Witness Statement

Name: Prudence Buist

Occupation: Chief Executive Officer, COORDINARE Limited, trading as South Eastern NSW Primary Health Network (**SE NSW PHN**).

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

A. Role

3. I am the Chief Executive Officer of SE NSW PHN. I have held this role since January 2023.
4. I have more than 25 years of experience in health care including nursing to executive level roles in both metropolitan and rural hospitals in NSW and New Zealand. A copy of my CV is exhibited to this statement SCI.0011.0343.0001, with my personal contact details redacted.

B. Overview of SE NSW PHN

5. SE NSW PHN extends from Helensburgh in the north to the Victorian border in the south and inland to Cooma, Monaro, Queanbeyan, Yass and Goulburn. SE NSW PHN covers 12 local government areas and territories, and includes two LHD areas, the Illawarra Shoalhaven Local Health District (**ISLHD**) and Southern NSW LHD (**SNSWLHD**). The SE NSW PHN region has a population of over 641,960 people, with 790 general practitioners (**GP**s), across a distance of 50,000 square km. There are over 33,180 First Nations people living in SE NSW PHN.
6. The SE NSW PHN service area includes metropolitan, regional, and rural areas. The older population within SE NSW PHN is greater than the national average. For example, in the Eurobodalla region, people aged 65 years and over make up about 32% of the population. The national average is around 17%.
7. The role of SE NSW PHN is to improve the health and wellbeing of our community. SE NSW PHN works with government, non-profit, healthcare providers, service partners and

communities to commission, coordinate and capacity-build local health services and support those at risk of poor health outcomes. We envision one coordinated regional health system that provides exceptional care, promotes healthy choices and supports resilient communities.

8. SE NSW PHN's *Strategic Directions for 2024-2027* sets out the three key priorities for 2024-2027, which it uses to plan the highest impact activities:
   a. Accessible care – to improve access to services such as mental health, alcohol and other drugs, chronic conditions, after hours and urgent care, and Aboriginal health.
   b. Systemised care – to support the primary care workforce, primary care quality and integration, data synthesis, care coordination and virtual care.
   c. An activated community – to foster health across the lifespan, addressing the social determinants of health, increasing prevention activities, and improving community resilience and social connectedness.
9. A copy of this document is exhibited to this statement SCI.0011.0329.0001.

C. Primary Health Care and Medical Workforce Challenges

10. SE NSW PHN has engaged with the Department of Health and Aged Care (**DOHAC**) to map the distribution of GPs in our area. The SE NSW PHN estimates there is presently a 20% deficit against population health needs of GPs in the Southern NSW region. I understand that there is currently about a six-week wait on average to see a GP for many of the smaller towns across Southern NSW.
11. GP workforce information is routinely collected by the SE NSW PHN using information gathered directly by the PHN practice support team who work closely with local GPs and their staff to identify and understand their workforce needs and capacity. SE NSW PHN is also advised on local issues by two Clinical Councils (one for each region) that includes GPs and other health professionals, a Community Advisory Committee, and an Aboriginal Health Council. SE NSW PHN has recently been collaborating with SNSWLHD to host medical

engagement dinners across the region, with all local GPs invited to attend and discuss local issues (see Needs Assessment section below).

12. Workforce information is then reported to DOHAC via programs such as the *Workforce Planning and Prioritisation Program* (**WPP**), or consultations such as the *Supply and Demand Study: General Practitioners in Australia* survey (currently underway). Under the WPP, NSW and ACT PHNs work with the LHDs and medical colleges to determine the optimal general practice locations to place GP trainees (registrars), so they receive training from qualified supervisors as well as serve the community. As part of their training, GP registrars also complete several hospital rotations.
13. I expect that the deficit in GP availability in the area will get worse in the next few years. There are several reasons for this, including that the population in the region has increased but the GP recruitment in the area has not kept pace. One of the major issues is the ageing and retirement of general practitioners in the region. The area is also susceptible to population peaks and troughs, with numbers swelling during holidays; snow season and Christmas/summer holidays.
14. There is significant pressure on GPs in smaller communities. Many of the GPs in smaller communities not only have their general practice patients, but they may also work in a hospital or Multi Purpose Service, as well as also possibly supporting an aged care service. Practices in the region also report challenges with backfilling positions when their doctors have gone on maternity or other blocks of leave.
15. There are also challenges with the viability of practices around the introduction of payroll tax, without the ability to bulk bill sufficient patients and maintain financial viability. I am aware of practices contemplating selling because they are not going to meet the bulk billing threshold of the NSW Government payroll tax initiative.
16. SE NSW PHN is aware of a high use of a locum medical workforce in the Southern NSW region and that there are issues attracting candidates into the training pipeline at the LHD-based

junior medical officer (**JMO**) level. SE NSW PHN is attempting to support general practices recruit general practitioners, nurses and allied health to the region, however with minimal success under the current Medicare funding model.

17. Difficulties with attracting allied health professionals to the region, has resulted in SE NSW PHN commissioned allied health services being underspent due to providers not being able to recruit allied health professionals. This is a system-wide issue, but SE NSW PHN has observed this particularly in the mental health, and drug and alcohol space.

18. Access to specialists is a key issue for residents of Southern NSW. Many areas have no easy local access to psychiatrists, paediatricians, geriatricians, respiratory, dermatology and other specialists.

D. Batemans Bay Medicare Urgent Care Clinic

19. On 4 December 2023, the Batemans Bay Medicare Urgent Care Clinic (**the BBUCC**) opened, under a Commonwealth funding initiative.

20. Under the current funding model, the BBUCC is open 7 days a week, from 8am to 6pm. The BBUCC clinic offers a range of bulk billed medical services for conditions that are not immediately life threatening but require timely treatment (classed as triage category 4 and 5 by emergency departments).

21. Some of the common services provided at the urgent care clinic include:

    a. Basic imaging services, such as x-rays, to diagnose fractures or sprains.

    b. Treatment of minor injuries including, minor burns, cuts sprains, fractures.

    c. Wound dressing services.

    d. Treatment of common illnesses such as colds, flu, and minor infections.

    e. On-site laboratory services for blood tests, urinalysis, influenza and COVID tests, and other common diagnostic tests.

    f. Management of asthma attacks and allergic reactions.

    g. Administration of IV fluids for dehydration.

22. Reports provided by the BBUCC have shown that over an 8-month period, since the BBUCC opened in December 2023, it has had over 6,600 patient presentations, an average of 29 patients per day.

23. Community access to urgent care is a priority of both state and federal governments. The BBUC is a Commonwealth initiative. SE NSW PHN has also assisted with NSW Health-funded urgent care facilities in Goulburn and Wollongong. The main difference is that the NSW Health facilities are encouraging people to be triaged by first calling the Healthdirect telephone line before being directed to an appropriate health service. The Commonwealth clinics are designed as walk-in clinics.

E. Role of PHNs in Urgent Care

24. PHNs are tasked with commissioning urgent care centres on behalf of the government, meaning they assist with the tender process to choose an urgent care operator, and oversee the establishment and ongoing monitoring of these facilities. The PHN role is vital in ensuring that the urgent care centres meet the needs of the communities they serve. This involves collaborating with local stakeholders, healthcare providers, the community and LHDs to ensure that the centres are appropriately equipped, staffed with qualified professionals and have clear referral pathways to the local hospital emergency departments.

25. I understand from verbal communication with SNSWLHD executive here has been a 20% reduction in triage category 4 and 5 patients in the Batemans Bay District Hospital Emergency Department (**ED**) over this same period.

26. The BBUCC has employed two new GPs to the area. We have had feedback from the GP located across the road from the clinic that their practice has had lower patient numbers since the BBUCC opened, but otherwise no negative patient attendance onflow reported at other general practices in the area.

27. I am aware that there has been significant community concern expressed about the closure of the Batemans Bay hospital ED. There was a petition against its closure that I understand gained about 18,000 signatures (noting that the population of that area is approximately 17,000). There were also community events to draw the issue to the attention of politicians.
28. The BBUC was a Labor Party election promise, based on community concerns regarding health services in the area. When SE NSW PHN was tasked with assisting with the commissioning the BBUC, we worked closely with Margaret Bennett, the Chief Executive of SNSWLHD. This partnership aimed to ensure that the clinic was designed to meet the needs of the region, enhance access to care for the local community, and established effective processes for transferring patients to Batemans Bay District Hospital when required.
29. SE NSW PHN's consultation regarding the clinic was primarily with the local medical community and liaising with the local Member for Gilmore, Fiona Phillips MP, to ensure the clinic would appropriately address gaps in the local service system. Our practice support team regularly engaged with local general practices to ensure that the clinic would be supported by the local healthcare workforce.
30. SE NSW PHN has presented a proposal in conjunction with SWNSW LHD to Mark Butler MP, the Minister for Health and Aged Care, and Ryan Park MP the NSW Minister of Health, for a Federal and State co-funded 24-hour Urgent Care Clinic model. Under a co-funded model, the scope of the current service would be expanded from being able to accept triage category 4 and 5 patients, to being able to accept triage category 2 to 5 patients, and additionally, to add services such as outpatient service appointments to address the community's needs and concerns around not having a hospital in Batemans Bay.
31. Any expanded Urgent Care Clinic would be located within the current structure of the hospital. Once the Batemans Bay ED closes, the Urgent Care Clinic could move into the ED's footprint.
32. In my view, the standout feature of BBUCC that contributes to its effectiveness, and the community's awareness of it and trust in it, is its co-location with the Bateman's Bay hospital

ED. A formal protocol is in place that allows patients to be seamlessly transferred between the two facilities when required. It currently works well because its doors are side by side with the ED and that the staff of both facilities comply with the patient transfer protocol.

33. If an expanded Urgent Care Clinic is not implemented once the Batemans Bay District Hospital ED closes, in my view, the overall effectiveness of the BBUCC will not be realised, as a higher urgency category of patients will not be able to be seen on-site.

F. Limitations to Aboriginal workforce training pathways

34. SE NSW PHN is aware that there is currently no local training pipeline for a First Nations health workforce in SNSWLHD. We have been seeking to work with our commissioned providers such as headspace to try and employ First Nations people in their workforce.

G. Barriers to Joint Service Planning and Delivery – Funding Models

35. SE NSW PHN receives funding from the Commonwealth and the NSW governments, which, to our observation, can have different priorities. Existing funding models prioritise activity rather than value-based care. With more flexibility and certainty in the funding models at both national and state level, we would be better able to develop and sustain innovative and collaborative service models that genuinely focus on the needs of local communities and consumers. This would also encourage greater efficiency by creating a more seamless health system for consumers and shifting the balance towards primary care.

36. The majority of the funding we receive is from the Commonwealth DOHAC.

37. SE NSW PHN has a Collaborative Commissioning Project Agreement with the NSW Ministry of Health, the ISLHD, and the SNSWLHD.

38. On occasions, SNSWLHD will jointly contribute funding together with SE NSW PHN for place-based solutions. For example, SNSWLHD co-funded four part-time GPs to be placed in medical leadership roles at local hospitals from January 2018 to June 2023. The General Practice Liaison Officer (**GPLO**) roles were dedicated to developing new approaches to improve

communication, integration and coordination between hospitals and community GPs. GPLOs were employed by the LHD allowing them to work from within the system to effect change.

39. GPLOs played a key role during the COVID-19 pandemic representing primary care in outbreak planning working groups and developing models of care for management of COVID positive patients in the community and developing communication protocols. Other projects undertaken involved an antenatal care model, preparation of patients prior to surgery, improving access to palliative care, and assisting with the development of referral pathways.
40. SE NSW PHN is attempting to identify other funding sources. Philanthropic funding models to address place-based issues are being considered, but this is not a long-term solution. For example, we have applied for philanthropic grants to enable a paediatrician to hold clinics at disadvantaged schools across Southern NSW, as the current Medicare funding model is not designed to support this type of program.
41. A longer-term funding solution for rural primary care is required to ensure sustainable and optimal healthcare services.

H. Integrated Care – Strategic Alliance Plan

42. Integrated care is a key aim of all modern health systems. Integrated care is a coordinated approach to delivering healthcare across different organisations and levels of health care that aims to provide a seamless and comprehensive service to patients. Ideally it involves combining different aspects of healthcare—such as primary care, hospital care, mental health services, and social services—so that all parts work together effectively. This approach seeks to improve the quality of care, enhance patient outcomes, and increase efficiency by ensuring that all providers are communicating and working towards the same goals.
43. SE NSW PHN works with local health providers to ensure greater service and system integration between primary and acute care. Examples are the Collaborative Commissioning Chronic Obstructive Pulmonary Disease (**COPD**) program, and projects that enable hospital

specialists such as geriatricians to assist and up-skill general practitioners to provide optimal care to their patients.

44. Starting in 2015, SE NSW PHN entered into a formal Strategic Alliance with ISLHD and SNSWLHD.
45. The purpose of the Strategic Alliance is to collaborate to drive a "one health system" mindset, in order to collectively deliver the best health outcomes. A key aim of the Strategic Alliance is to support integration across the health and social care systems, leveraging technology to enhance care and increase accessibility of care. This approach will enable us to strengthen service delivery, align and optimise the use of resources, and avoid duplication of services.
46. Under the Alliance, the chief executives meet regularly and hold joint governance meetings.
47. A Strategic Alliance Plan was developed at the end of 2023, with each agency taking the lead on agreed actions. For example, the ISLHD is leading the approach to joint planning activities. SNSWLHD is the lead agency on profiling major allied health groups to support the joint planning activities. SE NSW PHN is the lead for developing a Data Sharing Agreement to support regular data and information exchange for specific projects. Another action is to pilot a care transition service to improve how patients move between hospital and primary care.
48. A previous successful outcome of earlier Alliance work was the joint *South Eastern NSW Regional Mental Health Plan* in 2018. A copy of this document is exhibited to this statement SCI.0011.0327.0001.
49. We were the first PHN area in NSW to develop this approach to mental health planning. We are collaborating with the LHDs on updating the Plan.
50. Our organisations are also part of the NSW Health and NSW Primary Health Networks' Joint Statement: *Working Together to Deliver Person-Centred Healthcare*. A copy of this document is exhibited to this statement MLH.0001.0014.0001; Exhibit C.33.15.

I. Collaborative Commissioning

51. Collaborative Commissioning is a partnership between the Ministry of Health, LHDs, PHNs, and other service providers to address community health needs and reduce hospital visits. The program is funded by NSW Ministry of Health. In the SE NSW PHN region, the COPD Collaborative Commissioning project brings together various healthcare professionals, including GPs, pulmonologists, nurses, respiratory therapists, physiotherapists, dietitians, and social workers. Collaborative Commissioning enables the team to collaborate and communicate to deliver consistent, holistic care tailored to the patient's needs – whether they are in the hospital or being treated by their GP.

52. As part of the trial phase, the COPD program aims to recruit 18 general practices to work with a multidisciplinary team of specialists based at ISLHD and SNSWLHD.

J. Benefits of Collaborative Commissioning.

53. Under this type of model of care, the patient is more routinely and carefully monitored so that they can better manage their symptoms and avoid being admitted to hospital where possible. The program supports practice nurses and allied health professionals to work to top of their scope of practice.

54. Effective communication and coordination among healthcare providers, caregivers, and patients are vital. As part of the program, we have provided an electronic health record platform (Inca) that allows the team members involved in the patient's care to access relevant health information about the patient including the 'shared care plans' that the care team can view and contribute to.

K. Challenges of Collaborative Commissioning.

55. The key challenges with implementing a Collaborative Commissioning or integrated care program is that it requires a lot of joint planning, organising and change management for many different types of health care professionals and organisations. Collaborative Commissioning takes a lot of time, funding and resources, especially to develop and implement new governance models, IT systems and care pathways.

L. Integrated Care – Data Sharing Agreement

56. SE NSW PHN is seeking to create formal data sharing agreements between ISLHD, SNSWLHD that will improve the ability of the organisations to jointly undertake innovative healthcare projects. The first stage of this has been completed, with a data sharing protocol established. The next step is to create a data sharing agreement for any specific project that arises, for example, the COPD project will have a data sharing agreement relating to that project, and which is currently in draft form.

M. Integrated Care - The Lumos Program

57. The Lumos program is an example of effective collaboration between the NSW Ministry of Health, PHNs and general practices.

58. The Lumos program links de-identified patient records from general practices with NSW Health records, to map patient journeys across the NSW health system. Participation is free of charge and provides insights on how patients are interacting with the health system.

59. PHNs recruit local general practices to join the Lumos Program. Participating general practices receive a report every 6 months with information about the services their patients' access, such as ED presentations and hospital admissions as well as a comparison to the average practice cohort in the area and across NSW. This assists GPs to understand their patient cohort – including the main types of health conditions and chronic diseases they have – and how well the practice is managing those patients compared to others. PHNs work with participating practices to develop quality improvement responses to any issues identified in their Lumos reports.

N. Social Prescribing Service

60. Many factors that affect health and wellbeing cannot be treated by medicine alone. Approximately 1 in 5 GP consultations are for social factors such as unemployment, housing and economic stress, relationship issues, loneliness and social isolation. In 2021, SE NSW PHN

commissioned a Social Prescribing Service for people living with chronic health conditions. Social prescribing is an innovative approach to health care that allows GPs and other health care professionals, including those based at hospitals and Aboriginal Community Controlled Health Organisations (**ACCHOs**), to refer patients to the Social Prescribing Service in order to improve their health and wellbeing. That is, to 'prescribe' non-medical treatments to assist their patients.

61. The Social Prescribing Service will look different in the city to in rural areas, and it could include activities like art programs for mental health and wellbeing and improving a person's social connections within their community.

62. Using a unique and innovative model of care, the Social Prescribing Program involves a 12-week intensive program of 45 minutes contact each week with a 'link worker.' The social prescribing program model is unique in that the link worker spends significant time coaching the client and assisting with practical issues (such as obtaining social services including the NDIS and housing support) and assisting them to take part in community activities that could include art or yoga classes, or other health and lifestyle programs. The service currently employs seven link workers, who are supported by a database of over 2,800 local community and wellbeing activities.

O. Needs Assessment and GP Engagement

63. As part of our commitment to evidence-based planning and commissioning, SE NSW PHN conducts a regular Needs Assessment process to identify gaps and opportunities in health and service needs, particularly for vulnerable and priority populations. The Needs Assessment is a comprehensive compilation of health and socio-demographic data, with contextual information from our Advisory Groups, and key stakeholders including community members, general practices, commissioned service providers, peak bodies, and the LHDs. Our Clinical Councils, Community Advisory Committee and Aboriginal Health Council also inform the Needs Assessment. The most recent Needs Assessment identified high rates of morbidity from

chronic conditions including cardiovascular disease, respiratory conditions (asthma, COPD), mental health issues and musculoskeletal conditions (arthritis and osteoporosis).

64. More informally, SE NSW PHN engages with local doctors in the region through twice yearly dinners. The dinners are an informal forum for local doctors to raise issues to be addressed. The dinners are attended by GPs working in regional areas who may also have affiliations with the LHDs via Visiting Medical Officer contracts. They are also attended by specialists practicing in the SE NSW PHN region.

65. Engagement via these dinners with the ACCHO located within the SNSWLHD, Katungul Aboriginal Corporation Regional Health and Community Services, has been more challenging as they largely have a locum medical workforce, and it is hard for them to attend these events.

Signature: 

Name: Prudence Smith

Date: 14/8/24