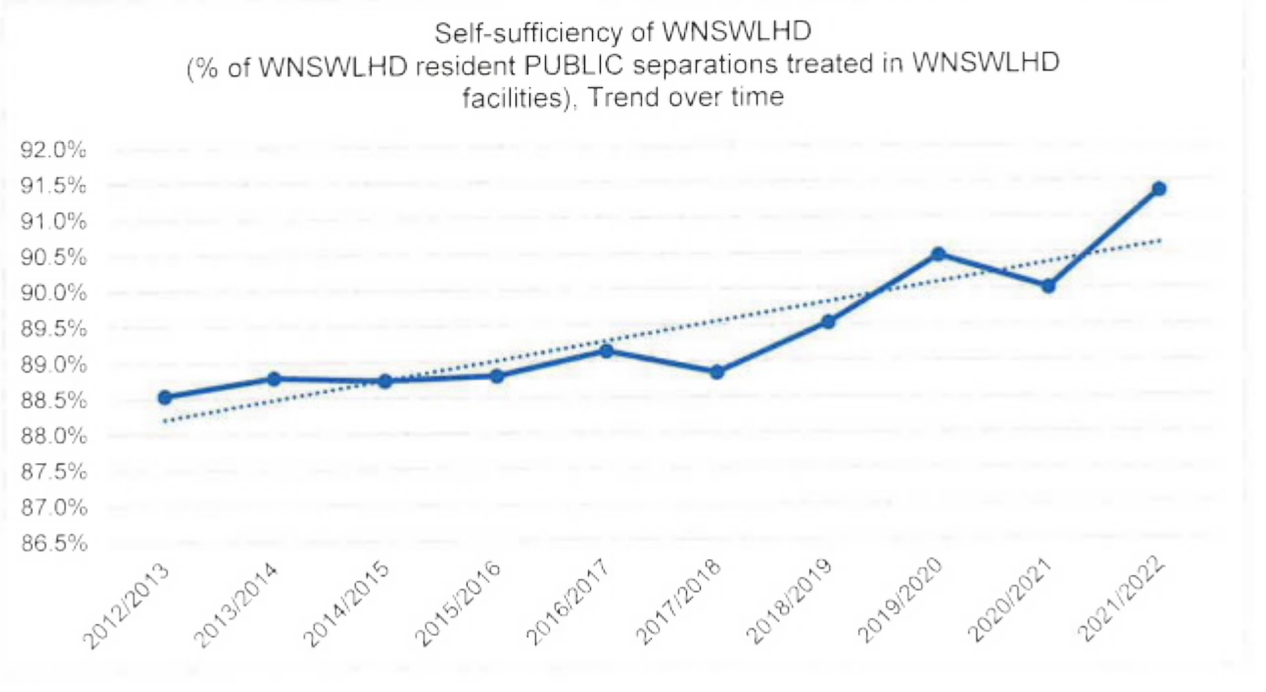
Indicator	65-74 age group	75-84 age group	85+ age group
Annual ED presentations per 100,000 population	37,000	58,000	85,000
Annual hospitalisations per 100,000 population	46,000	79,000	93,000
Average length of stay (days)	3.7	4.6	7.0
Admitted patients with incontinence	1.6%	3.2%	7.5%
Admitted patients with dementia	2.3%	6.0%	14.7%
Unplanned readmission rate within 28 days	5.6%	7.1%	10.9%

Analysis of indicators relative to age in NSW Health System (2011-2021) for Value Based Care Initiative.

58. For example, people who are aged 85 years and older are almost five times as likely to be incontinent when they are admitted as those in the 65-74 age group. Similarly they are 6.4 times more likely to have dementia when they are admitted. There will need to be an investment in specialised resources and training to address these expected changes in the population.

59. Additional residential aged care places will be required in the LHD's MPSs to meet projected demand over the coming 10 – 20 years. (There are approximately 3,000 private Residential Aged Care beds in facilities not operated by the WNSWLHD across the District, mostly located in the larger urban centres.)

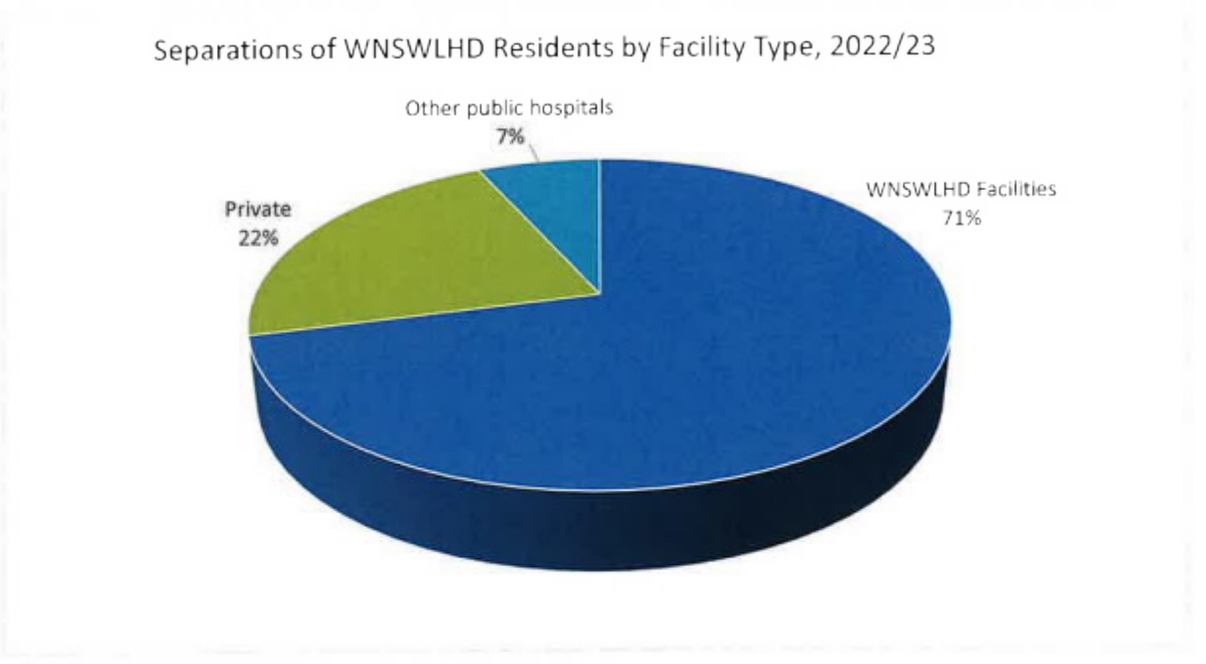
60. There has been a small increase in self-sufficiency (the proportion of WNSWLHD residents treated within a WNSWLHD facility) over time, noting highly specialised health care interventions will always need to be provided by a larger tertiary or quaternary centre. Excluding private hospital activity, in 2021/22, 91.4% of public inpatient activity (all patient types) was provided in WNSWLHD facilities, an increase from 88.5% in 2012/13. This shift towards self-sufficiency in Western NSW has been particularly marked for interventional cardiology services and cancer.



61. Self-sufficiency enables care to be delivered closer to a patient's home whilst concurrently reducing pressure on services provided by metropolitan LHDs who face significant demand pressures from their own local populations.

62. This shift to provide specialised services closer to home has had a demonstrably beneficial effect on early diagnosis and the uptake of treatment by rural people and ultimately, on their health outcomes.

63. Of all inpatient separations by WSNWLHD residents, 78% occur in public sector hospitals (regardless of the hospital's location) which underscores the importance of the public hospital system for WNSWLHD residents who need inpatient care.



D. CLINICAL NETWORKS AND/OR PARTNERSHIPS

64. WNSWLHD's main clinical networks or partnerships include:

a) The Western Primary Health Network (**WNSWPHN**): the WNSWLHD Board and the WNSWPHN Board are currently in the process of establishing a joint-Boards subcommittee to oversee the maturation of shared planning and health system reform, especially in relation to small towns.

b) Rural Doctors Network (**RDN**): the WNSWLHD, the RDN, Far West Local Health District (**FWLHD**) and the WNSWPHN jointly make up the WNSW Collaboration, a partnership forum at Chief Executive level which exists to facilitate improved collaboration between the organisations. The Collaborative Care and Collaborative Commissioning projects undertaken in the District have been overseen through this collaboration. The LHD is also working with the RDN on workforce analysis projects across the LHD. The RDN provides the following outreach programmes in the district; Ear and Eye Surgical Support (EESS), Medical Outreach Indigenous Chronic Disease Program (MOICDP), Healthy Ears, Better Hearing, Better Listening (HEBHBL), Visiting Optometry Scheme (VOS) and the Aboriginal Eye Health Coordination (AEHC) program.

c) Aboriginal Community Controlled Health Organisations (**ACCHOs**, Aboriginal Medical Services): Various memoranda of understanding or service level agreements exist. For example, a project to provide psychology support through the Orange AMS is underway. Multiple services are provided in partnerships with ACCHOs including Aboriginal Maternal and Infant Health Services, oral health, women's health and HARP (HIV and Related Programs).

d) Three Rivers Regional Assembly (**TRA**): A joint accord and health action plan is currently being reviewed.

e) Murdi Paaki Regional Assembly (**MPRA**): A joint accord and health action plan is currently being reviewed, with expected endorsement by both MPRA and NSW Health in the coming months.

f) Western NSW Health and Care Employment Collaboration Group: Marathon Health, RFDS, Live Better and WNSWLHD have formed a collaborative to address issues in the community service and allied health sectors.

g) Far West LHD (**FWLHD**): the WNSWLHD provides a range of corporate and public health services and specialist intellectual disability services to the FWLHD;

h) Murrumbidgee LHD (**MLHD**): the WNSWLHD and MLHD have a collaborative employment arrangement with the (former) Department of Regional NSW to coordinate allied health student placements across both districts. WNSWLHD provides specialist intellectual disability services to the MLHD.

i) Southern NSW LHD (**SNSWLHD**): the WNWSLHD provides Virtual Rural Generalist services to the SNSWLHD;

j) Sydney LHD (**SLHD**): SLHD is the primary provider of tertiary services to the WNSWLHD catchment. SLHD has provided virtual geriatrician services in the community across the WNSWLHD for over 10 years;

k) Sydney Children's Hospital Network (**SCHN**) and John Hunter Children's Hospital (**HNE**): a Single Front Door model commenced on 30 October 2023, and other collaborations related to the care of children with ADHD are in development;

l) NSW Telestroke Service: provides people across NSW with rapid virtual access to specialist stroke diagnosis and treatment, connecting WNSWLHD with the Prince of Wales Hospital.

m) Downer: public/private partnerships for the facility and support services in Bathurst and Orange hospitals;

n) Ochre Health: the WNSWLHD contracts Ochre Health to provide medical services across the six most northern towns in WNSWLHD;

o) NSW Trauma Services Referral Network: the receiving hospital is Westmead Hospital;

p) NSW Severe Burn Injury Service Referral Network: Concord Repatriation General Hospital;

q) NSW Critical Care Tertiary Networks (Adults) and NSW Cardiac Catheterisations Laboratory Referral Network (to Royal Prince Alfred Hospital);

r) The Paediatric Critical Care Tertiary Referral Network (to the Children's Hospital at Westmead);

s) Tiered networking for perinatal care (to Nepean Hospital);

t) RACF (Residential Aged Care Facilities) Community of Practice: the LHD's aged care community of practice draws together multiple residential aged care providers, the Australian Department of Health and Aged Care, the WSWNPHN and NSW Ambulance to discuss matters of mutual interest.

u) Outback Eye Service: Prince of Wales Hospital administrate comprehensive ophthalmic services to patients residing in WNSWLHD, including referral to Prince of Wales Hospital for complex clinical cases.

v) The Child Wellbeing Unit, located in Dubbo, provides Child Protection and Wellbeing support to health workers in WNSWLHD; as well as Western Sydney LHD, South West Sydney LHD, Napean Blue Mountains LHD, FWLHD and the Children's Hospital Westmead.

w) New Street Western provides specialist counselling services for children who have sexually harmed others. These services are delivered with their family/carers and are provided to both WNSWLHD and FWLHD.

x) The WNSWLHD has a range of agreements and contracts in place with a wide variety of NGOs, such as Tresillian, LiveBetter, Stride, Marathon Health and the Royal Flying Doctor Service (**RFDS**), (to name but a few of many), for the provision of a wide range of health and support services, especially related to either mental health or services to very remote communities.

y) NSW Health Shared Services: eHealth, HealthShare and NSW Pathology provide a range of shared services to WNSWLHD.

65. Within WNSWLHD the Collaborative Care pilots undertaken in partnership with the RDN, and the LHD led pilot of joined-up general practice and hospital/MPS service delivery across the 4Ts (the towns of Tottenham, Tullamore, Trundle and Trangie), are examples of significant system reform that can be achieved whilst simultaneously minimising the impact of that reform on local communities.

E. FUNDING

66. The 2023 – 2024 Performance Agreement (**EXHIBIT D)** sets out WNSWLHD's budget for the period 1 July 2023 to 30 June 3024. **(MOH.9999.1212.0001)**

67. The initial WNSWLHD budget per the 2023/24 Service Agreement was $1.16 billion. The budget can change during the year to reflect additional budget supplementation received post Service Agreement finalisation. The budget as at March 2024 was $1.21 billion.

68. WNSWLHD expenditure for 2022-2023 was:
    a) Employee related – 58%;
    b) Other operating expenses – 28%;
    c) Depreciation – 6%;
    d) VMO payments – 8%

69. Bathurst, Cowra, Dubbo, Orange, Forbes, Parkes and Mudgee Health Services are funded by activity based funding (ABF). Dental and Drug and Alcohol are also ABF funded services.

70. The WNSWLHD's small hospitals are funded via block funding, which includes MPS and small community hospitals of Baradine MPS, Blayney MPS, Bourke MPS, Collarenebri MPS, Coolah MPS, Coonamble MPS, Eugowra MPS, Gilgandra MPS, Gulgong MPS, Lightning Ridge MPS, Molong MPS, Nyngan MPS, Oberon MPS, Peak Hill MPS, Rylstone MPS, Tottenham MPS, Trangie MPS, Trundle MPS, Tullamore MPS, Walgett MPS, Warren MPS, Canowindra, Cobar, Condobolin, Coonabarabran, Narromine and Wellington hospitals.

71. The future funding mechanisms for a range of Mental Health services are currently under discussion (block versus activity funding).

72. The funding mechanisms for Breast-screening services have been under review for several years.

73. The LHD receives Commonwealth funding for aged care assessment services, transitional aged care (TACP), and community home support services (CHSP, MPS/RAC funding), aged care registered nurse payments, home care packages program (variable funding) and the Indigenous Australians Health Programme.

74. For the last five years, up until the end of the 2022/23 year, the WNSWLHD has met its financial objectives and maintained the highest level of performance against the key performance measures set for the NSW Health system.

75. The WNSWLHD was one of only two LHDs in the NSW Health system to deliver a positive next cost of service in the 2022/23 financial year.

76. Due to significant changes in the LHD's financial position across the 23/24 financial year the WNSWLHD was moved onto the second tier of LHD performance (level one) in February 2024. The LHD is forecasting an annual financial deficit of $48M for the 2023/24 financial year.

77. The primary driver of this deterioration in financial performance is related to unavoidable workforce costs, and in particular the costs associated with locum medical and agency nursing personnel. Approximately 60% of the deterioration is associated with the costs of medical personnel including medical contractors. This includes new positions, the introduction of new staffing models to address the shortage of GPVMOs working in the procedural and smaller facilities, and the significantly increased costs associated with locum medical staff across the District, including the regional hospitals, some of whom are working at quite junior levels. Increased premium labour costs related to nursing agencies accounts for roughly a third of the gap. The costs of workforce recruitment and retention, and hyperinflation in the medical/agency nursing markets require urgent repair if the NSW public is to receive good value for money.

78. Improving the LHD's financial position is a key priority. The WNSWLHD is actively engaged in a range of both local and state-wide initiatives as part of a comprehensive expenditure review in order to address these, and other, drivers of cost across the WNSWLHD and the NSW Health system more generally.

F. CHALLENGES

79. Some of the more significant challenges to health care in WNSWLHD include:

i. access to public outpatient clinics
ii. access to retrieval services
iii. community-based mental health and drug and alcohol services
iv. infrastructure
v. funding
vi. thin markets for primary care
vii. increasingly fragile aged care services
viii. disability care services
ix. workforce
x. research
xi. environment and climate change.

i. Access to public outpatient clinics

80. Analysis of outpatient clinics in the LHD's three rural referral centres (Bathurst, Dubbo and Orange) suggests there are several outpatient medical services where demand far exceeds capacity. Demand significantly outweighs capacity in paediatric services across the region, where children with behavioural issues can wait extended or infinite periods to access specialist care. Demand and capacity mismatch is demonstrated across a number of other specialities, including endocrinology, neurology, geriatrics, cardiology and gynaecology. Access to publicly funded specialist outpatient services is unequal, even between the regional towns of Bathurst, Dubbo and Orange. The historical development of outpatient services has not necessarily matched the disease or demographic profile of communities, rather, it has most often been clinician dependent or targeted programme dependent. Matching supply to demand based on community demographics, disease profiles and need across the region will be a significant future challenge.

81. A similar analysis has yet to be undertaken for specialist outpatient surgical services or for access to surgical procedures in the WNSWLHD's regional and rural context.

82. Poor access to specialist outpatient services has a direct impact on primary care. There is a symbiotic relationship between the two. Specialists need referrals from primary care practitioners. Primary care practitioners need specialists to refer to. An inability for a GP to refer a patient to necessary specialist care that they can afford and receive in a timely way diminishes some of the effectiveness of primary care.

83. In regional NSW there are very limited private outpatient options compared to metropolitan areas.

84. There are number of funding sources for visiting (fly in fly out, or drive in drive out) outpatient services in some rural communities, which are often historical, clinician specific or targeted programme dependent. This may include services commissioned by the RDN, PHN, RFDS, Aboriginal Medical Services or NGOs. Currently it is very challenging for WNSWLHD, the PHN and ACCHO sector providers to cogently plan for outpatient specialist services, as no single agency has an overview of what services are available, where and when.

85. The split Commonwealth/State and public/private funding models currently make it almost impossible to plan for an adequate supply and distribution of specialist clinics in any given community, let alone monitor them or accurately inform local communities and

GPs of the full range of services that will be available and when. It is common for members of our communities to raise this concern during the LHD's local engagements with them.

86. A comprehensive programme of investment in publicly funded outpatient services, targeted at those who cannot afford to access them privately, will be required if health outcomes are to be improved for the people who live in WNSWLHD.

ii. *Access to retrieval services*

87. Access to retrieval services is an issue in rural and regional areas, and of most concern in the northwest of the LHD, exacerbated by workforce availability and geography.

88. Access to an expanded breadth and depth of retrieval options - road, fixed wing and helicopter - will be necessary to meet demand over the next 10-20 years, especially in the context of changing models of service distribution and clinical models of care.

iii. Mental Health and Drug & Alcohol services

89. The disproportionate rate of mental health and drug and alcohol presentations at EDs within the WNSWLHD suggest a fundamental lack of strength in community-based services within the District, which is particularly pronounced in smaller more remote towns.

90. This is often less an issue of overall investment than a reflection of the extreme difficulty of attracting and retaining skilled clinicians with the appropriate expertise to work in more remote and rural areas.

91. The disaggregation of these services, which is the result of multiple State and Commonwealth departments funding services in fragile markets in a disjointed, short-term and uncoordinated way, often makes the health system extremely complex for communities and consumers to navigate, especially in regional, rural and remote settings.

iv. Infrastructure

92. While the LHD has a reasonable capacity of hospital beds across the footprint, they are not distributed in a way that matches the needs of communities or contemporary models of health care delivery. For example, because the location and size of facilities reflects the historical rather than the contemporary distribution of the population, the LHD's smaller facilities are often needed to provide 'step down' or sub-acute care for people away from where they, or their family, live.

93. Almost half of WNSWLHD's buildings have low functional suitability resulting in high maintenance costs and challenges to implementing contemporary models of care.

94. There is currently no clear funding path to support the redevelopment of the infrastructure in the six ageing Community Hospitals.

95. Much of the MPS infrastructure in WNSWLHD needs refurbishment (and/or replacement), creating challenges in delivering contemporary models of residential aged care. Many MPSs are not environmentally designed to care for high care needs as people are living longer with slow deterioration, especially those with specific needs (such as a person with amputation, and / or disability as they age). Whilst five MPSs in the WNSWLHD region have been redeveloped as part of the NSW Government MPS

stage 5 programme, there remain a substantial number that require upgrade or enhancement to meet contemporary models of care or the needs of the community into the future. A number of comprehensive planning documents have been prepared by the LHD to support applications for any future MPS rebuilding programme should the opportunity arise.

96. The NSW 20 Year Health Infrastructure Strategy, NSW Health Investment and Prioritisation Framework, updated processes of facility planning, and the introduction of Strategic Asset Management Plans have significantly improved the infrastructure planning process across the NSW Health system. However, the drivers for infrastructure investment in rural health services, such as poor asset functionality or clinical and patient safety, are not particularly well reflected in cost benefit or other economic value tools in the absence of significantly increasing activity (compared to metropolitan services). This disadvantages rural health services and reinforces a hospital centric model of planning based on historic patterns of service delivery.

97. The substantial improvements that have already been made in infrastructure planning by NSW Health could be enhanced in rural and regional settings by closer collaboration with Commonwealth partners (who fund the development of Aboriginal Medical Service facilities for example) to support the development of broader health precincts and / or health places. Currently both levels of government support capital investment in rural towns entirely independently of each other.

98. The current process in NSW for Strategic Asset Management encourages a facility-based approach rather than developing networks of services, each of which may require service evolution or change, to best service the community overall. For example, the network of health services across Dubbo, Narromine and Wellington would more sensibly be planned and operated as an integrated whole rather than being considered as discrete facilities.

v. Funding

99. The current healthcare financing model used in NSW is largely an incrementalist one, which has heavily utilised ABF to promote greater productive efficiency within hospitals over time. An element of incremental programme based funding (to enable LHDs to deliver new services planned and designed by the Ministry of Health) and, in more recent years, service development funding specifically linked to facility redevelopments is also utilised. Some activities, such as services in small rural and remote towns, are funded on a block funding basis.

100. This funding model is underpinned by Commonwealth and State negotiations reflected in the National Health Reform Agreement (NHRA) which are undertaken on behalf of the NSW Health system by the NSW Ministry of Health.

101. The LHD also receives Commonwealth funding for a range of services that it delivers that ordinarily fall within the remit of the Federal government, such as aged care assessment services, transitional aged care (TACP), and community home support services (CHSP).

102. In my opinion there are important deficiencies within the healthcare financing models used across both the Commonwealth and NSW Health systems.

103. In NSW healthcare financing models have understandably had a heavy emphasis on productive efficiency (using ABF as a mechanism to achieve this). This emphasis, which is intended to dis-incentivise unproductive waste, has generated positive benefits for the

community. Hospital services are delivered more efficiently today than they were prior to the introduction of ABF. That emphasis has, and will continue to, benefit society.

104. The critical deficiency in the model, however, is that it does not equally balance the public policy tensions between compassion, social justice and the efficient stewardship (productive efficiency) of taxpayer resources. The current focus is almost solely on productive efficiency at the expense of both allocative efficiency (investing in the interventions that deliver the greatest benefit) and considerations of social equity (distributive justice).

105. In my view the current funding system pays marginal attention to issues of allocative efficiency and social equity. The system itself has largely evolved from an a-priori assumption that the distribution of healthcare resources across NSW that existed prior to the introduction of ABF was both equitable and optimal. The evidence of profound differences in health outcomes and access to services provides very little support for that assumption.

106. There is significant system-wide rigidity that undermines well-considered attempts to alter historic patterns of resource distribution. As a result, in my opinion, the current system of financing healthcare in NSW, and especially in remote, rural and regional NSW, will be increasingly incapable of delivering what the community expects of it.

107. Both the current emphasis on productive efficiency and the current funding model are hospital centric with an activity-based focus, which risks diminishing the importance of preventative health, lower cost community-based interventions, and population health generally. That is, it does not address the issue of allocative efficiency (investing in the things that deliver the greatest benefit for the least cost) at all well.

108. Evidence suggests that the return on investment for health expenditure is greatest with preventative legislative / regulatory public health measures, followed by health protection and health promotion. The latter has a much lower return on investment, but is still return on investment positive. Successive governments in NSW, across all political persuasions, have arguably made comparatively less use of legislative/regulatory intervention to improve health outcomes than many other jurisdictions internationally. The evidence suggests that such measures have high efficacy in areas such as alcohol advertising and consumption, gambling reduction, and the minimisation of higher risk food products (such as sugar levels in processed foods).

109. Interventions that reduce the need to resource unplanned acute care in small and more remote communities (such as effective chronic disease management, community care and hospital avoidance programmes) are likely to generate a higher return for the community for every dollar invested than hospital care will. Heavy investment in virtual and community-based services occurred during the COVID-19 pandemic. These services were intentionally designed to drive hospital avoidance and reduce the demand for both ED treatment and inpatient care. In WNSWLHD, people were supported with high quality care at home, supported by local Aboriginal Health and community based staff and virtual care. This resulted in a lower hospitalisation rate for the WNSWLHD population compared to NSW overall (47.6/100,000 population compared with 97.7/100,000 crude hospitalisation rate). In general, the feature of this intervention that was successful was the opportunity for local innovation to reduce the traditional silos that exist between specialty services (each with its own disease specific focus), opting instead for more holistic solutions that had a generalist approach relevant to the real world contexts of the patients and their families. After the pandemic, WNSWLHD no longer had the financial capacity to continue to underwrite these alternative models of non-hospital care.

110. The current funding model is largely cost based and based on the law of averages. There is a 12-24 month lag in the funding model which does not play out well in rural settings that have such inherent variation. The model does not allow for adequate consideration of fixed versus variable cost which is essential. This is counterintuitive; the costs of delivering health services are rarely linear, rather they tend to be stepwise in nature.

111. Inadequate attention has been paid to the development of a robust funding model for ED and acute inpatient services in small towns, where the costs of service provision are often driven more by the stand-by costs associated with clinical risk management (such as staffing a small ED or inpatient beds with low patient demand, just in case someone presents in extremis). A model of ABF that incentivises efficiency in such situations will, by definition, need very different price weights than ABF in any other setting. The converse, a block funding model (such as is currently used for small hospitals) will unavoidably limit the incentive to achieve wider allocative efficiency or social equity outcomes across the delivery system as a whole.

112. In the real world these funding models matter. In the case of WNSWLHD there is currently no mechanism by which the tension between reduced levels of demand in remote towns, and rapidly increasing high acuity demand in regional centres, can be adequately addressed.

113. In my opinion, the current healthcare financing model preserves the status quo rather than allowing for adaptation and transformation as the needs of the population change. That preference is strongly reinforced by a multiplicity of interests. The combined effect of these twin forces in the rural LHD context is that the rubber band of service provision is being increasingly stretched. It is logical to suggest that the current approach will inevitably break the rural healthcare system. In the WNSWLHD that breakage will most likely be seen in the increasing strain being placed on acute procedural and regional hospitals while the smaller more remote facilities become less and less utilised whilst being forced to maintain an increasingly expensive resource base.

114. In my opinion, the current funding mechanisms used for both generalised service provision as well as specific programmatic interventions have a weak correlation with considerations of equity.

115. Significant reform in the funding model to better address social equity will be required if it is to be addressed. A number of other international jurisdictions have greater maturity in this regard and an examination of the funding mechanisms developed elsewhere, such as New Zealand and further afield, could yield valuable insights.

116. Population capitation (payment to look after the health needs of a population over time) can incentivise the healthcare system appropriately if the payment system is designed to avoid cream skimming (for example, not taking on responsibility for more risky members of the community).

117. In my opinion, if NSW Health was to adopt a funding mechanism that was more explicitly anchored to some form of population-based capitation, adjusted for a range of risk factors including deprivation and indicators of social risk, then the system would achieve much greater efficiency in distributive terms, inclusive of considerations of social justice. If improving overall health outcomes is an overarching goal of the health system then this is essential. Population health outcomes will not markedly improve without a greater emphasis on funding for equity of health outcomes.

118. It is my experience that funding mechanisms which are anchored in population capitation tend to drive the whole of the health system together, particularly in relation to primary

and secondary care and programmes to address both social determinants and other risk factors, than mechanisms that are almost solely focussed on the productive efficiency of specific outputs.

119. It is also my experience that health financing mechanisms that improve distributive efficiency are not inconsistent, or incompatible with financing mechanisms that are designed to promote productive efficiency. For example, for decades the New Zealand Health system has synthesised forms of both ABF and population capitation in a way that that is adjusted for social deprivation and other risk factors.

120. That said, it is essential that capitated funding systems have very strong governance mechanisms built into them at both the political level of government and within the public service. If appropriate checks and balances are implemented, the case for a blended model of capitated population-based funding (equity adjusted) coupled with activity based incentives appears to be stronger than the case for a perpetuation of the status quo.

121. The evidence, drawn from across a wide range of health and social outcomes in the WNSWLHD catchment, strongly supports the view that the current healthcare financing mechanisms do not adequately balance the tension between productive efficiency on the one hand and distributive efficiency, inclusive of considerations of social equity, on the other. That evidence suggests that the current system of financing healthcare is out of balance with the range of health and social objectives that the health system is expected to deliver, unless it is accepted that the perpetuation of significant disparity in the health outcomes for particular groups within our society is a socially just outcome.

122. In my view it is possible to achieve a greater balance than is currently evident without wholescale upheaval and disruption, but that is not the same as suggesting that it could be achieved without significant reform, including legislative reform. For example, Australia provides ample evidence that it is possible to reform funding mechanisms, such as when it introduced ABF funding (which emphasises productive efficiency) in a way that allowed for greater levels of productive efficiency to be achieved over time. It is also true, however, that reform would not have been achieved without fundamental and systemic reform in the approach to healthcare financing.

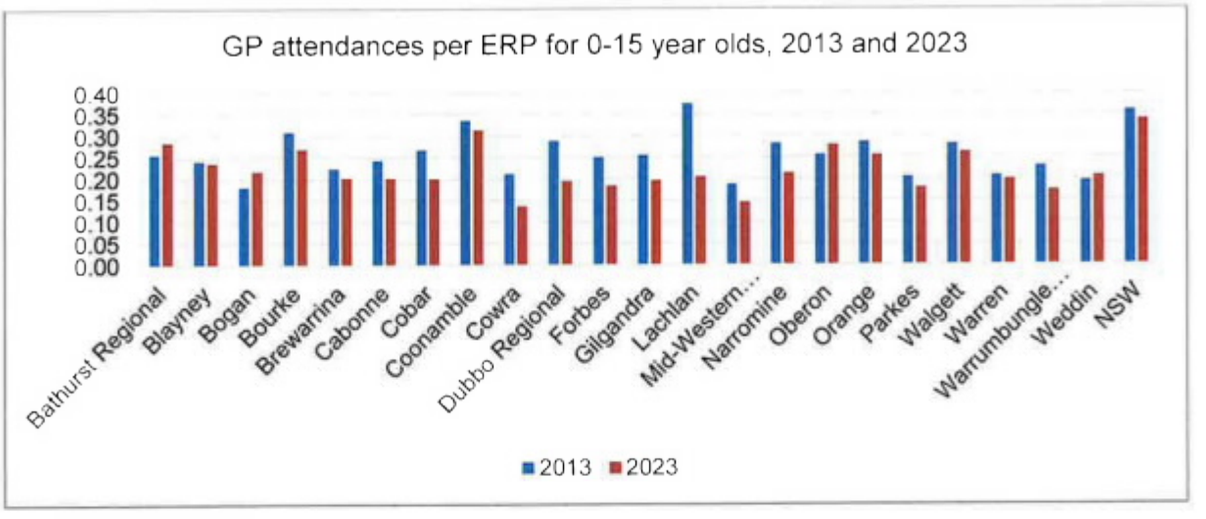
123. The current MPS funding model creates a significant financial gap due to the Commonwealth funding model relative to the cost of operating MPS residential aged care (discussed below in Aged Care).

vi. Primary care

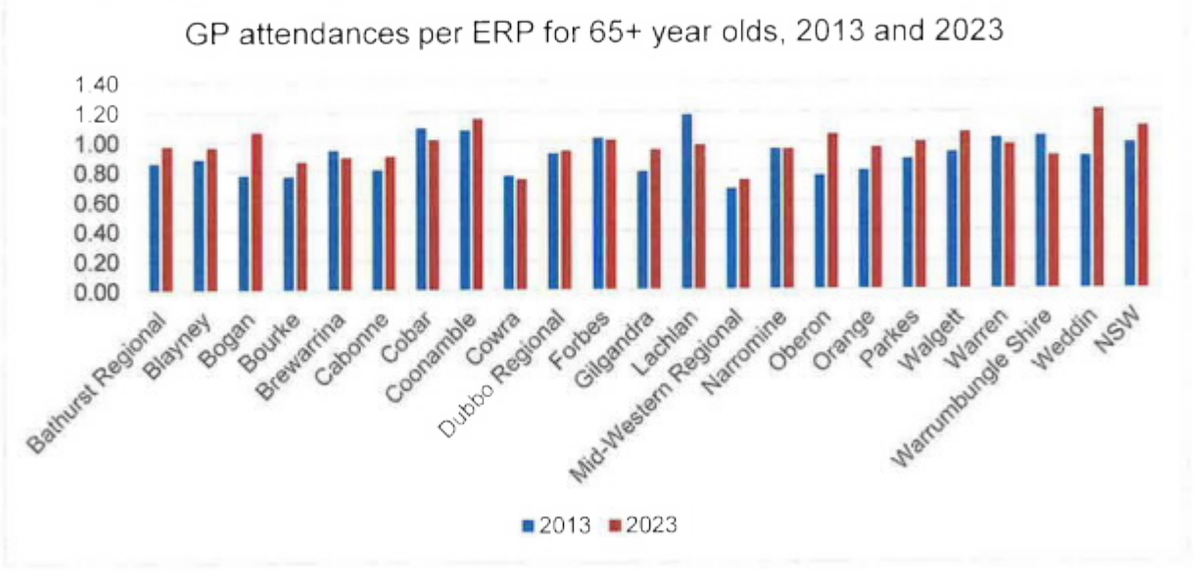
124. A major challenge to healthcare in WNSWLHD is the inequity of access to, and decline in the availability of primary care. While this is the remit of the Commonwealth Government the practical reality is that the WNSWLHD is the provider of last resort through its ED and acute services when access to affordable primary care services reduces. Without exception community stakeholders look to rural LHDs to solve deficits in primary and community and aged care provision.

125. Internal analysis of AIHW MBS data shows that GP attendance for 0-15 year olds decreased across 17/22 (77%) of the LGAs in WNSWLHD between 2013 and 2023. Bogan, Bathurst, Oberon, Weddin and Blayney LGAs had an increase in GP attendances

for 0-15 year olds. Dubbo LGA had 19% less GP attendances for 0-15 year olds compared with NSW in 2013, and 42% fewer than the average for NSW in 2023.



126. Internal analysis of AIHW MBS data shows 8/22 (36%) of LGAs experienced a decrease in GP attendances for people aged 65 years and over between 2013 and 2023 – Narromine, Forbes, Cowra, Warren, Brewarrina, Cobar, Warrumbungle and Lachlan. The remaining LGAs experienced an increase in GP attendances between 2013 and 2023 for people aged 65 years and over. In 2023 there were two small LGAs with higher rates of GP attendance than the average for NSW in this age group – Weddin and Coonamble. All other LGAs (20/22 or 91%) had fewer GP attendances by those aged 65 years and older than the average for NSW in 2023.



127. People living in WNSWLHD access primary health care, allied health and specialist care at much lower rates than other regional and metropolitan centres, despite a more significant profile of chronic disease and biomedical risk factors.

128. In 2021-22 GP attendances were 16% less than the national average and 20% less than the metropolitan average. Specialist attendances were 23% less than the metropolitan

average. Allied health attendances were 28% less than the metropolitan average. For the people who live in WNSWLHD these comparative attendance figures have all declined since 2018-2019.

129. Primary health care and general practice in small communities in WNSWLHD has reached a critical point. In 2018, one-third of the practices in the region were operated by sole practitioners. In 2019, the WNSWPHN identified up to 41 towns that are at significant risk of not having a GP within the next ten years. Many towns in WNSWLHD do not have a permanent GP in their community, for example Coolah. The historic models of 1 or 2 GPs who service a community as well as the local hospital are no longer either realistic or sustainable. There has been a large scale exit and retirement of GP VMOs, combined with a reluctance of many local GPs to work in the local hospital / MPS when they do remain in the town.

130. The availability of timely and affordable access to primary health care has declined for residents across WNSWLHD, including in the larger regional cities. Many communities report that general practices in the region have been unable to continue traditional bulk billing models as Medicare rebates become increasingly unviable for private practice.

131. This has implications for provision of health care services to rural communities in the primary care setting, and is also associated with increasing demand on EDs within WNSWLHD. Other factors impacting on increasing ED demand is the ageing, disease, and socioeconomic profile of communities.

132. Using linear trend analysis for emergency care activity, over the last 5 years, demand has increased across WNSWLHD in all ED triage categories, and all time periods, with an 11% increase overall since 2018/19.

133. Presentations to WNSWLHD EDs by First Nations people have increased by 28% across the five years and represent a much greater percentage of presentations (23%) than the First Nations population of the region (14%).

134. A table of the WNSWLHD emergency linear trend analysis from 2018-19 to 2022-2023 is set out below. This analysis excludes fever clinics, planned visits and disasters so is not inclusive of all presentations to an ED during that period.

Western NSW LHD Emergency Care	2018/19	2019/20	2020/21	2021/22	2022/23	Sparkline	Trend % change
All Presentations	179,151	174,648	188,747	187,392	196,268		11%
Triage 1 & 2	19,627	18,656	19,838	19,937	20,868		8%
Triage 3	49,343	49,569	52,034	52,944	57,508		16%
Triage 4 & 5	109,758	106,137	116,700	114,311	117,678		9%
Mon-Fri, 9-5	65,062	65,464	75,107	74,372	78,081		22%
Sat-Sun	54,074	50,841	52,536	52,231	54,091		1%
Out of hours Mon-Fri	60,015	58,343	61,104	60,789	64,096		7%
First Nations Presentations	34,768	37,172	39,422	40,746	45,111		28%

Key

Increasing with strong correlation

Increasing with low correlation

135. Our analysis of AIHW Commonwealth MBS data for GP attendances and its correlation to NSW ED attendance data indicates that in 2023 every LGA in WNSWLHD had a higher rate of non-urgent ED attendances than the average for NSW as a whole.

Furthermore 9/22 (41%) of the LGAs had rates of non-urgent ED attendances that were five or more times higher than the average for the State. The evidence suggests that the reducing availability of affordable and timely access to Commonwealth-funded primary care is failing to meet the needs of communities in remote, rural and regional NSW.

136. There is nuance in ED activity across WNSWLHD. Bourke, Condobolin, Warren, Narromine, Cowra, Dunedoo and Lightning Ridge have experienced the greatest percentage increase in ED presentations, while the increase in the number of presentations was greatest for Dubbo, followed by Mudgee, Orange, Cowra, Bourke, Condobolin, Parkes, Narromine, Warren and Lightning Ridge. In 2022/23, the rural referral hospitals of Bathurst, Orange and Dubbo saw, on average, 72 to 106 patients per day, while the procedural hospitals of Cowra, Parkes, Forbes and Mudgee saw on average, 21 to 41 patients per day.

137. However, some rural MPS sites have experienced a decrease in presentations over the 5-year period. These include Trangie, Tullamore, Collarenebri, Peak Hill, Tottenham, Baradine, Nyngan, Oberon, Brewarrina, and Canowindra. Trangie and Tullamore experienced the largest reduction, which is likely to have been a benefit of the introduction of the 4Ts model (discussed below). In 2022/23 Collarenebri, Baradine and Peak Hill MPS EDs saw, on average, 1 to 2 patients per day, while Tullamore and Tottenham MPS EDs saw, on average, 1 patient or less per day. (There are seven EDs in MPSs in small towns across WNSWLHD that see fewer than 1,000 patients a year.)

138. In response to this, WNSWLHD has supported primary care services in rural towns. This includes contractual arrangements with practices to deliver GPVMO services to the local hospitals which enables those practices to be more economically viable. In particular, the WNSWLHD has developed the Virtual Rural Generalist Service (**VRGS**), a hybrid medical model providing 24/7 support for healthcare provision to MPS and small hospitals across WNSWLHD and SNSWLHD catchments. The service provides both virtual and in-person medical support to local facilities where local doctors need support or are unavailable. The service is not solely a replacement service for in-person doctors – all of the participating doctors commit to providing 25% of their shifts in person in the LHD. The service primarily supports lower acuity emergency presentations and daily ward rounds for inpatients. It enables doctors in these communities to achieve an essential work life balance that would otherwise be impossible by providing after hours cover. Formal evaluation of the model has demonstrated that the service can provide high quality medical care that is largely accepted and positively viewed by patients and clinicians. Where there are no permanent doctors, the service can be provided more consistently and at lower cost than intermittent locum services.

139. High users of ED care frequently live with a range of risk factors that have a significant influence on their health. Most of these risk factors will be more efficiently addressed through a range of interventions across multiple layers and parts of government, including Federal and State, well upstream of the hospital system and downstream from it. These risk factors point to profound differences in social equity.

140. An example of this fundamental inequity that drives differential health outcomes can be seen in data drawn from the WNSWLHD's Planned Care for Better Health programme. One part of this programme identifies people who have had ten or more presentations to an ED in NSW within the last twelve months. A community based clinical team then proactively wraps a range of supports around them. The goal is to reduce their ED presentations by working upstream to provide healthcare to them in the community, including better coordination with primary care. The interventions have as much to do

with care system navigation, care coordination, health coaching and establishing shared care plans between the individual and multiple parts of the health system, as they do with direct clinical intervention in the traditional, biomedical, sense. Many of these individuals have extremely complex and unstable living circumstances and have a range of comorbid health concerns, including those related to mental health, substance abuse, disability, chronic health conditions and past trauma. Many navigate a complex range of societal risk factors on a daily basis. In response the programme facilitates complex case management/case review across multiple agencies including police, ambulance, NDIS, Corrections, Department of Communities and Justice, NGOs, GPs practices and both ACCHO and ACCO (Aboriginal Community-Controlled Organisation) sector providers when required.

141. In contrast, and by definition, the highly episodic care provided by an ED has no possibility of meeting the complex needs that these individuals have. Most often the clinical staff working in the ED are unlikely to have the line of sight to the broader health or social issues that a primary or community care provider would. No amount of improved productive efficiency in the ED will get a better outcome for those individuals or for the community as a whole. More efficiently run inpatient wards will have little chance of addressing the root causes of their ill-health in the likely event that the person is admitted. The likelihood is that the cycle of presentation and admission and discharge will repeat.

142. Of the individuals enrolled in the Planned Care for Better Health programme, 67% have a very high risk of future hospitalisation (RoH Score >0.8). In addition, 31% of the individuals enrolled in the programme do not have a GP, whether regular or otherwise. Of the people currently engaged in the programme, 48% are First Nations people. Issues of inequality of access to the health system as well as more general societal inequality are a unifying feature. Our data demonstrates that interventions like Planned Care for Better Health have a demonstrable effect on ED presentations, ambulance utilisation and hospitalisation.

vii. Aged care

143. People living in many of the WNSWLHD's smaller towns frequently have no access to even entry level community-based home support services that are intended to enable older people to remain living at home. In addition, rural home care package recipients frequently pay a larger proportion of their package in provider travel fees. While home care package fees are capped, the incursion of travel fees is not. The lack of competition among providers can give rise to increased prices with very little consumer protection. As the community's 'provider of last resort', WNSWLHD has frequently stepped in to undertake this work without remuneration when a private provider has not been able to meet requirements.

144. The NSW Health system incurs considerable cost due to delays in people being able to access Commonwealth funded aged care in either community or residential aged care facilities. For example, across WNSWLHD each day on average there are more than 32 people in an acute hospital bed who do not have an acute clinical need to be there, but who are waiting for placement in a non-MPS aged care facility.

145. In terms of residential aged care, WNSWLHD's MPSs are often the only option in many rural and remote communities.

146. While the WNSWLHD region experienced a net loss of only 3 residential aged care facilities overall between 2019 and 2023, the impact on specific small communities when a local provider closes, such as Peak Hill (10 beds) or Walgett (8 beds), is significant.

147. There has been a reduction in operational bed capacity in a number of other RAC facilities across the district. Anecdotally this has been, in part, due to providers reducing beds to meet the dispensation requirements available to RACs that operate with fewer than 30 beds. (Providers whose residential services are located in Modified Monash Model areas 5, 6 and/or 7 and have fewer than 30 operational beds may apply to the Department of Health and Aged Care for an exemption from the 24/7 registered nurse responsibility based on their alternative clinical care arrangements.)

148. The MPS model has not continued to evolve with changing demographics and health care delivery trends. As increasingly more health care can be delivered safely in a community or ambulatory setting, and as specialised health care is increasing at regional referral hospitals, acute care capacity in some MPSs operates at low occupancy (ranging from 45% to 55% over the last 5 years). In contrast, residential aged care, palliative care and respite demand in MPSs remains high.

149. Analysis of Commonwealth funding models relative to the cost of operating MPS residential aged care has identified a substantial financial gap created by the current MPS funding model. For the WNSWLHD this is approximately $100 a day, which is fully subsided by WNSWLHD (or more precisely the State of NSW). Extrapolated across the number of residential aged beds it operates, the WNSWLHD is subsidising aged care in this District to an estimated value of approximately $16 million annually. The increasing premium labour costs being incurred to maintain service provision are only exacerbating this deficit.

150. The current funding model does not adequately address either the impact of hyperinflation impacting the MPS model or the subsidisation of Commonwealth aged care in the MPS setting. This affects the ability of LHDs who provide RAC services to use growth funding for much needed other services, such as publicly funded specialist outpatients. The true cost of providing aged care in rural communities through the MPS model requires recognition from both levels of Government to allow health service funding to be directed more appropriately. (I am aware there is a Senior Officials MPS Working Group exploring alternative MPS funding models in an attempt to close the gap between Commonwealth funding and the real cost of providing residential aged care in an MPS.)

151. The WNSWLHD strongly supports reform of the MPS model so that it is reoriented to incentivise the integration of general practice and primary care, community services and aged care in the MPS setting. The evidence of the LHD's 4Ts model is that effective and well-integrated primary care profoundly reduces the demand for ED visits in an MPS setting.

viii. *Disability Care*

152. Overall, the WNSWPHN region has the second lowest NDIS budget utilisation across all ages, disabilities and all participants both within and outside supported independent living. This suggests that either rural people face greater barriers in being assessed for NDIS eligibility, or that NDIS clients are unable or unwilling to access providers, or that the State-funded health system is stepping in to support these individuals through programmes that are not funded by NDIS.

ix. *Workforce*

153. Around 8,279 staff are employed across WNSWLHD in approximately 5,222 full time equivalent (**FTE**) positions. Of the WNSWLHD staff, 599 identify as Aboriginal and / or

Torres Strait Islander. On average, our staff work for WNSWLHD for 15 years. Our retention rate is 88.6%.

154. The workforce comprises 3,565 people working in nursing roles; 891 doctors; 550 allied health professionals; and 3,273 enabling staff, that support our clinical and corporate services and include cleaning, catering, information technology, maintenance, engineers as well as finance, data, communication, planning and programme roles.

155. The WNSWLHD has a higher percentage of its workforce who identify as being of Aboriginal or Torres Strait Islander descent than is the average of NSW Health as a whole. In 2022/23 7.8% of the WNSLHD workforce identified as being First Nations people compared with 3.1% for NSW Health as a whole.

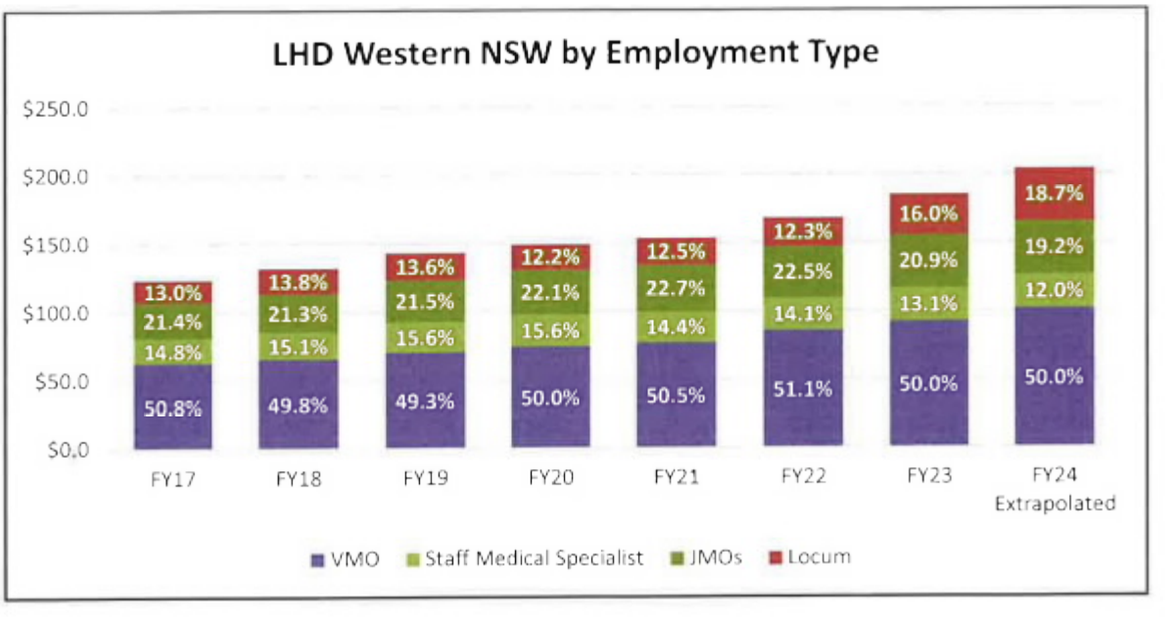
156. The main **medical officer** workforce challenges are:

a) geographic maldistribution in favour of metropolitan areas, and challenges to attraction and retention of a skilled regional workforce. Metropolitan services have the advantages of being the location where specialists are trained, and have further access to doctorate opportunities, clinical fellow positions, and clinical superintendent/private practice opportunities;

b) premium labour costs:
   i. medical staff costs have increased by 50% for WNSWLHD overall over the preceding 7 years, with the most significant increases occurring over the last three;
   ii. the locum medical cost has increased from $16 million to $38 million in the same period;
   iii. it is almost impossible for rural and regional LHDs to offer newly emerging medical staff an attractive enough option to counter the locum model;

c) on-boarding, training and support, including support for the wellbeing of medical officers, remains a challenge.

157. The table below sets out the WNSLHD medical workforce by employment type for the financial years 2017 to 2024 (forecast):



158. The industrial instruments that govern the employment of Visiting Medical Officers, Staff Specialists and the Rural Doctors settlement package are no longer fit for purpose which exacerbates the problem of recruiting and retaining medical personnel.

159. Reliance on **agency nursing** has also increased significantly. The agency nursing costs (excluding travel) incurred by the WNSWLHD have increased to from $6 million to $37 million over the last seven years and have increased 238% in the last three years alone.

160. In relation to **allied health**, recruiting roles to psychology, speech pathology, hospital pharmacy, occupational therapy, and physiotherapy is challenging in WNSWLHD, and most remote communities have experienced sustained vacancies for allied health for over 10 years, with the magnitude of the deficit now markedly greater. Similarly, 65% of oral health (dental) positions across rural and regional NSW were vacant when the WNSWLHD last formally assessed its own local difficulties in attracting these staff.

161. **WNSWLHD responses to date** include the 4T model, a novel healthcare workforce planning model established in Trangie, Tottenham, Tullamore and Trundle since July 2019. It is a single-employer, central administrator (WNSWLHD) model to deliver primary care via networked primary care clinics and virtual health services across the four communities, co-located with the MPS in each town. The model was developed in response to primary health care market failure in the subregion, which made it financially unviable to operate private general practice, and the closure of all private GP clinics in the four communities. The underpinning premise, with partnership and strong community involvement, was that the individual communities would be stronger together.

162. Although LHDs have not traditionally engaged in primary care delivery, the transfer of governance and operation of the primary care medical centres to the LHD has allowed the maintenance of primary care and medical support for the MPSs in these communities (supported by virtual health where required). The model draws on a section 19(2) exemption of the *Health Insurance Act 1973 (Cth)* to permit state renumerated health services to claim Medicare Benefits, contributions from the WNSWLHD, RDN and WNSWPHN, as well as other resources and in kind contribution from community stakeholders. An independent evaluation has been completed by the Sax Institute. This work is significant for many other rural areas where blended-jurisdiction funding and single employer models could be used to sustain high quality primary health care in the face of market failure.

163. Other existing models that appear to have merit include further development and evolution of the HealthOne model with a single workforce employer and more integration of services; a rural pilot of a virtual Urgent Care Centre (adapted to include primary and secondary care alongside urgent care); and the Single Employer Model to support the training of Rural Generalists that has been piloted by the Murrumbidgee LHD.

164. In response to some of these challenges across the allied health professions, the WNSWLHD has formed collaborative partnerships with the larger NGO providers in the District who face similar difficulties. The shared intent is to enter into 'single employer' models with them in small towns through which either an NGO or the LHD will be the employer of a health professional who will then provide service across the collaborative. This is a sensible response to the needs of small communities which could ameliorate the disaggregation of part-time specialised health worker roles that have been the traditional alternative. By pooling the myriad component portions of work in small communities to create full time work opportunities, more attractive jobs may be able to be developed.

165. The WNSWLHD has actively supported the development of the Western NSW Health and Care Employment Collaboration along with Marathon Health, Live Better, and the RFDS which is actively working with Charles Sturt University and TAFE NSW to develop an employer-led Regional Workforce Activation Hub for community and allied health support staff.

166. In November 2022, the WNSWLHD committed to deliver a three-year People Strategy, which includes 45 initiatives, aiming to address workforce shortage, improve wellbeing and culture, reduce burnout, develop leadership, and allow staff to innovate. A copy of the People Strategy is at **Exhibit E**; **(MOH.9999.1213.0001)**

167. One of the immediate strategies enacted by the LHD was the local implementation of recruitment and retention incentives for hard to fill roles. NSW Health introduced the Rural Health Workforce Incentives Scheme (**RHWIS**) in July 2022. The RHWIS is a comprehensive incentive package that aims to attract, recruit, and retain key health workers in rural and regional locations employed in positions that are hard-to-fill or critically vacant.

168. As of the end of June 2023, 263 roles have been identified as 'hard to fill' with over 1,000 staff receiving attraction and retention payments. From August 2023 until June 2026 staff who take up new roles with NSW Health in regional and rural locations can receive incentive packages up to $20,000. In the last year the LHD has commenced 76 nurses from overseas and another 29 are due to start in the next few months.

169. Accommodation for staff is a key factor for recruitment and retention in rural areas. Key health worker accommodation has, or is being, established in locations of high need, including Warren, Collarenebri, Walgett, Condobolin, Baradine, Mudgee, Trundle, Tullamore, Dubbo and Wellington. Inevitably, more will be needed to continue to support the attraction and retention of a rural health workforce across the District.

170. As part of the LHD's commitment to training and supporting the new graduate and overseas qualified nursing workforce, the Centre for Rural Education, Simulation and Training-Simulation Centre (**CREST-Sim**) was established in Wellington. CREST-Sim supports nurses, who may not immediately have the skills to practice in a rural and remote facility, to attain the requisite skills and confidence through high quality simulation-based education incorporating Virtual Reality and Augmented Reality training programmes. The centre also offers programs in advanced skills including critical, emergency and perioperative care.

171. To help secure the future workforce pipeline, clinical nurse educators and new graduate programme intakes have been increased as well as increasing Enrolled Nursing cadetships and AIN (Assistant in Nursing) scholarships. The LHD launched a two-year programme for new graduates across the range of Allied Health disciplines, which was a first in regional NSW. That programme was oversubscribed and an annual intake will be established from 2024 onwards. Additional staff wellbeing and leadership programmes have been delivered to several staff across the region as part of the LHD's People Strategy.

172. Through the investment in LHD staff there has already been an overall growth of 178 FTE into frontline clinical roles and a subsequent 3% reduction in the number of staff with excess leave. The benefits are expected to increase over time, working towards a reduction in both premium labour-agency utilisation and overtime to ensure a sustainable and productive workforce into the future.

x. Research

173. Research funding disproportionally favours metropolitan centres. Consideration should be given to needs and differences in capability and capacity between metropolitan and rural, regional and remote (R3) areas and mechanisms for funding for rural LHDs to address deficits in research capability and capacity. Areas of focus to enhance rural research include decentralisation of funding to rural LHDs, specifically to build clinical trials (for example the R3 clinical trials programme); opportunities to develop innovative co-funded models of research, and more rurally focussed clinician researcher PhDs or Masters programmes. Clinician researchers are well placed to identify issues and research opportunities related to patients and health care delivery, and to promote the translation of findings.

xi. Environment

174. Climate change may exacerbate the rate of population decline in more remote communities and amplify the existing health inequalities in rural communities.

175. There is an opportunity to reduce the impact of health services emissions on the climate and prepare NSW Health for the future impacts of climate. Recently, WNSWLHD has installed large solar power arrays. Energy efficiency, waste reduction and water harvesting programmes are variously well underway or in the final stages of planning. Changes in the use of particular therapeutic goods, and particularly anaesthetic drugs, are being introduced given the impact that pharmaceuticals and other medical supplies have on the industry's carbon footprint.

176. The WNSWLHD has committed to an Environmental Strategy to progress environmentally sustainable activities and initiatives to reduce our carbon footprint while delivering sustainable rural healthcare ready to adapt to climate challenges. This includes work to improve and maintain health in a changing climate as well as minimise emissions from the health service and provide low carbon and climate resilient health care. Sustainable procurement with regard to pharmaceuticals and consumables, sustainable building practices, water harvesting, waste management and sustainable travel form some of the practical strategies to achieve this.

177. Future government priorities and funding mechanisms should support, and incentivise, capital investment and behavioural change programmes that ameliorate the impacts of climate change across the entire health industry. This needs to include both the supply chain(s) and the providers of medical consumables and equipment. Appropriate legislation may be an enabler of this change.

G. CONCLUSION

178. In conclusion there is broad evidence of the need for reform in the way that healthcare is financed and operates in remote, rural and regional NSW.

179. The most obvious need across the entire Australian health system is for the component parts of the system, divided as they are into Commonwealth and State responsibilities, to work more cohesively together.

180. The most effective way to resolve the boundary disputes, complexity, and entirely different planning and operating paradigms between the two levels of the overall system is some form of pooled funding, from which the sensible reform of health services in small towns is able to emerge.

181. Effective models to address this issue are most likely to emerge in the regional, rural and remote setting simply because the local consequences of not doing so are more profound.

182. The WNSWLHD is willing, and has the technical and leadership capability, motivation and innovative spirit to be a test bed for such reform in partnership with its local communities, the Commonwealth, the Ministry of Health, the Rural Health Division and partner organisations relevant to the WNSWLHD context.

183. This level of reform will not, of itself, be sufficient to address the needs of the people of NSW who live in remote, rural and regional NSW, nor the many health care staff who are employed to meet their needs. In this statement I have provided, on behalf of the WNSWLHD, a broad array of evidence of the profound disparity in health and social outcomes and access to both primary care and specialist services that the people who live in the WNSWLHD area experience.

184. Those issues will only be meaningfully addressed if the healthcare financing model is substantially and resolutely evolved to achieve a far greater balance of tension between distributive equity, equity of health outcomes, investing in the things that deliver the greatest benefit, and productive efficiency.

185. Such reform will be difficult to navigate. Nevertheless the evidence suggests that not doing so is already a root cause of the fragility seen in parts of the healthcare system.

186. Put in the simplest of terms, our clinical staff are confronted by difficult diagnoses, complex prescription and long hours of hard work every day. Our patients show remarkable bravery as they place their trust in us while they navigate the unknown, arduous journey of despair, hope and recovery. It is very reasonable that they, the people who we have the privilege to serve, should expect that those who govern the State's health system, and those of us who lead within it, will have the courage to diligently undertake the sensible and necessary reforms that are required to improve their lives and the health of the system overall.

187. Mandaang Guwu (thank you).

Mark Spittal

30-4-24

Date

Witness: JS Singh

30/4/24

Date