Special Commission of Inquiry into Healthcare Funding

Outline of anticipated evidence

Name: Greg Sam

Occupation: Chief Executive Officer of the Royal Flying Doctor Service, South Eastern Section

Name: Associate Professor Shannon Nott

Occupation: Executive General Manager Health & Clinical Services; and Chief Medical Officer of Royal Flying Doctor Service, South Eastern Section

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

A. Role and Overview of RFDS

2. Mr Greg Sam is the Chief Executive Officer of the Royal Flying Doctor Service South Eastern Section (**RFDS SE**). He has held this role since February 2014.
3. Associate Professor Shannon Nott is the Executive General Manager Health & Clinical Services and Chief Medical Officer of RFDS SE. He has held this role since March 2024. Prior to this role, Associate Professor Nott was the Rural Health Director of Medical Services for Western NSW Local Health District for 7 years (**WNSWLHD**).
4. The RFDS is a not-for-profit charity with a 95-year history of providing emergency and essential care to remote, rural and vulnerable communities throughout NSW and Australia.
5. Nationally, the RFDS operates as a federation of state member organisations, all of which are community member-based organisations, governed by their own boards. RFDS SE is responsible for providing services across NSW and the Australian Capital Territory
6. In the last four years alone, with a fleet of 14 aircraft and some 68 road vehicles, RFDS SE travelled 17.8 million kilometres across NSW to provide lifesaving, emergency and primary

health services, patient transfers, mental, dental and other vital health care services in a quality assured manner. During this time the RFDS SE provided more than more than 300,000 occasions of care to people living across regional, rural and remote NSW. This including:

i. Nearly 28,000 aeromedical retrievals and inter-hospital transfers;
ii. 28,700 GP medical practice consultations (commenced FY23)
iii. More than 30,000 primary health consultations;
iv. Over 14,000 mental health, alcohol and other drugs consultations
v. 20,000 telehealth consultations
vi. Over 17,000dental consultations
vii. 400 medical chests

7. RFDS SE services are designed and delivered through a place-based collaborative health service planning approach, to align with community health needs.
8. The RFDS SE has delivered services in very tough times and absorbed escalating transport, delivery, maintenance and resourcing costs so it can continue to deliver vital medical services to communities in need in remote and rural locations. The past four years have been particularly tough, and the impacts of COVID-19, a series of natural disasters and continuing inflationary pressures are taking their toll.
9. In order to maintain its operations at present levels, the RFDS SE would benefit from:
   a. recognition of the vital role it plays in the NSW Health system, in providing emergency and health services to communities who may not otherwise have access to healthcare;
   b. (equal) access to Government incentives and programs aimed at strengthening NSW's rural and remote health workforce;
   c. funding models, programs and incentives that reflect actual costs and support equity of access to vulnerable communities;

d. funding certainty (including through long-term contracts).

B. RFDS SE

10. In 2022/2023, the RFDS SE flew over 3 million kilometres to provide critical emergency and primary health care services across more than 70 regional, rural and remote locations in NSW and provided more than 68,000 occasions of care.
11. The RFDS SE's two key regional bases in NSW are located at Broken Hill and Dubbo. They deliver Emergency Retrievals, Acute Inter-Hospital Transfers (Air Ambulance), the Clive Bishop Medical Centre and Primary Healthcare Clinic, Dental Care, Mental Health, and Alcohol and Other Drugs Counselling Outreach, to people in rural and remote communities across NSW.
12. The RFDS SE works across all 15 NSW Local Health Districts (**LHDs**). RFDS SE has a long history, and close relationship, with the Far Western LHD (**FWLHD**) and the WNSWLHD. It works in partnership with these LHDs providing RFDS personnel and services. For example, in FWLHD, the RFDS SE provides medical clinics and 24/7 medical support to LHD staff in managing emergency presentations to the hospitals in Ivanhoe, Menindee, Tibooburra, Wanaaring, White Cliffs and Wilcannia.
13. In 2022/23, the RFDS SE employed around 350 staff across Broken Hill, Cobar, Dubbo, Essendon, Launceston, Lightning Ridge and Sydney, including medical practitioners, nurses, ambulance transport attendants, mental health clinicians, alcohol and other drug clinicians, dental health practitioners, pilots and engineers. Two thirds (2/3) of RFDS SE employees are based out of its two main regional bases in Dubbo and Broken Hill.
14. A copy of the RFDS SE's 'Year in Review 2022-2023' Report is at SCI.0009.0026.0001.

C. Funding arrangements

15. 52% of the RFDS SE's total funding is derived from bequests and donations, merchandise sales, and other activities. Approximately 34% is provided by the NSW Government, and a further 14% by the Commonwealth Government including through MBS payments and funding received from Primary Health Networks.
16. NSW Government funding (via contracts and grant agreements) is provided to the RFDS SE by NSW Health and its agencies, such as NSW Ambulance, NSW HealthShare, and Local Health Districts.
17. In recent years, particularly following the COVID-19 pandemic, costs incurred to deliver RFDS services have risen significantly.
18. In the RFDS SE's experience, existing funding models do not adequately cover the actual costs of delivering services and perpetuate further inequity between remote, rural and metropolitan areas. This is due a range of factors such as:
    a. use of activity-based methodology, which does not reflect the actual costs of delivering healthcare in rural and remote communities;
    b. lack of recognition for the higher cost of providing services from within rural and remote NSW;
    c. lack of recognition of core expenses associated with the delivery of these services, including base costs, workforce commitment costs, mandatory training costs, regulatory, compliance and risk management costs, and certain administrative and operational costs (essential to the efficient administration, management, coordination and delivery of services and use of resources).

19. Consequently, RFDS SE has increasingly needed to divert its philanthropic funding into core costs, in order to fill funding gaps, so that it can maintain its core operations and services. This has an opportunity-cost which limits the RFDS SE's ability to provide additional services to meet rising community demands.
20. At the same time, the RFDS SE continues to see poor, and in some areas, declining healthcare outcomes for people living in many regional NSW communities.
21. Demand for RFDS SE services continue to increase.
22. The RFDS SE recognises the demands on the public purse and the strong competition for the health dollar (regardless of whether budgets are in surplus or deficit).
23. It is our view that the health dollar should be prioritised and strategically invested to address the growing needs of the healthcare system and the growing inequities experienced by remote, rural and regional communities in NSW in accessing healthcare.
24. In this respect, a number of guiding principles warrant consideration:
    a. **Equity**: Government policies, funding programs and incentives should not exclude, disadvantage or discriminate against Not-for-Profit (NfP) organisations that provide health services in remote, rural and regional areas. Further, funding and health programs should be applied through an equity lens to support health needs in rural and remote communities. This includes increased investment for rural and remote communities where access challenges are compounded by social determinants of health, workforce access and geography.
    b. **Access**: Remote and regional communities need access to vital health services - including primary and allied health. The benefits of this are self-evident both in terms of health outcomes and reducing pressures on the health system. NfP organisations

should be funded to provide medical and health services to rural and remote communities where the public health system cannot.

c. **Certainty**: Given the challenges of servicing remote and rural communities, short term grants or funding arrangements, be they 1, 3 or 5 years, do not provide the funding certainty needed to make significant investment and resource commitments. In our view, longer term contracts provide greater investment certainty.

d. **Reimbursement of Actual Costs**: Funding models should reflect the true, actual, costs of delivering health and medical services. Previous inquiries have found that activity based funding models do not represent the true cost and nature of delivering these services. This is particularly the case with aeromedical services where activity based funding (measured, for example, by kms flown) does not reflect the true costs such as standby costs, full costs of use of aircraft or key personnel (including pilots, doctors and nurses).

25. Governments and policy makers alike unanimously agree that in the healthcare arena, remote and regional communities cannot, and should not, be left behind. Achieving that outcome is the challenge.

26. Investment of highly contested Government funds should be directed to, and invested in, priority healthcare capabilities that provide lasting outcomes in rural and remote communities. This could include:

a. Recognising and supporting NfP organisations, like RFDS SE, that operate from, and are locally invested in, rural and remote communities and have a track-record of collaboratively meeting community need with NSW health partners.

b. Valuing and recompensing NfPs for the actual costs of healthcare services in remote and regional areas - including allocating resources through an equity lens to reflect the complexity of health needs.

c. Supporting collaborative health planning between key health stakeholders, including NFPs, to clinically operationalise programs that meet health needs in rural and remote communities.

d. Supporting NFPs that currently service these community needs, to provide enduring capabilities, a more stable workforce, improved access to healthcare, better healthcare outcomes and reduced pressure on the health system overall.

D. Integration with Local Health Districts

27. The RFDS SE is a respected partner in the NSW health system, specifically to both WNSWLHD and FWLHD. Through partnership with health system stakeholders and communities RFDS SE works collaboratively to deploy its healthcare workforce and services to ensure they are directed to where they are most needed – where there are health system market failures.

28. In FWLHD, the RFDS SE is integrated within existing LHD structures including cross-credentialing medical staff, ensuring telehealth services into FWLHD facilities utilise NSW Health digital tools (eMR, eMeds, telehealth systems) and many staff sit on FWLHD clinical steering committees and feed into policy development.

29. For example, in Wilcannia, the RFDS SE utilises retrieval teams to provide telehealth services using NSW Health infrastructure to support the FWLHD staff on site. In providing that support, the RFDS SE is able to access NSW Health medical records directly through their digital systems, which allows the RFDS SE clinicians to prescribe medications where appropriate, as well as having full visibility of patient records such as pathology results, imaging and other hospital documentation. In Wilcannia, RFDS SE emergency teams can provide 24/7 virtual support and retrieval/transport services if required and RFDS SE GPs support aged care residents in the facility.

30. While there have been some hurdles to achieving this type of integration, these hurdles have decreased as NSW Health's digital infrastructure has matured. Cross-credentialing was one of those challenges but is now streamlined within the FWLHD.

31. While the RFDS SE collaborates with other Local Health Districts (predominantly for the provision of aeromedical services), the RFDS SE has been able to integrate its services with those delivered by the FWLHD and to a lesser degree WNSWLHD.

E. Workforce

32. The RFDS operates with a predominantly regionally based workforce (2/3rds).

33. The RFDS SE relies heavily on a specialist workforce.

34. The nature of RFDS SE services and their location require the workforce to have particular skills and experience. Like most other health services across NSW, RFDS SE is experiencing many changes in workforce supply, retention, and affordability.

35. RFDS has recently taken on the running of three regional GP medical practices that had either closed down or were at risk of closing. The RFDS did so in response to community approaches and concerns, and because it saw a need, with the traditional primary care model that focuses on a Medicare-supported private general practitioner declining quite quickly in rural and remote areas.

36. Based on surveys completed by the Western NSW Primary Health Network, it's estimated 41 towns in the Western PHN region may not have a GP practicing there in 10 years.[1]

37. A copy of the RFDS SE's 'Best for the Bush' Report 2023, which sets out key findings on concerning trends in health outcomes and service access for people living in rural and remote areas, and the urgent need for improvement, is at SCI.0009.0025.0001.

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[1] Securing the future of Primary Health Care in small towns in Western NSW, Western NSW Primary Health Network, 2019.

38. Even if mechanisms were implemented to address workforce movements across the state and country, there will likely be a gap or delay in being able to address these issues in the next 5-10 years, given the length of time it takes to train new practitioners.

Date: 21 May 2024