Legislative Assembly Select Committee on Remote, Rural and Regional Health

LEGISLATIVE ASSEMBLY

Final report – The implementation of recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities

Report 3/58 - May 2025

New South Wales Parliamentary Library cataloguing-in-publication data:

A catalogue record for this book is available from the National Library of Australia

ISBN: 978-1-925214-63-5

The motto of the coat of arms for the state of New South Wales is “Orta recens quam pura nites”. It is written in Latin and means “newly risen, how brightly you shine”.

Contents

Membership

Chair	Dr Joe McGirr MP
Deputy Chair	Ms Janelle Saffin MP
Members	Mr Clayton Barr MP Ms Liza Butler MP Mr Justin Clancy MP (from 18 February 2025) Ms Trish Doyle MP Mrs Tanya Thompson MP The Hon. Leslie Williams MP (until 31 January 2025)
Contact details	Legislative Assembly Select Committee on Remote, Rural and Regional Health Parliament House Macquarie Street SYDNEY NSW 2000
Telephone	(02) 9230 2821
E-mail	remoteruralregionalhealth@parliament.nsw.gov.au
Website	Legislative Assembly Select Committee on Remote, Rural and Regional Health

Chair's foreword

Three years on from the Portfolio Committee No. 2's (PC2) report, communities in remote, rural and regional (RRR) NSW continue to face significant challenges in accessing health services, especially rural primary care and maternity services.

The Select Committee on Remote, Rural and Regional Health (the Committee) was established to inquire into and report on the implementation of recommendations made by PC2 in its 2022 report, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales.* The PC2 report shed light on the poor state of the regional health system in NSW and made 44 recommendations for reform.

Over the past two years, the Committee has been monitoring progress against these recommendations across the course of three inquiries. Our first report examined workforce issues, workplace culture and funding, while our second report looked at the delivery of specific health services and specialist care. As Chair of the Committee, I am pleased to table our third and final report. This report examines cross-jurisdictional health reform, collaboration, and government consultation with local communities. Importantly, this report also sets out a recommended pathway forward to facilitate reform and ensure that the health needs of rural and regional communities are appropriately addressed.

As of June 2024, NSW Health reported that 25 of the 44 PC2 recommendations had been completed. However, the progress reported by NSW Health continues to be at odds with what communities and stakeholders are experiencing on the ground. The Committee is concerned about the extent of progress reported against recommendations and believes that the intent of many of these recommendations remains unfulfilled.

There is a clear need for ongoing accountability measures to ensure that reforms are implemented and the health needs of RRR communities are appropriately addressed. To do this, we recommend the establishment of an independent NSW Remote, Rural and Regional Health Commissioner that is empowered to hold NSW Health accountable in implementing reforms to improve the RRR health system. We also call for a number of other monitoring mechanisms, including regular reporting to NSW Parliament and additional funding for the Audit Office to undertake performance audits into key priority areas.

This report begins by examining cross-jurisdictional health reform, with a focus on rural and remote primary care and collaboration between Local Health Districts (LHDs) and Primary Health Networks. During the inquiry, we heard that rural and remote primary care is in crisis, with general practitioner (GP) staffing shortages predicted to worsen by the end of the decade. Despite this, government responsibilities to address GP shortages remain unclear and this critical work is falling between gaps in governance. We recommend measures to improve shared governance arrangements and the development of a new long-term funding model for rural and remote primary care. This funding model should consider how funding can be pooled to overcome service fragmentation.

We also consider the need to support the implementation of innovative, multidisciplinary models of health service delivery that are responsive to the needs of remote, rural and regional communities. This includes the health precinct model, which aims to facilitate partnerships across the public and private sector, and bring together hospital-based care,

primary care, education, industry, local government and non-governmental organisations. This model will facilitate collaboration between the many organisations involved in health and education to improve workforce supply, research and services for RRR communities.

Chapter Two of the report examines issues around government consultation and engagement with rural and regional communities, including through the Local Health Advisory Committee model. During the inquiry, the Committee heard that despite some progress, there are still barriers to effectively consulting and communicating with communities on local health services. We recommend that NSW Health work with LHDs to formalise the requirement for genuine consultation as part of each LHD's health service planning process, and ensure that all communities have access to a forum that enables frank and meaningful feedback. The proposed NSW Remote, Rural and Regional Health Commissioner should also be given responsibilities to ensure that the health needs of RRR communities are appropriately considered as part of government decision-making.

The final chapter of the report looks back at some of the persistent, unresolved issues that this Committee has observed over the course of its three inquiries, which lie at the core of NSW's overburdened RRR health system. During the current inquiry, we were disappointed to hear that the same issues raised in the PC2 report and in our first report continue to persist. These include critical staffing shortages within the rural and regional health system, a poor workplace culture and working conditions, and an over-reliance on locum doctors. We conclude the report with our assessment of progress against the 25 PC2 recommendations that NSW Health has reported as complete, as well as a summary of key priorities and next steps. These include recommended changes to governance and the implementation of monitoring mechanisms, as noted above.

The Committee commends the NSW Government's stated commitment to implement all of the 44 PC2 recommendations, and for its support of the Committee's work. We also acknowledge the positive steps that have been taken since the PC2 report. These include the implementation of the Rural Health Workforce Incentive Scheme, improvements to the Isolated Patients Travel and Accommodation Assistance Scheme, and expansion of the Rural Generalist Single Employer Pathway.

However, the rate of progress has been too slow, considering the amount of time that has passed since the PC2 report, and significant reform of the remote, rural and regional health system is needed. We understand that this will take time, dedicated resourcing, and collaboration between all levels of government, but we are hopeful that this can be achieved. We believe that the implementation of recommendations in this report, including mechanisms for ongoing oversight, will help to ensure that RRR health remains a priority into the future.

On behalf of the Committee, I thank every organisation, health care worker, and individual that has taken the time to write to or meet with the Committee, and share their knowledge and personal stories with us. Many stakeholders have made sustained contributions across two or three of the Committee's inquiries. I also acknowledge the work of NSW Health and their assistance across each of our inquiries. Finally, I would like to thank my fellow Committee members for their sincere engagement and ongoing collaboration over the two years of our work, and the Committee staff for all of their support.

Dr Joe McGirr
Chair

Findings and recommendations

Chapter One – Cross-jurisdictional health reform and collaboration

Introduction

Finding 1

Existing governance and funding arrangements between the NSW Government and Australian Government are not sufficiently supporting cross-jurisdictional collaboration and health reform for remote, rural and regional communities.

1.1 In its 2022 report on health outcomes and access to health services, the NSW Legislative Council's Portfolio Committee No. 2 (PC2) found that the Commonwealth-state divide regarding health funding had led to both duplication and gaps in service delivery.[1]

1.2 To address this, PC2 made a number of recommendations for collaboration between the NSW Government and the Australian Government to deliver on health reform in rural, regional and remote (RRR) areas. Supporting the growth and development of the primary health sector was a key area of reform. PC2 also recommended greater collaboration between NSW Local Health Districts (LHDs) and the Commonwealth-funded Primary Health Networks (PHNs) to improve cooperative planning of health services and drive innovative models of service delivery.[2]

1.3 During the current inquiry, we heard that little progress has been made in this area, with the state of primary care worsening in many rural and remote areas, and responsibility for addressing primary care issues continuing to fall through gaps in governance.[3] The crisis in rural and remote primary care has been an ongoing area of concern for the Committee across our three inquiries.[4]

1.4 This chapter begins by examining some of the positive initiatives taken by NSW Health, including the expansion of the Rural Generalist Single Employer Model. It will then examine the current state of rural and remote primary care in NSW, including the governance and funding arrangements that support this care. Finally, it discusses collaboration between rural and regional LHDs and PHNs, and the innovative service delivery models that offer the potential for reform.

---

[1] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, p 72.

[2] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 72, 179.

[3] Submission 6, Parkes Shire Council, pp 1 and 3; Submission 103, Royal Flying Doctor Service (South Eastern Section), p 5.

[4] Select Committee on Remote, Rural and Regional Health, *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, report 1/58, Parliament of New South Wales, August 2024, pp iv, 33-34, 66-67; Select Committee on Remote, Rural and Regional Health, *The implementation of recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW*, report 2/58, Parliament of New South Wales, March 2025, p v.

1.5 Related issues that this Committee examined in its first report, including workforce issues, remuneration, and workplace culture, are explored in more detail in Chapter Three.

Rural and remote primary care

Primary care refers to the health care that people generally seek first in their community, rather than specialist care or acute hospital care. It includes care provided across general practice, pharmacy and community health settings.[5]

1.6 In 2022, PC2 described the 'inadequate' doctor coverage in rural and remote locations, largely due to the maldistribution of doctors and a declining general practitioner (GP) workforce. To address this, the PC2 report recommended that the NSW Government:

- urgently engage with the Australian Government at a ministerial level to establish 'clear governance arrangements and a strategic plan' to deliver on health reforms to improve doctor workforce issues (Recommendation 7)
- investigate ways to support the growth and development of the primary health sector in RRR areas (Recommendation 8).[6]

1.7 Additionally, PC2 recommended that NSW Health work with the Australian Government and PHNs to expedite the implementation of a single employer model for GP trainees across RRR NSW (Recommendation 9).[7]

1.8 In its 2024 Progress Report on the implementation of the PC2 recommendations, NSW Health reported that all three of these recommendations had been completed. The implementation of the Rural Generalist Single Employer Pathway was one of the key actions cited in relation to all three recommendations.[8]

Expansion of the Rural Generalist Single Employer Pathway is a positive step

Under single employer models such as the Rural Generalist Single Employer Pathway, Local Health Districts (LHDs) employ GP trainees, rotate them across hospital training positions and GP practices for the duration of their training, and then potentially employ them as specialists within the NSW Health system. This offers trainees a more seamless transition between their hospital and GP training placements, while allowing them to keep their NSW Health employment entitlements.[9]

[5] Australian Government Department of Health and Aged Care, About primary care, viewed 31 March 2025.

[6] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 41, 72.

[7] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 74.

[8] NSW Health, *Progress Report: Parliamentary inquiry into health outcomes and access to health and hospital services in Rural, Regional and Remote New South Wales*, September 2024, pp 22-27.

[9] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 73; NSW Health, NSW Rural Generalist Single Employer Pathway, viewed 14 April 2025.

1.9 In its 2024 Progress Report, NSW Health reported that the Rural Generalist Single Employer Pathway had been established, with 21 rural generalist trainees commencing in 2024. The Pathway is being expanded over a four-year trial period (2024-2027), with 80 positions available in NSW for each of those years, and eight regional LHDs participating.[10]

1.10 During the current inquiry, a number of stakeholders described the expansion of the Pathway as a positive step in attracting and retaining rural generalists, given the benefits of single employer models for employee remuneration, entitlements and security.[11]

1.11 However, some stakeholders were cautiously supportive, noting that there is limited research in terms of the model's success and scalability. The impact of the Pathway on permanent GP attraction and retention also remains to be seen at this stage.[12] NSW Health notes that it is working with the Department of Health and Aged Care to evaluate the NSW model, in the context of a wider evaluation of the national Single Employer Model trial.[13]

1.12 While the Committee commends the work that NSW Health has done to expand the Pathway, this alone is not enough to support the primary care sector. As discussed below, stakeholders do not feel that much progress has been made since the PC2 report in terms of rural and remote general practice.

Rural and remote areas continue to be impacted by a lack of general practitioners

Finding 2

Rural and remote primary care is in crisis, despite the reported completion of actions by NSW Health to address general practitioner workforce issues.

1.13 During the current inquiry, the Committee heard about an increasing lack of primary care options in rural and remote areas, with general practice in a state of crisis.[14] Stakeholders reported that doctor shortages continue to impact many rural areas, with 'critical' shortages reported in Parkes and Inverell.[15]

1.14 In Orange, some GPs are booked out three months in advance.[16] Meanwhile, in Wellington, one GP is contemplating retirement, but may become the sole GP by

[10] *Progress Report*, September 2024, p 26; NSW Government, *Response to Inquiry into the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, February 2025, p 14.

[11] Submission 92, Rural Doctors Association of NSW, p 2; Submission 95, Local Government NSW, p 7; Submission 44, Australian Medical Association NSW, p 3; Submission 82, National Rural Health Alliance, p 8; Submission 34, Narrabri Shire Council, p 7; Submission 91, The Royal Australian College of General Practitioners (RACGP) Rural, p 5.

[12] Submission 34, p 7; Submission 92, p 2; Submission 91, pp 5-6; Submission 82, p 8.

[13] Submission 106, NSW Health, p 8.

[14] Submission 103, p 2; Submission 44, p 2.

[15] Submission 6, p 1; Submission 96, Inverell Health Forum, p 3; Submission 92, p 6; Submission 91, p 3; Councillor Louise O'Leary, Parkes Shire Council, Transcript of evidence, 13 December 2024, p 3; Answers to questions on notice, Parkes Shire Council, 13 December 2024, p 1.

[16] Submission 102, Pharmaceutical Society of Australia, p 13.

the end of the year. Australian Medical Association NSW told the Committee that this scenario reflects a 'broader crisis' impacting rural NSW.[17]

1.15 A high volume of submissions also identified the dire state of general practice in the rural town of Gulgong, 30 km north of Mudgee.[18] A case study on Gulgong and Mudgee is included below.

1.16 This lack of access to rural primary care means that local hospitals are under increasing pressure to meet routine care needs. In some cases, patients are deferring or going without care, leading to delayed diagnoses, untreated conditions and higher rates of hospital admissions.[19]

1.17 We heard that 'the exodus of GPs from rural towns continues unabated', and this situation is only expected to worsen, with more than 40 towns across rural NSW expected to lose their doctor by the end of the decade.[20]

Case study: Gulgong and Mudgee

The Committee heard that the Gulgong community has been without a doctor since the retirement of its only general practitioner (GP) in March 2024.[21] The two medical practices in nearby Mudgee have also closed their books to new patients, and there are four- to six-week wait times for registered patients to see a GP, partly due to the increased demand from Gulgong residents.[22]

As a result, many residents have no access to a GP within 100 km and are regularly travelling to areas such as Dubbo, Tamworth, Bathurst and Orange. Some are travelling as far as Sydney to see a GP, and others are simply going without critical care.[23]

Community members also described the impact of GP shortages on the already overburdened Mudgee Hospital Emergency Department, with an increase in low acuity

[17] Submission 44, p 2.

[18] Submission 5, Ms Voren O'Brien, pp 1-3; Submission 4, Mr Rod Pryor, p 1; Submission 10, Ms Amanda Whiles, p 1; Submission 12, Mr Matthew Baskerville, p 1; Submission 17, Mrs Rosemarie Griffiths, p 1; Submission 22, Mrs Kerry Warner, p 1; Submission 23, Mrs Amanda Large, p 1; Submission 24, Mrs Marian Imrie, p 1; Submission 25, Mrs Danielle Hollow, p 1; Submission 27, Mr Ashley Cooper, p 1; Submission 30, Mrs Debra Kerr, p 1; Submission 33, Mr Gordon McDonnell, p 1; Submission 35, Mr Stephen Taverner, p 1; Submission 36, Ms Kathryn Ryan, p 1; Submission 37, Ms Biruta Kass, p 1; Submission 38, Mrs Linda Bennett, p 1; Submission 39, Ms Samantha Cosgrove, p 1; Submission 40, Mrs Louise Bligh, p 1; Submission 45, Ms Sharelle Fellows, pp 1-6; Submission 46, Ms Jess Ewin, p 1; Submission 47, Mrs Anne Boyd, p 1; Submission 48, Mrs Carmelina Leotta, p 1; Submission 49, Mr Peter Leotta, p 1; Submission 51, Ms Jacinta Green, p 1; Submission 55, Mr Graham Mercer, p 1; Submission 56, Ms Marea Lerade, p 1; Submission 58, Ms Caitlin O'Sullivan, p 1; Submission 59, Mrs Sharon Morrow, p 1; Submission 60, Mrs Toni Morrison, p 1; Submission 62, Mrs Justine MacLennan, p 1; Submission 63, Mr Peter Clarke, p 1; Submission 65, Mr Steve Fitzgerald, p 1; Submission 66, Name suppressed, p 1; Submission 67, Mrs Kathryn Pearson, p 1; Submission 69, Mr Matthew Azzopardi, p 1; Submission 70, Ms Wendy Borchert, p 1; Submission 71, Mr Christopher Pearson, p 1; Submission 72, Mrs Linda Edwards, p 1; Submission 80, Mrs Belinda O'Gorman, p 1; Submission 89, Ms Maxine Most, p 1; Submission 104, Ms Sarah Elliott-Troy, p 4.

[19] Submission 6, pp 1, 3; Submission 82, p 5; Submission 72, p 1.

[20] Submission 103, p 5.

[21] Submission 5, p 1; Submission 45, p 1; Ms Fellows, Evidence, 12 December 2024, p 30.

[22] Submission 5, p 1; Submission 10, p 1; Submission 17, p 1; Submission 35, p 1; Submission 45, p 1.

[23] Submission 39, p 2; Submission 45, p 1; Submission 48, p 1; Submission 49, p 1; Submission 63, p 1; Submission 67, p 1.

presentations.[24] This is expected to worsen as the population increases, with significant renewable energy projects planned in the region, including the development of the Central-West Orana Renewable Energy Zone.[25]

During the hearings for this inquiry, the Committee heard that in the community 'the prevailing sentiment is one of abandonment', following a perceived lack of government action to restore access to primary care in Gulgong.[26] The community has called for urgent action to address the current crisis, as well as longer-term measures, including improved incentives for medical students to choose rural general practice, improved incentives for GPs to relocate to regional areas, and long-term workforce strategies that consider greater roles for pharmacists and nurse practitioners.[27]

Government responsibilities for addressing primary care issues remain unclear

Finding 3

Government responsibilities for addressing general practitioner shortages are unclear and continue to fall through gaps in governance.

Recommendation 1

That the NSW Government work with the Australian Government to establish new mechanisms for collaboration and shared governance, with a view to meeting rising need in the rural primary care sector more efficiently and reliably.

1.18 The Committee is concerned that, despite the reported completion of PC2 recommendations, responsibilities for addressing the primary care crisis continue to fall through gaps in governance.

1.19 As noted earlier, Recommendation 7 called upon the NSW Government and Australian Government to establish clear governance arrangements and a strategic plan to deliver on health reforms to improve doctor workforce issues. In reporting on progress against this recommendation, NSW Health referred to a number of meetings and forums between relevant NSW and Australian Government Ministers, including two meetings of the Bilateral Regional Health Forum, where 'joint interests in rural and regional primary care, mental health and suicide prevention and aged care' were discussed.[28]

1.20 However, it is unclear whether these actions have led to any tangible improvements to address general practice workforce issues. The Committee is also concerned that there is no evidence of clear governance arrangements or an action plan to deliver on the health reforms recommended by PC2.

[24] Submission 5, p 1; Submission 45, p 1.

[25] Submission 5, pp 1-3; Submission 45, pp 1-6; Ms Fellows, Evidence, 12 December 2024, p 31.

[26] Ms Fellows, Evidence, 12 December 2024, p 30.

[27] Submission 5, pp 2-3; Submission 12, p 1; Submission 40, p 1; Submission 45, p 1; Submission 48, p 1; Submission 49, p 1; Submission 67, p 1; Submission 71, p 1.

[28] *Progress Report*, September 2024, p 22.

1.21 During the current inquiry, stakeholders noted that primary care challenges continue to be exacerbated by the overlapping and 'ever-increasing blurred lines' between state and Commonwealth responsibilities. This lack of coordination between the two levels of government can result in service delivery gaps, funding shortfalls and inefficiencies.[29]

State and federal responsibilities for primary care

As noted in the PC2 report, the Australian Government and NSW Government both have a role in the employment, training and supply of doctors.

The Australian Government's main responsibilities in relation to primary care include providing a universal public health care scheme, primarily funding primary care (including funding for Medicare and the Pharmaceutical Benefits Scheme), and supporting primary health care services through Primary Health Networks (PHNs). The role of PHNs is discussed later in this chapter.

Although NSW Health is predominantly responsible for managing and administering public hospitals, this includes employing doctors and engaging general practitioners (GPs) as Visiting Medical Officers (VMOs). There are also a number of areas where the Australian and NSW Governments have joint responsibility, including educating and training health professionals, regulating the health workforce, and funding and delivering community health services.[30]

1.22 Mr Matthew Clancy, Culcairn Local Health Advisory Committee, explained why the distinct roles of Local Health Districts (LHDs) and Primary Health Networks (PHNs) require coordination:

> The obligations of the PHN just relate to a GP and those of the LHD relate specifically to the VMO. But the actual historical model of how you put those two together is that they both rely on both activities for that doctor.[31]

1.23 The Committee heard that, in Culcairn, LHDs and PHNs are failing to coordinate to respond to doctor shortages:

> We probably talk to both organisations at least once a month to work out how to actually move the issue forward. They have been very cooperative in being available. I think the bigger issue comes back to what their role and responsibilities are and where they see them starting and stopping. There are things that have fallen through those roles that no-one's picking up.[32]

[29] Submission 6, pp 1, 3; Submission 103, p 5.

[30] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 2-3; Australian Government Department of Health and Aged Care, Primary care in Australia, viewed 24 April 2025; Australian Institute of Health and Welfare, Primary health care in Australia, viewed 24 April 2025; Services Australia, Pharmaceutical Benefits Scheme, viewed 24 April 2025.

[31] Mr Matthew Clancy, Chair, Culcairn Local Health Advisory Committee, Transcript of evidence, 12 December 2024, p 36.

[32] Mr Clancy, Evidence, 12 December 2024, p 36.

1.24 Dr Rachel Christmas, President of Rural Doctors Association of NSW, General Practitioner and VMO Obstetrician, also told the Committee about a lack of support from NSW Health when it comes to addressing primary care issues:

> From a NSW Health perspective, we [VMOs] are not employees; we are contractors. Therefore, we don't actually come under any support from NSW Health or the New South Wales Government in terms of incentivising us to stay, in terms of support for workforce. If I leave my practice, the town loses a GP and the hospital loses a VMO. However, traditionally, LHDs have not taken any role in looking to recruit GPs to towns or to hospitals. This is an area where there is that breakdown in that State Government and Federal Government divide.[33]

1.25 Despite NSW Health reporting the completion of actions to address Recommendations 7 and 8, the Committee is concerned that responsibilities for addressing doctor workforce shortages are continuing to fall through gaps in Commonwealth-state governance, in the absence of effective coordination. We recommend that NSW Health work with the Australian Government to establish new mechanisms for collaboration and shared governance, with a view to meeting rising need in the rural primary care sector more efficiently and reliably.

1.26 These mechanisms should be more efficient and effective than holding infrequent meetings, with little transparency as to what specific issues, data or planned actions are discussed between the NSW and Australian governments. This goal of new governance and collaboration mechanisms should also include the development of a new, long-term funding model for rural and remote primary care, as discussed below.

Funding models for remote, rural and regional health

A new funding model for rural and remote primary care is needed

Finding 4

Funding streams for primary care are siloed, short-term and rely on fee-for-service arrangements, which results in fragmentation of services and care.

Recommendation 2

That the NSW Government work with the Australian Government in developing a new, long-term funding model for rural and remote primary care. This model should consider how funding can be pooled from different sources to support services more effectively, without relying on fee-for-service arrangements.

1.27 The PC2 report found that the provision of health funding through Commonwealth and state funding streams had led to both duplication and gaps in service delivery. PC2 recommended clear governance arrangements and a strategic plan to address this issue (Recommendation 7).[34]

---

[33] Dr Rachel Christmas, General Practitioner, Visiting Medical Officer Obstetrician, and President of Rural Doctors Association of NSW, Transcript of evidence, 12 December 2024, p 18.

[34] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 72.

1.28 However, during the current inquiry, we heard that the existing system of funding for primary care remains fractured and creates barriers to coordinated, cost-effective care.[35] While the NSW and Australian governments have committed to improving the interface between primary and acute care services under the National Health Reform Agreement, funding silos persist that hinder effective service delivery.[36]

1.29 We also heard that fee-for-service arrangements, such as Medicare bulk billing, contribute to fragmentation and are often not implemented in a way that meets the community's need for coordinated care.[37]

1.30 Inquiry participants told the Committee that incremental changes to health expenditure will not be sustainable, and that a fundamental shift is required to support greater investment into primary care.[38] They called for significant reform to primary care funding that includes:

- a shift away from fee-for-service service models to alternative models that incentivise improving value for patients[39]
- blended payment models that allow providers to coordinate care across different settings[40]
- funding for the type of care required (for example, primary care) rather than the site of care (for example, GPs providing care in emergency settings)[41]
- long-term funding to support sustainable system change.[42]

1.31 As the North Coast Primary Health Network, Healthy North Coast, explained:

> A shift from funding the site of healthcare to funding the type of care will not only alleviate the limited and short-term gains resulting from incremental change, it will also have the potential benefits of providing more valuable preventative care and early intervention that is not always present in emergency episodic occasions of care. [43]

1.32 The Committee notes the way in which funding for primary care continues to drive fragmentation of care, particularly in rural and remote NSW. To address this, we recommend that the NSW Government work with the Australian Government in developing a new, long-term funding model for rural and remote primary care. This model should consider blended funding models, including how

[35] Submission 88, NSW Nurses and Midwives' Association, p 5; Submission 3, Bulgarr Ngaru Medical Aboriginal Corporation, p 2; Submission 103, p 5; Submission 82, p 6.

[36] Submission 82, p 6.

[37] Correspondence from Susi Tegen, CEO, National Rural Health Alliance to the Chair, 13 March 2025, p 2; Submission 94, Healthy North Coast (North Coast Primary Health Network), p 6.

[38] Submission 94, pp 2, 5.

[39] Submission 94, p 6.

[40] Submission 94, p 6.

[41] Submission 94, pp 2-3, 5.

[42] Ms Narelle Mills, Executive Integration and Partnerships, Murrumbidgee Primary Health Network, Transcript of evidence, 12 December 2024, p 4.

[43] Submission 94, p 5.

funding can be pooled from different sources to support services more effectively, without relying on fee-for-service arrangements. It should also consider the innovative and multidisciplinary models of health service delivery that are covered later in this chapter.

1.33 Additionally, we note that a Special Commission of Inquiry into Healthcare Funding in NSW has been completed, with the report delivered to the Governor on 24 April 2025, along with a request for the report to be made public.[44] In developing a new funding model for rural and remote primary care, we expect that NSW Health will incorporate any relevant findings from the Special Commission of Inquiry.

The Small Hospitals Funding Model review has been completed but actions are yet to be implemented

Recommendation 3

That NSW Health provide an update within six months on the implementation of recommendations from its Small Hospitals Funding Model review.

The Small Hospitals Funding Model is based on activity, as well as fixed and variable operating costs of small public hospitals. It aims to better harmonise funding and activity flow between small hospitals and activity-based funding (ABF) hospitals in rural settings.

ABF is a way of funding public hospitals according to the number and mix of patients they treat, and their complexity. Under ABF in NSW, health services are funded at a unit price (weighted activity unit) based on the agreed activity in Service Agreements.

Block funding, alternatively, applies to facilities/services that are not funded under the Small Hospitals Funding methodology or ABF.[45]

1.34 In addition to the findings about Commonwealth-state health funding discussed above, the PC2 report found that activity-based funding was not appropriate or viable for all rural and remote hospitals, due to the lack of economies of scale in smaller communities and facilities. The report recommended that NSW Health review the current funding models for all rural and regional Local Health Districts in order to identify any service delivery gaps and provide any recommendations for funding increases (Recommendation 1).[46]

1.35 In its 2024 Progress Report, NSW Health reported that Recommendation 1 had been completed, citing its review of the NSW Small Hospitals Funding Model (SHFM).[47] The Committee is pleased to note that, following our recommendation for the review to be published,[48] NSW Health's SHFM review was finally published

[44] The Special Commission of Inquiry into Healthcare Funding, *Special Commission of Inquiry into Healthcare Funding to deliver report today*, media release, 24 April 2025, viewed 2 May 2025.

[45] NSW Health, *Small Hospitals Funding Model Review*, January 2025, pp 6-7.

[46] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 34, 73.

[47] *Progress Report*, September 2024, p 10.

[48] *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, August 2024, p 58.

in January 2025. The review made five overarching findings and nine recommendations for action.[49]

1.36 One of the key findings from the review was that 'the approach to funding small hospitals is not responsive enough to changes in costs and models of care'. To address this, the review recommended that NSW Health consider how to better account for 'recognised structural costs' (such as providing patient transport and employing staff), noting that these costs are not adequately accounted for in small hospitals, particularly in rural and remote settings.[50]

1.37 Another key finding was that the Australian Government's share of funding for small hospitals has reduced. The review noted that:

> Under the 2020-25 National Health Reform Agreement (NHRA) Addendum, the Australian Government committed to increasing its share of public hospital funding through a 45 per cent contribution to the costs of growth, subject to a funding cap. However, the Australian Government's funding share for NSW hospitals has decreased compared to where it was before the commencement of the current Addendum period and has not met the 45 per cent contribution commitment.[51]

1.38 Negotiations are currently underway between the Australian and state and territory governments to establish the next NHRA Addendum for 2025-30. The review recommended that the NHRA 2025-30 address barriers impeding the Australian Government from meeting the 45 per cent share of funding for public hospitals in NSW.[52]

1.39 Finally, the review found that there is an opportunity to develop a more sustainable funding model for small hospitals in the longer term. It recommended that NSW Health establish a working group to explore future funding models for small hospitals, to ensure the provision of sustainable, integrated care.[53]

1.40 The Committee supports the findings and recommendations from this review, and is particularly pleased to see a commitment to explore funding models that focus on more integrated care. However, we note that these recommendations are yet to be implemented, with no timeframe for the proposed actions. To improve transparency and accountability regarding the progress made, we recommend that NSW Health provide an update within six months on the implementation of recommendations from the SHFM review.

[49] *Small Hospitals Funding Model Review*, January 2025, pp 2-3; *Progress Report*, September 2024, p 10.

[50] *Small Hospitals Funding Model Review*, January 2025, pp 19, 21.

[51] *Small Hospitals Funding Model Review*, January 2025, pp 22.

[52] *Small Hospitals Funding Model Review*, January 2025, pp 22-23.

[53] *Small Hospitals Funding Model Review*, January 2025, pp 26-30.

Collaboration between Local Health Districts and Primary Health Networks

Primary Health Networks (PHNs) are independent health organisations that are responsible for coordinating primary care in their local health region. There are ten PHNs across NSW, which are established and funded by the Australian Government.

PHNs do not directly provide health services. Rather, they commission and connect health services to meet the needs of the community, consistent with national priorities set by the Australian Government. Commissioning is a strategic and evidence-based approach to planning and procuring of new health services or changing existing health services.

PHNs work with Local Health Districts (LHDs) to integrate and support local health services to encourage better use of resources, eliminate service duplication, and improve quality of care for patients. They regularly conduct population health needs assessments and service mapping in collaboration with LHDs to address gaps and better meet community needs.[54]

1.41 The PC2 inquiry found that partnerships between NSW Health, LHDs and PHNs varied across RRR NSW, which had a direct impact on the delivery and quality of health services. The report recommended that NSW Health and rural and regional LHDs upgrade and enhance their collaborative work with PHNs to ensure that high quality services are cooperatively planned and delivered across NSW (Recommendation 39).[55]

1.42 NSW Health has since reported that the implementation of this recommendation has been completed, noting:

- discussions between NSW and Australian Government Ministers at two meetings of the Bilateral Regional Health Forum
- implementation of the Joint Statement between NSW PHNs and the Australian Government Department of Health
- expansion of Collaborative Care sites, and collaboration between LHDs and regionally located PHNs to develop place-based needs assessments (discussed further below)[56]
- additional examples of collaborative projects between specific LHDs and PHNs, such as the Yellow Envelope Project in Western LHD, and the Health, Healing and Wellbeing Schedule at Murrumbidgee LHD.[57]

[54] Australian Government Department of Health and Aged Care, What Primary Health Networks are, viewed 7 April 2025; Australian Government Department of Health and Aged Care, What Primary Health Networks do, viewed 7 April 2025; Department of Health, Submission 38 to Senate Standing Committee on Community Affairs, Parliament of Australia, *The provision of general practitioner and related primary health services to outer metropolitan, rural and regional Australians*, 15 October 2021, p 80.

[55] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 168, 178-179.

[56] *Progress Report*, September 2024, pp 83-84.

[57] Submission 106, pp 12-13.

1.43 While the Committee acknowledges these examples of collaboration, we heard that, in practice, collaboration between LHDs and PHNs is still variable across rural and regional NSW, as discussed below.

Implementation of the NSW PHN-NSW Health Joint Statement has been inconsistent

In September 2021, NSW Health, the NSW PHNs and the Australian Government Department of Health signed a Joint Statement, which expressed a shared commitment to work together to deliver patient-centred health care in September 2021.

The Joint Statement sets out how the organisations will collaborate on three key priority areas: focusing on care in the community, establishing regional planning processes and governance, and data and outcomes. Full implementation of the Joint Statement is expected to improve the integration of health services, data sharing and community co-design.[58]

1.44 Despite reporting that PC2 Recommendation 39 has been completed, NSW Health noted that work to address the three priority areas in the Joint Statement is still ongoing and will continue over the next two years.[59] The Committee also notes that implementation of the Joint Statement appears to be at varying levels of maturity across regions.

1.45 For example, Murrumbidgee PHN told the Committee that they have a 'robust and productive working relationship' with the Murrumbidgee LHD, and are working together to implement innovative models of service delivery in the form of the Murrumbidgee Health and Knowledge Precinct.[60] A case study on Murrumbidgee is included later in this section, noting the effective collaboration occurring in this region and the joint governance that enables it.

1.46 Mr Brad Porter, CEO, Western NSW PHN, told the Committee that the Joint Statement is being implemented 'in practice' in Western NSW. The PHN is also commencing a supplementary First Nations health needs assessment with the Far West and Western LHDs.[61]

1.47 However, Ms Monika Wheeler, CEO of the North Coast PHN, Healthy North Coast, told the Committee that implementation has been delayed in the North Coast region, despite plans for the three key priority areas being developed in 2022. Ms Wheeler told the Committee that Healthy North Coast is having 'active conversations' with NSW Health, but implementation needs to be prioritised.[62]

1.48 Ms Wheeler further explained that this implementation should involve an ongoing partnership with regular monitoring and evaluation to inform continual growth, integrated digital systems, adequate funding models, and meaningful collaboration across acute and primary care. Furthermore, primary health care

[58] *Progress Report*, September 2024, p 84; NSW Health, NSW Health and NSW Primary Health Networks: Working together to deliver person-centred healthcare Joint Statement, viewed 7 April 2025, p 2; Submission 94, p 7.

[59] *Progress Report*, September 2024, pp 83-84.

[60] Submission 43, Murrumbidgee Primary Health Network, p 1; Mr Stewart Gordon, Chief Executive Officer, Murrumbidgee Primary Health Network, Transcript of evidence, 12 December 2024, p 9.

[61] Mr Brad Porter, Chief Executive Officer, Western NSW Primary Health Network, Transcript of evidence, 12 December 2024, p 9.

[62] Ms Monika Wheeler, Chief Executive Officer, Healthy North Coast, Transcript of evidence, 12 December 2024, p 9.

partners should be 'viewed as equals to NSW Health organisations, rather than support agents called upon only when needed'.[63]

1.49 The Committee agrees that the Joint Statement should be implemented across all rural and regional LHDs as a matter of priority. As discussed below, the Joint Statement would be implemented more consistently if it was supported by strengthened shared governance arrangements at the local level.

Governance between Local Health Districts and Primary Health Networks needs to be strengthened

Finding 5

Collaboration between Local Health Districts (LHDs) and Primary Health Networks (PHNs) relies on individual personalities, as there is no requirement for shared governance arrangements with PHNs in LHD service agreements.

Recommendation 4

That NSW Health embed the requirement for shared governance arrangements with Primary Health Networks (PHNs) in Local Health District (LHD) service agreements, in order to support effective collaboration, information sharing and joint planning between LHDs and PHNs at the local level.

1.50 During the inquiry, we heard that collaboration between LHDs and PHNs is still variable, as it often relies on individual personalities and relationships rather than shared governance arrangements.[64]

1.51 For example, Ms Monika Wheeler, CEO of Healthy North Coast, told the Committee that the development of shared governance is 'personality driven'. She explained that integrated approaches to shared governance are dependent on the LHD and PHN CEO and board members, and if these individuals change, then the shared governance and collaboration changes too.[65]

1.52 Similarly, Mr Stewart Gordon, CEO of Murrumbidgee PHN, told the Committee that the PHN's strong collaboration with Murrumbidgee LHD is 'very much relationship based' and a result of the executive teams of both organisations working closely together on projects and initiatives.[66]

1.53 Mr Luke Sloane, Deputy Secretary, Regional Health Division, NSW Health, told the Committee that the Australian Government has established clear outlines and frameworks regarding collaboration between PHNs and LHDs, including on place-based planning. He explained that these frameworks are also set by reciprocal work, memorandums of understanding and joint documents between PHNs and

[63] Submission 94, p 7.

[64] Ms Wheeler, Evidence, 12 December 2024, p 5; Mr Gordon, Evidence, 12 December 2024, pp 3-4; Mr Luke Sloane, Deputy Secretary, Rural and Regional Health, NSW Health, Transcript of evidence, 13 December 2024, p 24.

[65] Ms Wheeler, Evidence, 12 December 2024, p 5.

[66] Mr Gordon, Evidence, 12 December 2024, pp 3-4.

LHDs. However, he acknowledged that these are 'extremely dependent on the personalities in the roles that deliver those'.[67]

1.54 The Committee also heard that while some PHNs are required to have shared governance with LHDs in a number of their funding agreements, this requirement is not reciprocal.[68]

1.55 For example, Healthy North Coast told the Committee that PHNs are required to complete joint regional mental health and suicide prevention service planning with LHDs, as part of funding specifications in the Primary Mental Health Care Funding Schedule. However, NSW Health service agreements do not require LHDs to actively work in collaboration with PHNs to develop and implement joint regional plans. Healthy North Coast advocated for LHD service agreements to include requirements to develop and implement joint regional plans.[69]

1.56 The Committee acknowledges that a robust document alone is not sufficient, and that effective working relationships are critical in ensuring that collaborative programs are implemented effectively. However, embedding requirements within all LHD service agreements will help to promote consistency across LHDs and ensure that effective collaboration is not entirely dependent on the work of a handful of committed leaders. We recommend that NSW Health embed the requirement for shared governance arrangements with PHNs in LHD service agreements to support effective collaboration, information sharing and joint planning at the local level.

Case Study: Murrumbidgee Local Health District and Primary Health Network

1.57 The Committee heard that Murrumbidgee LHD and Murrumbidgee PHN have a particularly strong and collaborative relationship, which is underpinned by 'very deliberate and strong governance' set out in a Joint Collaborative Agreement between both organisations.[70] This Joint Collaborative Agreement covers enhancing collaboration, identifying, reviewing, developing and implementing models of care, and facilitating information sharing between organisations.[71]

1.58 Murrumbidgee PHN and LHD also have a Joint Board and work plan, and in December 2024 they reported further work to 'hardwire' collaborative ways of working between the two organisations.[72]

1.59 Mr Stewart Gordon, CEO of Murrumbidgee PHN, told the Committee that the strong relationship between the Murrumbidgee PHN and LHD means they are well placed to progress the work of planning and delivering an integrated health system into the future.[73]

[67] Mr Sloane, Evidence, 13 December 2024, p 24.

[68] Ms Wheeler, Evidence, 12 December 2024, p 5.

[69] Submission 94, p 10.

[70] Mr Gordon, Evidence, 12 December 2024, p 4; Submission 43, p 5.

[71] Mr Gordon, Evidence, 12 December 2024, p 4.

[72] Submission 43, p 5; Mr Gordon, Evidence, 12 December 2024, p 3.

[73] Mr Gordon, Evidence, 12 December 2024, p 3.

1.60 The Collaborative Commissioning approach for the 'Living Well, Your Way' initiative is an example of this effective collaboration, as outlined below.

Collaborative Commissioning: 'Living Well, Your Way'

Collaborative Commissioning is a partnership between LHDs and PHNs and other service providers, which 'promotes local autonomy and accountability in delivering patient-centred care.' It is guided by a set of principles that, in part, promote the design of local care pathways and consumer engagement.[74]

Murrumbidgee is one of six Collaborative Commissioning partnerships.[75] The Murrumbidgee Collaborative Commissioning approach commenced in 2019 and receives funding from NSW Health. Murrumbidgee is one of the regions with the highest hospital admissions for Chronic Obstructive Pulmonary Disease (COPD) and Chronic Heart Failure (CHF) in NSW. Working under the Collaborative Commissioning model, the PHN and LHD have jointly identified needs, tracked and mapped the patient journey across primary, acute and community-based care, identified gaps within the journey, and made funding allocation decisions.[76]

As a result, they developed the 'Living Well, Your Way' Collaborative Commissioning initiative to improve the patient care pathway and reduce ED presentations and hospitalisations for COPD and CHF.[77]

Ms Narelle Mills, Executive Integration and Partnerships, Murrumbidgee PHN, estimated that it took 12 months to design this model, which has been implemented over the past three years.[78] As of September 2024, there were 6,941 patient enrolments in the 'Living Well, Your Way' care pathway.[79] In the initiative's second year of implementation, Murrumbidgee PHN reported an 18.3 per cent reduction in ED presentations and a 37 per cent decline in hospital admissions for people with COPD and CHF, compared to the baseline levels in 2018-2019.[80]

1.61 Murrumbidgee PHN told the Committee that their collaborative work has been productive, but more work is still needed. They called for this collaborative approach to be fostered and supported through ongoing commitments from all levels of government.[81]

1.62 The Committee also notes that limited funding arrangements pose a challenge for the ongoing future and sustainability of Collaborative Commissioning work. Ms Mills told the Committee that in the next 12 months, there will no longer be seed funding to finance it, and the approach needs longer than three years to result in sustainable system change.[82] We hope that some of these concerns can

[74] NSW Health, Collaborative Commissioning, viewed 7 April 2025.

[75] NSW Health, Current partnerships, viewed 30 April 2025.

[76] Ms Mills, Evidence, 12 December 2024, p 4.

[77] Ms Mills, Evidence, 12 December 2024, p 4; Answers to questions on notice, Murrumbidgee Primary Health Network, 24 January 2025, p 30.

[78] Ms Mills, Evidence, 12 December 2024, p 4.

[79] Answers to questions on notice, Murrumbidgee Primary Health Network, 24 January 2025, p 29.

[80] Answers to questions on notice, Murrumbidgee Primary Health Network, 24 January 2025, pp 30-31.

[81] Submission 43, pp 5-6.

[82] Ms Mills, Evidence, 12 December 2024, p 4.

be addressed as part of a long-term funding model for rural and remote primary care, as recommended earlier in this chapter.

Information sharing and communication between LHDs and PHNs needs to be improved

1.63 The PC2 inquiry found that communication between various health providers was often limited for certain specialised multidisciplinary health services such as palliative care and oncology.[83] To address this, the PC2 report recommended that NSW Health and the rural and regional LHDs work with PHNs and other partners to promote improved communication between service providers. This included through the use of shared medical record systems to ensure continuity of care for patients (Recommendation 22).[84]

1.64 NSW Health has reported that the implementation of this recommendation is in progress. In its Progress Report, NSW Health noted collaborative work between PHNs, partner agencies, vendors and cross-jurisdictional agencies. This work aims to improve the communication and sharing of patient information between LHDs and the primary care sector. This includes:

- the Lumos program, which links de-identified data from GPs with other health service data to provide a more comprehensive view of patient pathways. As of June 2024, 28 per cent of regional general practices were enrolled in the program.
- the Co-Located Clinics project, an initiative that leverages existing systems to share patient information between NSW Health and external health care providers and services. As part of this program, eHealth NSW has partnered with the Western NSW and Far West LHDs, Western NSW PHN, Royal Flying Doctor Service and Aboriginal Medical Services. NSW Health is aiming to have 50 per cent of general practices signed up to this program by 2026.[85]

1.65 However, the Committee heard that current communication and medical record systems continue to impact the ability of PHNs to collaborate with LHDs. Barriers to information exchange can also limit the ability of PHNs and LHDs to produce joint regional needs assessments to inform joint regional planning approaches.[86]

1.66 For example, the CEOs of Murrumbidgee PHN and Healthy North Coast (North Coast PHN) told the Committee that privacy legislation makes it difficult for data to be shared between LHDs and PHNs, and the free flow of information between health entities would result in better informed health planning.[87]

1.67 The Committee also heard that patient results and records are siloed both within and across Australian jurisdictions, which has resulted in increased risks to

[83] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 140.

[84] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 140.

[85] *Progress Report*, September 2024, pp 52-53.

[86] Mr Gordon, Evidence, 12 December 2024, p 8.

[87] Ms Wheeler, Evidence, 12 December 2024, p 8; Mr Gordon, Evidence, 12 December 2024, p 8.

patients and inefficient, more expensive service delivery.[88] The Rural Doctors Association of NSW said there is no shared communication process, which impacts the role of GPs as the main coordinator of patient care.[89]

1.68 In relation to cross-border care, Mr Matthew Clancy, Chair of the Culcairn Local Health Advisory Committee, told the Committee that a lack of connectivity between Victorian and NSW health systems impacts patients that are transferred interstate for care. This is particularly concerning for patients that are transferred from Culcairn to Albury, which falls under Albury-Wodonga Health (part of the Victorian health system), and need to have their data entered into the systems of both states.[90]

1.69 Mr Sloane explained that the complex governance and privacy issues that impact effective data sharing are being worked through as part of the development of the Single Digital Patient Record (SDPR). The SDPR is a NSW-based clinical tool to ensure continuity of patient information, which is designed to integrate with the federal My Health Record platform. The first 'go-live' for the SDPR is scheduled for March 2026 in the Hunter New England LHD, Justice Health & Forensic Mental Health Network and Laboratory Information Management Systems North. NSW Health reported that the potential for further access by PHNs and primary care providers is 'being assessed as part of the configuration process that is underway' for the first go-live.[91]

1.70 Healthy North Coast told the Committee that digitisation into 'one health system' would contribute to improved health outcomes and better support continuity of care in NSW.[92] Members of the Royal Australian College of General Practitioners (RACGP) Rural also called for better interoperability. RACGP Rural stated that expansion of the SDPR to include GPs would improve information sharing at transitions of care.[93]

1.71 While its implementation is complex and will take some time, the Committee acknowledges that the SDPR will offer a significant opportunity to improve on the various disparate solutions that are currently in place. This new tool has the potential to provide a more seamless transition of patient information between health services within RRR NSW and across jurisdictions.

Innovative and multidisciplinary models of service delivery

Finding 6

The funding and implementation of innovative and multidisciplinary health service delivery models is urgently needed to facilitate collaboration.

[88] Submission 75, The Royal Australian and New Zealand College of Ophthalmologists (RANZCO), p 5.

[89] Submission 92, p 5.

[90] Mr Clancy, Evidence, 12 December 2024, p 30.

[91] Mr Sloane, Evidence, 13 December 2024, p 20; Answers to questions on notice, NSW Health, 24 January 2025, p 4.

[92] Submission 94, p 13.

[93] Submission 91, pp 3-4.

1.72 To address the escalating rural primary care crisis and support cross-jurisdictional collaboration, innovative models of health service delivery need to be funded and implemented as a matter of priority.

1.73 The 2022 PC2 report recognised that the scale of challenges in rural NSW demanded 'big thinking', as well as the development of innovative, flexible and localised models tailored to local communities. As a first step, the report recommended that the NSW Government work with the Australian Government to establish a Rural Area Community Controlled Health Organisation (RACCHO) pilot, with a view to evaluating and refining it for roll-out in all areas where existing rural health services do not meet community needs (Recommendation 10):

> This model would fundamentally restructure the way health services are provided in rural areas, in that each RACCHO would employ a multi-disciplinary team including GPs, nurses and midwives, and allied health professionals to enhance the provision of both primary and secondary health care. Benefits of such a model would include providing health care professionals with secure ongoing employment and professional support, and providing rural communities with ready access to 'one stop shop' healthcare services.[94]

1.74 In reporting against Recommendation 10, NSW Health noted that its commitment was to develop and trial models where existing rural health services do not meet community needs. While RACCHO was one proposed model, NSW Health also identified Urgent Care Services and Collaborative Care as alternative models to fulfil the intent of this recommendation.[95]

1.75 The Committee acknowledges the positive work that has since been done to establish eight additional Urgent Care Services in regional NSW.[96] However, we also note that Urgent Care Services are intended to address gaps in hospital emergency departments rather than primary care, and they are no substitute for a strong regional primary care workforce.

The Collaborative Care program has received some positive feedback

Collaborative Care is a community centred, place-based approach to mapping and planning solutions to address health care challenges in rural and regional communities. The program is coordinated by the Rural Doctors Network and 'involves partnering with key stakeholders in a community to understand health needs and identify fit-for-purpose solutions.'[97]

1.76 NSW Health reported that a scalability assessment of the Collaborative Care program has been conducted, and groundwork has been laid to expand the program to an additional five sites across regional NSW. This includes the commencement of engagement in Wee Waa, Leeton and the Liverpool Plains.[98]

---

[94] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 74.

[95] *Progress Report*, September 2024, p 28.

[96] Submission 106, pp 9–10; *Progress Report*, September 2024, p 28.

[97] Submission 106, p 9.

[98] Submission 106, p 9.

1.77 In explaining how the model operates, Mr Luke Sloane, Deputy Secretary, Regional Health Division, NSW Health, told the Committee:

> We can see collaborative care as a real—not an all-encompassing, fixing everything—solution. But that's part of sitting down with the community, with a trusted community leader leading the project—and we're seeing that play out in Wee Waa and Leeton—to understand what these services are, both NSW Health services, non-government services, charity organisations and Commonwealth and PHN. We're all at the table. The community are leading this themselves through their project officer that we work with. Rural Doctors Network is a bit of an independent, United Nations-like figure to facilitate this process.[99]

1.78 During the current inquiry, the Committee heard positive feedback about the program's implementation to date and its ability to support a place-based approach to planning.[100]

1.79 However, in describing the impact in Wee Waa, Mayor Darrell Tiemens told the Committee:

> We've had what's called a Collaborative Care model, which is an interesting model. I think it's a good word. It's a nice, trendy term. The community sees right through that. If you don't have the health system in a local community built on the solid foundations of a solid hospital with real doctors and 24-hour care, then it's a house of cards. It has genuinely gotten worse in Wee Waa. [101]

1.80 We also heard that funding mechanisms continue to present structural barriers to the adoption of Collaborative Care in some areas.[102]

1.81 During the current inquiry, Parkes Shire Council submitted that 'the way we are working is not working and new models must be trialled'.[103] Other councils also identified the need to pool resources and support multi-skilled practitioners to meet the needs of rural communities and providers.[104]

1.82 The following sections discuss the Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS) model and the health precinct model as potential options for wider implementation.

Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS) should be piloted

PRIM-HS are not-for-profit organisations that are funded by government, and designed and established by local communities to meet their primary healthcare needs in flexible and responsive ways.

---

[99] Mr Luke Sloane, Deputy Secretary, Rural and Regional Health, NSW Health, Transcript of evidence, 13 December 2024, p 22.

[100] Submission 43, p 3; Submission 75, p 4; Submission 90, Rural Doctors Network, p 3; Ms Narelle Mills, Executive Integration and Partnerships, Murrumbidgee Primary Health Network, Transcript of evidence, 12 December 2024, p 8; Mr Mike Edwards, Chief Operating Officer, Rural Doctors Network, Transcript of evidence, 12 December 2024, p 19.

[101] Mayor Darrell Tiemens, Narrabri Shire Council, Transcript of evidence, 13 December 2024, pp 8-9.

[102] Submission 75, p 4.

[103] Submission 6, p 2; Councillor Louise O'Leary, Transcript of evidence, 13 December 2024, p 3.

[104] Submission 64, Lithgow City Council, p 2; Submission 34, p 6.

According to the National Rural Health Alliance, the PRIM-HS model aims to overcome 'many of the barriers to attracting and retaining a rural health workforce' by bringing all rural stakeholders together, including local government, local health districts, private and public health services, and local industry. The model involves discussion and planning between stakeholders in order to provide the services needed by a local community.[105]

A key feature of the PRIM-HS model is the use of dedicated block funding to support the employment of a multidisciplinary workforce of primary healthcare professionals, in addition to usual fee-for-service arrangements. This approach is particularly important in thin markets.[106]

Recommendation 5

That the NSW Government seek funding from the Australian Government to expedite the use of innovative and multidisciplinary health service delivery models, including a pilot of the Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS) model.

1.83 The RACCHO model proposed as part of Recommendation 10 was developed by the National Rural Health Alliance (NRHA). The model is now referred to as the Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS) model, to avoid confusion with Aboriginal Community Controlled Health Organisations.[107] The Committee noted the potential of the PRIM-HS model in its first report.[108]

1.84 As noted above, NSW Health has chosen to focus on the Collaborative Care program and Urgent Care Service expansion to fulfil the intent of Recommendation 10. However, during the current inquiry, NRHA submitted that the NSW Government has not responded adequately to this recommendation and that it should commit to identifying sites where the PRIM-HS model could be implemented.[109]

1.85 NRHA noted that a PRIM-HS trial was in place in Mareeba, Queensland and recommended that NSW sites trial the model concurrently to 'enable exchange of information and evaluation methodologies, and to provide evidence for the value of the model across different jurisdictions and community profiles'. NRHA noted that this would provide an evidence base for evaluating the models' potential to improve access to primary care.[110]

1.86 In correspondence with the Committee, Ms Susi Tegen, Chief Executive, NRHA, reiterated:

---

[105] Submission 82, p 12; National Rural Health Alliance, Primary Care Rural Integrated Multidisciplinary Health Services (PRIM-HS), p 4.

[106] Correspondence from Susi Tegen, CEO, National Rural Health Alliance to the Chair, 13 March 2025, p 2.

[107] Submission 82, p 11.

[108] *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, August 2024, pp 68–70.

[109] Submission 82, p 11.

[110] Submission 82, p 13.

> I understand the Collaborative Care approach is a place-based planning approach to help develop a site-specific model of care, which appears to have some synergies with the Alliance's PRIM-HS model. However, they are not the same, and we believe there is merit in NSW funding test sites for PRIM-HS as a way of comparing different models and determining how investment in primary health care can lead to improved health outcomes for rural communities and reduce State expenditure through the more expensive hospital and acute sector…
>
> In the case of Recommendation 10, it would be a missed opportunity for the NSW Government if it has indeed abandoned the PRIM-HS model, as it has the potential to improve access to primary healthcare and reduce avoidable hospitalisations for rural NSW residents.[111]

1.87 The Committee notes the importance of dedicated block funding to support these proposed health services, particularly in thin markets where fee-for-service arrangements are failing to meet the community's primary health care needs. We also note that the PRIM-HS model aligns with what was specifically put forward in the PC2 report.

1.88 We recommend that NSW Health seek funding from the Australian Government to pilot the PRIM-HS model, with a view to comparing its effectiveness with other community-led models of health service delivery.

The health precinct model also provides a potential model for more effective collaboration

Recommendation 6

That the NSW Government explore further opportunities for funding and implementing the health precinct model in rural areas, using the Murrumbidgee Health and Knowledge Precinct as a blueprint. This should include:

- **quarantined funding**
- **a separate board structure, in addition to Local Health District leadership**
- **partnerships across the public and private sector that bring together hospital-based care, primary care, education, industry, local government and non-governmental organisations**
- **a focus on research, workforce and system integration, with a view to creating a training pipeline for doctors and allied health professionals.**

1.89 During the current inquiry, we heard that the health precinct model may offer opportunities to improve collaboration between health providers and educational institutions, and improve the training pipeline for primary care professionals.[112]

[111] Correspondence from Susi Tegen, CEO, National Rural Health Alliance to the Chair, 13 March 2025, pp 2-3.

[112] Submission 6, p 2; Councillor Louise O'Leary, Transcript of evidence, 13 December 2024, p 3; Answers to questions on notice, Parkes Shire Council, 13 December 2024, p 1.

1.90 For example, Parkes Shire Council noted that a health precinct master plan has been developed with Western NSW LHD, which provides 'significant opportunities for health clusters' around Parkes Hospital. They advocated for a model that leverages and fosters existing relationships between universities and regional hospitals to create a training pipeline for doctors and allied health professionals. This would involve developing facilities on the new Parkes Health Precinct to support the initiative, including training facilities for students and new doctors.[113]

1.91 Charles Sturt University also emphasised the importance of genuine partnerships between health care providers, education providers and industry partners, supported by appropriate governance. As a key partner in the Murrumbidgee Health and Knowledge Precinct, they identified this precinct as a particularly effective example, with a strong emphasis on education, research, and integrated health care.[114]

Case study: Murrumbidgee Health and Knowledge Precinct

The Murrumbidgee Health and Knowledge Precinct is 'not a building or a set of buildings', but rather, a collaboration of health and social care providers and other partners across 126 000 kilometres. This includes private and public healthcare providers, educational institutions and industry partners. The precinct takes a three-tiered place-based approach, with participation from all levels of government (local government, LHDs and PHNs). [115]

Key elements of the model include:

- quarantined funding (the precinct commenced with $1 million in seed funding from the NSW Government over a 24 month period)
- a governance structure that includes its own board and independent Chair, in addition to strong LHD leadership
- partners including primary care, education, industry, local government and NGOs.

The Precinct has prioritised three key areas of work: education and workforce, research and innovation, and one-system integration.[116]

1.92 In relation to the one-system integration work currently underway, Ms Jill Ludford, Chief Executive, Murrumbidgee LHD, explained:

> We are developing a framework for place-based planning. This work actually fell out of the Joint Statement working parties, where it was identified that we should bring communities, councils and all of the providers in rural areas together to identify their problems, co-design and look at all of the funding mechanisms to see how they can

[113] Submission 6, p 2; Councillor Louise O'Leary, Transcript of evidence, 13 December 2024, p 3; Answers to questions on notice, Parkes Shire Council, 13 December 2024, p 1.

[114] Submission 93, Charles Sturt University, p 5.

[115] Ms Jill Ludford, Chief Executive, Murrumbidgee Local Health District, Transcript of evidence, 13 December 2024, p 26.

[116] Answers to supplementary questions, NSW Health, 24 January 2025, pp 17–21, 37.

> actually design services that meet the needs of communities, rather than the top-down approach of respective governments.[117]

1.93 To highlight how the Precinct's one-system approach works, Ms Ludford described a paediatric roundtable that took place in September 2024, regarding early intervention options for children with developmental vulnerabilities. This roundtable, facilitated by Business NSW, brought together 15 different health care providers to identify where the greatest need was and how scarce paediatric resources could be best prioritised.[118]

1.94 Ms Ludford also highlighted the importance of the 'alliance', made up of 45 member organisations, including local industries:

> The alliance meetings are really important because, in essence, they're our conduit with the entire community. They become very vibrant meetings for debates about topics, but also independent alliance members can ask for work to be done or ask to participate in work that is being done.[119]

1.95 One of the key strengths of the Murrumbidgee model is that it brings together partners with different funding sources and provides opportunities for alternative, pooled funding models going forward. However, as the Precinct moves out of its planning phase, Ms Ludford identified that 'ongoing financial resourcing' will be one of the key challenges.[120]

1.96 While the Committee recognises that the Murrumbidgee Health and Knowledge Precinct has been a particularly effective example of collaboration, we also acknowledge that quarantined funding is an important component of this model. We recommend that the NSW Government explore further opportunities for funding and implementing the health precinct model in rural areas, using the Murrumbidgee Health and Knowledge Precinct as a blueprint. Investing in collaborative, innovative, and multidisciplinary service delivery models will be critical in ensuring that resources can be used effectively to address local health challenges across RRR NSW.

[117] Ms Ludford, Evidence, p 26.

[118] Ms Ludford, Evidence, pp 26-27.

[119] Ms Ludford, Evidence, p 26.

[120] Ms Ludford, Evidence, p 27.

Chapter Two – Government consultation, engagement and decision-making

Introduction

2.1 The 2022 Portfolio Committee No. 2 (PC2) report found that there was a lack of communication and meaningful consultation between Local Health Districts (LHDs) and communities. To address this, the report recommended that rural and regional LHDs actively engage with local community groups and charities, and develop place-based health needs assessments and local health plans in collaboration with local stakeholders.[121]

2.2 The report also recommended reinvigorating the role of Local Health Advisory Committees (LHACs) to facilitate genuine community consultation and better inform communities about the services available to them.[122]

2.3 Additionally, PC2 made various recommendations to prioritise rural health within government policy and decision-making. This included the maintenance of a Regional Health Minister position, and work to evaluate and refresh the existing NSW Rural Health Plan.[123]

2.4 During the current inquiry, we found that although there is some local consultation occurring, community input on local health services remains limited in parts of remote, rural and regional (RRR) NSW. We also heard that the LHAC model is not consistently providing a forum for genuine community consultation and input into health services across RRR NSW.

2.5 This chapter explores initiatives that NSW Health has implemented to improve consultation with RRR communities, as well as some of the ongoing barriers to genuine consultation. It then discusses the actions that have been taken to prioritise rural health considerations within government decision-making, including work in developing the *NSW Regional Health Strategic Plan 2022-2032*. Noting the limitations of these actions, we advocate for the establishment of a NSW Remote, Rural and Regional Health Commissioner to ensure that the health needs of remote, rural and regional communities are appropriately considered as part of government decision-making.

Community and stakeholder consultation

2.6 The PC2 report recommended that NSW Health and rural and regional LHDs actively engage with local community groups and charities to understand the

[121] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, pp 37, 181-182.

[122] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 181-182.

[123] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 178.

services and resources they provide, and to ensure that service gaps are filled (Recommendation 5).

2.7 PC2 also recommended that rural and regional LHDs work with communities to develop place-based health needs assessments and local health plans. This was to include collaboration with key stakeholders – including the Department of Regional NSW, local government, education, human services, community services, First Nations organisations and local health providers – to ensure services are responsive to local variations in determinants, lifestyle and disease burden for each community (Recommendation 43).[124]

2.8 In their submission, NSW Health provided examples of local community engagement across all regional LHDs.[125] They also reported action on several specific initiatives against Recommendations 5 and 43, as outlined below.

NSW Health is promoting active engagement with charities and community groups

2.9 In its 2024 Progress Report on the implementation of PC2 recommendations, NSW Health reported that Recommendation 5 had been completed, citing its review of the role of charities in three regions (Mid North Coast, Hunter New England and Southern NSW).[126]

2.10 Following this work, NSW Health published a position paper titled *Understanding the charity and local community sector in regional NSW*, which 'shares key findings and opportunities for enhanced collaboration with charities and local community groups.'[127] NSW Health also lead a Project Reference Group that was due to meet and work on implementing actions from the paper in late 2024. The Group has LHD, Ministry of Health and charity representation.[128]

2.11 Additionally, NSW Health stated that it is conducting 'comprehensive resource mapping' with local community groups, and regional LHDs have been encouraged to conduct reviews to map local charities and community groups.[129]

2.12 During our inquiry, we were pleased to hear that positive engagement is occurring between LHDs and some local organisations. For example, Royal Far West submitted that collaboration between early childhood intervention service providers and NSW Health had increased in the past year.[130] Inverell Health Forum also described active government engagement with not-for-profit organisations and charities in their town.[131]

---

[124] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 37, 182.

[125] Submission 106, NSW Health, p 15.

[126] NSW Health, *Progress Report: Parliamentary inquiry into health outcomes and access to health and hospital services in Rural, Regional and Remote New South Wales*, September 2024, p 19; NSW Health, *Understanding the charity and local community sector in regional NSW*, April 2024, p 1.

[127] NSW Health, *Understanding the charity and local community sector in regional NSW*, April 2024, viewed 24 March 2025; Submission 106, p 13; *Progress Report*, September 2024, p 19.

[128] Submission 106, p 14.

[129] *Progress Report*, September 2024, p 19.

[130] Submission 78, Royal Far West, p 2.

[131] Submission 96, Inverell Health Forum, p 7.

Progress on developing place-based needs assessments varies across regions

2.13 The current status of Recommendation 43 is unclear, as NSW Health described this recommendation as 'in progress' and 'completed' in different sections of its Progress Report.[132]

2.14 In reporting on progress, NSW Health stated that all regional Primary Health Networks (PHNs) have developed place-based needs assessments in collaboration with LHDs and other stakeholders, including local councils and community members and organisations.[133] They noted that they are committed to assisting regional PHNs to review these assessments every two years.[134]

2.15 NSW Health also noted that the Collaborative Care program has been established at five sites across Murrumbidgee LHD, Western NSW LHD and Far West LHD. As we discussed in Chapter One, Collaborative Care is a 'community centred, place-based approach to mapping and planning solutions to address healthcare challenges in regional communities'.[135] The Committee has heard positive feedback about the program's ability to support a place-based approach to planning that considers the needs of the local community.[136]

2.16 During this inquiry, some stakeholders reported instances of community consultation and engagement occurring.[137] The Committee also heard about positive examples of place-based health initiatives across rural and regional LHDs, including:

- Far West LHD collaboration with the Murdii Paakii Regional Assembly Local Aboriginal Community Working Parties on developing localised Aboriginal Health Action plans[138]
- Central Coast LHD's work on the All Inclusive Care for Older People model, which was co-developed in collaboration with the community and local organisations[139]
- the 'Healthy Warrumbungle' project between Western NSW LHD and Western NSW PHN, which involves both health organisations mapping and

[132] *Progress Report*, September 2024, pp 5, 92.

[133] *Progress Report*, September 2024, p 92; Submission 106, p 17.

[134] *Progress Report*, September 2024, p 93.

[135] Submission 106, p 9.

[136] Submission 43, Murrumbidgee Primary Health Network, p 3; Submission 75, The Royal Australian and New Zealand College of Ophthalmologists (RANZCO), p 4; Submission 90, Rural Doctors Network, p 3; Ms Narelle Mills, Executive Integration and Partnerships, Murrumbidgee Primary Health Network, Transcript of evidence, 12 December 2024, p 8; Mr Mike Edwards, Chief Operating Officer, Rural Doctors Network, Transcript of evidence, 12 December 2024, p 19.

[137] Mr Craig Gross, Professional Officer, NSW Nurses and Midwives' Association, Transcript of evidence, 12 December 2024, p 47; Submission 95, Local Government NSW, pp 7-8.

[138] Submission 106, p 18.

[139] Submission 106, p 18.

planning services together within the community, pooling resources to fill service gaps, and co-designing with local communities.[140]

2.17 However, as we noted in Chapter One, evidence from some PHNs indicated that the nature and maturity of place-based needs assessments varies across regions. For example, while Western NSW PHN and Murrumbidgee PHN reported working with their LHDs to conduct health needs assessments, Healthy North Coast (North Coast PHN) was yet to complete a region- and population-wide place-based needs assessment.[141]

2.18 Mayor Julia Cornwell McKean, Berrigan Shire Council, told the Committee that there is no place-based health needs assessment nor any health planning for the current state or future population growth of her local area.[142]

2.19 The Committee is also concerned that health needs assessments may lack input from local stakeholders, which was a key component of PC2 Recommendation 43. For example, Narrabri Shire Council and Bulgarr Ngaru Medical Aboriginal Corporation indicated that they had not been involved in their respective place-based health needs assessments.[143]

Communities continue to have limited input into local health service planning

Finding 7

Consultation between Local Health Districts and communities remains limited in areas of remote, rural and regional NSW, including in relation to planning and decision-making for local health services.

Recommendation 7

That NSW Health work with rural and regional Local Health Districts (LHDs) to formalise the requirement for genuine community consultation within each LHD's health service planning process.

2.20 Collaborating and engaging with local communities on health care is particularly important in rural areas to understand local needs and deliver effective services.[144] However, consultation between LHDs and communities remains

[140] Mr Brad Porter, Chief Executive Officer, Western NSW Primary Health Network, Transcript of evidence, 12 December 2024, p 3.

[141] Mr Porter, Evidence, 12 December 2024, p 8; Mr Stewart Gordon, Chief Executive Officer, Murrumbidgee Primary Health Network, Transcript of evidence, 12 December 2024, p 8; Ms Monika Wheeler, Chief Executive Officer, Healthy North Coast, Transcript of evidence, 12 December 2024, p 9.

[142] Mayor Julia Cornwell McKean, Berrigan Shire Council, Transcript of evidence, 13 December 2024, p 9.

[143] Submission 3, Bulgarr Ngaru Medical Aboriginal Corporation, p 5; Mayor Darrell Tiemens, Narrabri Shire Council, Transcript of evidence, 13 December 2024, p 8.

[144] Submission 34, Narrabri Shire Council, p 12; Mr Richard Colbran, Chief Executive Officer, Rural Doctors Network, Transcript of evidence, 12 December 2024, p 12.

limited in areas of remote, rural and regional NSW.[145] This includes in relation to planning and making decisions for critical health services and infrastructure.[146]

2.21 The Committee heard that poor consultation or communication can lead to damaged trust and community frustration,[147] local health needs not being addressed,[148] and the construction of health facilities that are not fit-for-purpose.[149]

Consultation on the development of health infrastructure

2.22 The Committee acknowledges that some consultation with remote, rural and regional communities on the development of health infrastructure is occurring. For example, we were pleased to hear positive reports from Moree Plains Shire Council about collaboration and consultation on the redevelopment of their local hospital.[150] NSW Health also reported various efforts made by regional LHDs to aid greater community involvement in the planning and design of health services and/or facilities.[151]

2.23 However, a number of stakeholders reported minimal or poor community consultation on hospital redevelopments in Forbes, Parkes, Finley and Albury and Wodonga.[152]

2.24 Councillor Phyllis Miller, OAM, Vice-President, Local Government NSW (LGNSW), illustrated minimal consultation taking place at the local level by referencing the redevelopment of public hospitals in Forbes and Parkes.[153] Councillor Miller emphasised that the community knew the health services that were being delivered locally. However, decisions about the redevelopments were made without consultation, including from local health staff:

> When we rebuilt our hospitals, the bureaucrats assumed where the health services would be delivered from. They made their mark on the redevelopment of two hospitals…They decided which was going to be the biggest and the best, and they were very wrong.[154]

2.25 The Committee notes that when funding is available to build the capacity of RRR health facilities, consultation is necessary to help understand where resources

---

[145] Submission 34, pp 4, 6, 12; Submission 77, Berrigan Shire Council, p 4; Mayor Tiemens, Evidence, 13 December 2024, pp 2, 5-6; Ms Sharelle Fellows, Community Representative, Transcript of evidence, 12 December 2024, p 36; Mr Damian Thomas, Directory Advocacy, Local Government NSW, Transcript of evidence, 12 December 2024, p 40; Councillor Phyllis Miller, OAM, Vice-President, Local Government NSW, Transcript of evidence, 12 December 2024, pp 40-41; Mayor Neil Westcott, Parkes Shire Council, Transcript of evidence, 13 December 2024, p 7.

[146] Submission 34, p 4; Mayor Tiemens, Evidence, 13 December 2024, p 2; Mr Thomas, Evidence, 12 December 2024, p 40; Cr Miller, Evidence, 12 December 2024, p 41.

[147] Submission 34, pp 5, 12; Submission 92, Rural Doctors Association of NSW, p 5.

[148] Submission 77, p 9.

[149] Cr Miller, Evidence, 12 December 2024, pp 40-41.

[150] Cr Miller, Evidence, 12 December 2024, p 39; Mr Thomas, Evidence, 12 December 2024, p 41.

[151] Submission 106, pp 15-16.

[152] Cr Miller, Evidence, 12 December 2024, pp 40-41; Mr Thomas, Evidence, 12 December 2024, p 40; Submission 77, p 4.

[153] Cr Miller, Evidence, 12 December 2024, pp 40-41.

[154] Cr Miller, Evidence, 12 December 2024, p 40.

are needed most. For example, the Committee was disappointed to hear that following the Forbes and Parkes hospital redevelopments one hospital is not 'used at all'.[155]

2.26 LGNSW cited challenges for Albury-Wodonga Health being a cross-border health service and for Cootamundra-Gundagai where there is both state agencies and federal agencies seeking to engage with the community.[156] We acknowledge this and that effective community engagement by health services needs to occur in partnership with Commonwealth and other state health agencies in these situations.

2.27 Stakeholders also expressed concern that the people that run meetings with local stakeholders and make decisions about health infrastructure have limited knowledge about the rural communities they are servicing.[157] In relation to the Parkes and Forbes hospital redevelopments, the Committee heard that 'there were bureaucrats from Sydney who thought they knew more than [the community], and they didn't'.[158]

Consultation on the closure of health services

2.28 The Committee heard that minimal consultation with RRR communities has been an issue in relation to the closure of health services as well.[159] We are concerned that the repercussions of this are particularly dangerous if data is not appropriately utilised by LHDs to inform decisions about rural health services.

2.29 The Rural Doctors Association of NSW stated that the closure of health services, including operating theatres, usually occurs in a 'poorly forecast manner'. They noted that there can be minimal engagement either before or during the service closure process.[160]

2.30 Narrabri Shire Council also submitted that there was a lack of consultation and communication by their LHD regarding a proposal to downgrade pathology services at Narrabri Hospital.[161]

2.31 A lack of community consultation can be distressing for communities and places undue pressure on them to advocate for local health services under threat. For example, although Narrabri Shire Council reported that pathology services are now staying open, the community has been left with a 'sustained anxiety' and view that services were only kept as a result of their swift grassroots campaign.[162]

[155] Cr Miller, Evidence, 12 December 2024, p 40.

[156] Mr Thomas, Evidence, 12 December 2024, p 40.

[157] Cr Miller, Evidence, 12 December 2024, p 41; Mayor McKean, Evidence, 13 December 2024, p 6; Submission 77, p 4.

[158] Cr Miller, Evidence, 12 December 2024, p 41.

[159] Submission 92, p 5; Mayor Tiemens, Evidence, 13 December 2024, pp 2, 5-6.

[160] Submission 92, p 5.

[161] Submission 34, p 4; Mayor Tiemens, Evidence, 13 December 2024, pp 2, 5-6.

[162] Submission 34, p 12.

Lack of genuine community consultation

2.32 The Committee is concerned that community consultation by LHDs may not be used to genuinely inform service planning and drive local health reform. The Rural Doctors Association of NSW (RDA) stated that community feedback on health services plans is only sought after they are developed:

> Interval service "plans" carried out by LHDs will give the current statistics of a health service or facility and the services required and anticipated. Community feedback is then sought once the plan has been developed and future services forecast. This is not collaborative, nor is it capacity building in its approach.[163]

2.33 RDA also observed that while community engagement does happen prior to health infrastructure changes, the degree to which feedback is incorporated is unknown:

> Infrastructure changes, such as building new facilities, does follow community engagement however it is difficult to know how much feedback is actually taken into account or whether the overall design has been decided on and the process is merely ticking the box of consultation.[164]

2.34 In light of the mixed evidence that the Committee received during the inquiry, it is clear to us that consultation between LHDs and communities across RRR NSW is inconsistent. Councillor Miller warned the Committee that 'mistakes' with hospital rebuilds will continue unless formal arrangements are made to facilitate conservations between local communities, NSW Health and LHDs.[165]

2.35 Considering this, the Committee recommends that NSW Health work with rural and regional LHDs to formalise the requirement for genuine consultation with communities as part of their health service planning and decision-making process. Feedback from community consultation should be considered when making decisions for remote, rural and regional health services to appropriately address local health needs. We hope that this recommendation will facilitate genuine dialogue with local communities and ensure that communities are consulted with greater consistency across RRR NSW.

Poor communication from Local Health Districts has persisted

Recommendation 8

That NSW Health work with Local Health Districts to improve communication with remote, rural and regional communities by:

- **providing clear and accessible information to communities on significant changes to local health services, including the rationale for these changes, and**
- **increasing community awareness of existing consultation forums, where they are available to them.**

[163] Submission 92, p 5.

[164] Submission 92, p 5.

[165] Cr Miller, Evidence, 12 December 2024, p 40.

2.36 Part of Recommendation 42 was that rural and regional Local Health Districts (LHDs) explore ways to better inform communities about the services available to them and publish extra data such as wait times and minimum service standards for their facilities.[166]

2.37 In its Progress Report, NSW Health reported that implementation of this recommendation has been completed.[167] In reporting on progress against this recommendation, NSW Health stated that the national 24-hour healthdirect service provides access to health advice and connects people to care options that are available to them. NSW Health is also partnering with healthdirect Australia to create a localised app for NSW residents. This app will help rural patients to check symptoms, find services and book appointments.[168]

2.38 NSW Health also reported that wait times for the emergency departments of major NSW hospitals are published online in real-time.[169]

2.39 However, it is unclear if any progress has been made on informing communities about minimum service standards for public health facilities. For example, Culcairn Local Health Advisory Committee told us that it is very hard for communities to get information on local health services. They highlighted challenges with accessing information across the LHD and Primary Health Network systems.[170]

2.40 During our inquiry, we heard that communities in RRR NSW continue to receive little or poor communication about local health services.[171] This includes limited information about local health services and why certain services are unavailable.[172]

2.41 For example, Mayor Darrell Tiemens, Narrabri Shire Council, asserted that communication is the core of the issue for many RRR communities. He described Hunter New England LHD as 'opaque' in how it operates and stated that it is difficult to know how decisions are made in relation to his local community:

> We have communicated these needs over time, and they will never tell us why we've been denied these services. Fair's fair. If there's evidence that we have a lower needs state, then we're more than happy to cop that. But the needs state is really high … You cannot get to the evidence – [on] how they're making their decisions.[173]

2.42 The Committee is concerned that a lack of transparent communication can also result in a misalignment between community expectations and health service delivery. For example, Berrigan Shire Council stated that dialysis services and CT

[166] Submission 106, p 14.

[167] *Progress Report*, September 2024, p 89.

[168] Submission 106, p 15.

[169] *Progress Report*, September 2024, p 90.

[170] Answers to supplementary questions, Culcairn Local Health Advisory Committee, 12 December 2024, p 1.

[171] Mayor Tiemens, Evidence, 13 December 2024, p 5; Mayor McKean, Evidence, 13 December 2024, p 6; Ms Fellows, Evidence, 12 December 2024, p 36.

[172] Answers to supplementary questions, Culcairn Local Health Advisory Committee, 12 December 2024, p 1; Mayor Tiemens, Evidence, 13 December 2024, pp 5-6.

[173] Mayor Tiemens, Evidence, 13 December 2024, pp 5-6.

scanning were not included as part of the Finely Hospital redevelopment 'despite initial assurances' that they would be. They said that this illustrates a 'disconnect between community consultation and actual service delivery'.[174]

2.43 Some feedback from local councils indicated that there is a 'loss of trust' in health planning processes when actions identified in local health plans are de-funded.[175] The Committee acknowledges the important role that various local councils play in communicating with LHDs and advocating for their communities about local health matters.[176]

2.44 Ms Jill Ludford, Chief Executive, Murrumbidgee LHD, discussed the importance of communication and 'being very open' with communities about what can and can't be provided. She noted that local services may not be viable and subsequently may not be provided due to workforce and safety considerations.[177]

2.45 While the Committee acknowledges that there may be sound, evidence-based reasons for changes to health services, the rationale for major decisions should be communicated to communities. We believe that this will increase the accountability of decision-makers, help manage community expectation, foster collaborative relationships and inform communities about how LHDs intend on addressing their communities' health needs.

2.46 Mr Craig Gross, Professional Officer, NSW Nurses and Midwives' Association, also highlighted the need to inform communities about existing consultation forums that are in place. For example, although he acknowledged that there is community consultation occurring in RRR NSW, he explained that community members in his regional area only found out about their LHD's annual meeting after it had occurred.[178]

2.47 The Committee is of the view that poor communication from LHDs will hinder their ability to effectively engage and consult with communities. We recommend that NSW Health work with LHDs to improve communication with remote, rural and regional communities. This should be done by providing clear and accessible information on significant changes to local health services, including the rationale for these changes, and increasing an awareness of existing community consultation forums.

Local Health Advisory Committees

Local Health Advisory Committees (LHACs) are volunteer groups that act as a formal avenue for communities to offer input on their local health services. They aid community engagement and health advocacy in regional Local Health Districts (LHDs) and play a role in

[174] Submission 77, p 9.

[175] Submission 95, p 10.

[176] Mr Thomas, Evidence, 12 December 2024, pp 40-41; Submission 96, pp 3, 7; Deputy Mayor Steven Ring, Lithgow City Council, Transcript of evidence, 13 December 2024, p 5; Mr Shaun Elwood, Director, Lithgow City Council, Transcript of evidence, 13 December 2024, p 7.

[177] Ms Jill Ludford, Chief Executive, Murrumbidgee Local Health District, NSW Health, Transcript of evidence, 13 December 2024, p 18.

[178] Mr Craig Gross, Professional Officer, NSW Nurses and Midwives' Association, Transcript of evidence, 12 December 2024, p 47.

advising communities about services that are available to them. LHACs are known by a number of other names such as 'local health committees' or 'community advisory groups'.[179] This report follows the PC2 report in using the term LHAC to refer to these groups.

2.48 The 2022 PC2 report noted that the function of LHACs had changed considerably, with LHACs 'no longer serving as meaningful conduits between local communities and local health services for health planning and health reporting purposes'.[180] In response to this, part of Recommendation 42 was that rural and regional LHDs 'review, reinvigorate and promote' the role of LHACs to ensure genuine community consultation on local health service outcomes and planning.[181]

2.49 NSW Health have since reported that this recommendation has been completed.[182] During the current inquiry, we found that there are some examples of robust LHACs in rural and regional NSW. However, we also heard that, in other parts of NSW, these committees are often inactive or hindered by protocol and cultural challenges. As a result, the Committee has found that the current LHAC model is not consistently facilitating community consultation across remote, rural and regional NSW.

NSW Health have developed five guiding principles to strengthen LHACs

2.50 Following a review that was conducted in partnership with regional LHDs and LHACs, NSW Health identified five guiding principles to reinvigorate and promote community engagement through LHACs. The principles and key findings from the review were published in the 'Strengthening local health committees in regional NSW' report in February 2023.[183]

2.51 NSW Health stated that they are working with regional LHDs to implement these guiding principles and supporting this work 'through the development of a best practice toolkit and resource hub, and community of practice and masterclass series.' NSW Health is also tracking the progress of implementation, refining the implementation program and promoting local health committees across regional NSW.[184]

2.52 Mr Luke Sloane, Deputy Secretary, Rural and Regional Health, said that there is a myriad of LHACs in NSW and that NSW Health is regularly working to ensure that they are functioning and 'at critical mass for communication and consultation with the community.'[185]

---

[179] NSW Health, *Strengthening local health committees in regional NSW*, February 2023, p 3; Submission 106, p 14; Mr Luke Sloane, Deputy Secretary, Rural and Regional Health, NSW Health, Transcript of evidence, 13 December 2024, p 12.

[180] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 175.

[181] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 182.

[182] *Progress Report*, September 2024, p 89.

[183] *Progress Report*, September 2024, p 89; Submission 106, p 14.

[184] *Progress Report*, September 2024, p 89.

[185] Mr Sloane, Evidence, 13 December 2024, p 12.

There are active LHACs in some areas of remote, rural and regional NSW

2.53 Stakeholders reported active LHACs within the Murrumbidgee LHD (in Culcairn, Finley, Berrigan and Tocumwal), Western NSW LHD (in Gulgong), and Hunter New England LHD (in Moree).[186]

2.54 The Committee was also pleased to hear that the Northern NSW and Murrumbidgee LHDs have LHACs associated with each of their public health facilities and meet regularly.[187] For example, Ms Tracey Maisey, Chief Executive, Northern NSW LHD, told us that representatives from Northern NSW LHACs form part of a district-wide Community Partnership Advisory Committee that meets monthly. She said that their advocacy has led to change and affected how the LHD conducts its planning.[188] Further information on the Murrumbidgee LHAC model is included in the case study below.

Case study: Murrumbidgee Local Health Advisory Committees

There are 33 Local Health Advisory Committees (LHACs) that are jointly supported and managed by Murrumbidgee LHD and Murrumbidgee Primary Health Network (PHN).[189] The volunteer health advocates who work on these committees provide grassroots input on local health issues. This feedback is then used to inform local health needs assessments and planning.[190]

The PHN and LHD co-fund LHAC forums that occur twice a year and run LHAC recruitment drives together. A joint priority planning session is also run every two years, where PHN and LHD representatives provide health needs assessment data and collaborate with committee members to identify local issues and projects of work.[191] Both organisations also work to share LHAC resources online, which are hosted on MPHN's website.[192]

Over the last seven years, MPHN has provided their LHACs with $100 000 of funding through various grant initiatives including for palliative care and cancer screening. MPHN also stated 'it is our understanding MLHD provides nominal funding for each LHAC to implement local activities'.[193] The Committee commends MLHD and MPHN for their joint efforts in establishing and supporting a robust LHAC system across their region. However, this type of integrated model for rural and regional LHACs appears to be an isolated example.

[186] Submission 77, p 3; Mr Matthew Clancy, Chair, Culcairn Local Health Advisory Committee, Transcript of evidence, 12 December 2024, p 32; Mayor Julia Cornwell McKean, Berrigan Shire Council, Transcript of evidence, 13 December 2024, p 6; Ms Fellows, Evidence, 12 December 2024, p 37; Mr Thomas, Evidence, 12 December 2024, p 41.

[187] Ms Tracey Maisey, Chief Executive, Northern NSW Local Health District, NSW Health, Transcript of evidence, 13 December 2024, p 13; Ms Ludford, Evidence, 13 December 2024, p 13.

[188] Ms Maisey, Evidence, 13 December 2024, p 13.

[189] Ms Ludford, Evidence, 13 December 2024, p 13; Mr Gordon, Evidence, 12 December 2024, p 6; Answers to supplementary questions, Murrumbidgee Primary Health Network, 20 December 2024, p 2.

[190] Mr Gordon, Evidence, 12 December 2024, p 6.

[191] Mr Gordon, Evidence, 12 December 2024, p 6; Ms Mills, Evidence, 12 December 2024, p 6.

[192] Answers to supplementary questions, Murrumbidgee Primary Health Network, 20 December 2024, p 2.

[193] Answers to supplementary questions, Murrumbidgee Primary Health Network, 20 December 2024, p 2.

The LHAC model is not consistently facilitating community consultation

Finding 8

The Local Health Advisory Committee model is not providing a consistent forum for genuine community consultation and input into local health services across remote, rural and regional NSW.

Recommendation 9

That NSW Health work with rural and regional Local Health Districts to ensure that every remote, rural and regional community has access to a forum that enables them to provide frank and meaningful feedback on public health services.

2.55 Despite positive examples of LHACs operating in some areas, as noted above, we found that the LHAC model is not consistently providing a forum for community input into local health services across RRR NSW. This is due to various challenges, as outlined below.

An inconsistent model

2.56 LHACs vary across regional Local Health Districts (LHDs), with the number of committees ranging from one to 33 per District.[194]

2.57 Mr Sloane told the Committee that there was 'varying capability, capacity and engagement' with LHACs across rural and regional NSW. He also said that there is no edict for each public health facility to have a LHAC, noting that some LHDs are trialling regionally based consultation and engagement groups instead.[195]

2.58 The Committee acknowledges that each community is different and that consultation and LHAC models need to be flexible and tailored to local needs. However, we are concerned that in parts of NSW, these committees are inactive and there may be no avenue for consumer input on health matters.

Inactivity

2.59 LHACs in some NSW rural towns either do not exist or are inactive. For example, Bulgarr Ngaru Medical Aboriginal Corporation which provides health services out of Grafton, Casino and Tweed Heads South in the Northern Rivers region of NSW, reported that there are no active LHACs in their area.[196] Stakeholders also noted that there is no committee within the Murray River based town of Barooga or in Boggabri which is situated in NSW's north-east.[197]

2.60 Narrabri Shire Council stated that Wee Waa and Narrabri LHACs are 'effectively defunct and have not met in some time'. As a result, local government and the

[194] *Strengthening local health committees in regional NSW*, February 2023, p 6.

[195] Mr Sloane, Evidence, 13 December 2024, pp 11-12.

[196] Submission 3, p 5.

[197] Mayor McKean, Evidence, 13 December 2024, p 6; Submission 34, p 12.

community have no suitable mechanism to stay informed about health service changes.[198]

2.61 Ms Donna Ausling, Director, Planning and Sustainability, Narrabri Shire Council, called for dormant committees to be urgently re-activated and provided with appropriate resourcing.[199]

2.62 In their responses to questions on notice, NSW Health outlined the membership of a series of meetings in Wee Waa, including via the Wee Waa Hospital Working Party. The membership of the Hospital Working Party includes community representatives.[200] However, it is unclear how frequently this group meet and what their role is in facilitating community input on health service planning.

Protocol issues

2.63 LHACs may have certain rules or protocols that affect their viability and how freely their members can speak within the community. Local council feedback noted that protocols on how long LHAC members can serve have caused at least one LHAC to dissolve. Local Government NSW stated that it possible to apply for an exemption to this rule. However, this process is 'cumbersome' considering these committees already have limited resources. They described this process as a 'loss', as it is difficult to recruit LHAC volunteers.[201]

2.64 Ms Sharelle Fellows, a community representative from Gulgong, also explained that LHAC codes may set restrictive parameters around what committee members can say in public:

> I also read the code, and you can't necessarily speak in the community and publicly about...I'm quite outspoken, so I decided that perhaps that code of conduct may not be appropriate for me and I could do more actively on the outside than within that.[202]

A lack of open feedback forums

2.65 The Committee was concerned to hear that some LHACs are viewed as advocates for LHD policies, instead of advocates for their local communities. Some local council feedback noted that the role of LHACs in local health planning has decreased. Local Government NSW stated that there is an impression among some councils that the role of LHACs 'is to "sell" policies to the local community, rather than genuine consultation in the development of these policies'.[203]

---

[198] Submission 34, p 12.

[199] Ms Donna Ausling, Director, Planning and Sustainability, Narrabri Shire Council, Transcript of evidence, 13 December 2024, p 7.

[200] Answers to questions on notice, NSW Health, 24 January 2025, p 5.

[201] Submission 95, p 9.

[202] Ms Fellows, Evidence, 12 December 2024, p 37.

[203] Submission 95, p 8.

2.66 Ms Ausling also said that there are 'tokenistic committees that have no real purpose other than ticking a box.' She noted the need for the culture of LHACs to shift towards one of 'true engagement'.[204]

2.67 The Committee is of the view that, when there are no consultation forums that allow for the frank exchange of community views, rural and regional communities may have to turn to activism and informal communication channels to advocate for local health issues.

2.68 For example, Gulgong residents have written letters to politicians and organised an active social media campaign to raise awareness about there being no GP in their town. This is a situation that has been made worse by the fact that neighbouring Mudgee GP clinics no longer accept new patients (as discussed in Chapter One).[205] Both towns have active community groups called 'Doctors for Gulgong' and 'Mudgee 4 Doctors'.[206] However, Ms Sharelle Fellows, a community representative from the area, told the Committee that people still feel neglected and 'do not feel that their voices have been heard' or their health needs met.[207]

2.69 Mayor Darrell Tiemens, Narrabri Shire Council, said that there are WhatsApp instant messaging groups in place with various community members in Narrabri. These included hospital staff who were instructed to not communicate with local council representatives. He described these groups as a trusted setting in which residents were able to work together to consider need states and develop strong clinical solutions. These solutions have since been presented to their LHD.[208]

2.70 Mayor Tiemens called for committees that are 'close to the community' with access to health data:

> …actually having those open dialogues between elements of the community, where we can share the data, understand what the needs are and understand where to move forward, is what's required—having real committees.[209]

2.71 The Committee recommends NSW Health work with rural and regional LHDs to ensure that there are accessible feedback forums for each remote, rural and regional community. These forums should provide an avenue for frank and meaningful feedback on public health services.

Prioritising rural and regional health in government decision-making

Recommendation 10

That a NSW Remote, Rural and Regional Health Commissioner (or similar position) be established to ensure that the health needs of remote, rural and regional communities in NSW are appropriately considered as part of government decision-making. This function of the NSW Remote, Rural and

[204] Ms Ausling, Evidence, 13 December 2024, p 7.

[205] Ms Fellows, Evidence, 12 December 2024, pp 33-34; Submission 12, Mr Matthew Baskerville, p 1; Submission 71, Mr Christopher Pearson, p 1.

[206] Ms Fellows, Evidence, 12 December 2024, p 34.

[207] Ms Fellows, Evidence, 12 December 2024, p 33.

[208] Mayor Tiemens, Evidence, 13 December 2024, p 7.

[209] Mayor Tiemens, Evidence, 13 December 2024, p 7.

Regional Health Commissioner should complement the functions outlined in Recommendation 18 of this report.

2.72 The PC2 report made various recommendations to prioritise rural health within government policy and decision-making, including:

- maintaining a Regional Health Minister in Cabinet with the authority to address issues raised in the PC2 inquiry (Recommendation 36)
- publishing the final evaluation of the *NSW Rural Health Plan: Towards 2021* and considerations for the development of the next Rural Health Plan (Recommendations 37 and 38)
- adopting a Health in All Policies framework to ensure that the health of people in NSW is central to government decision-making, and to ensure 'whole-of-government ownership of health outcomes' (Recommendation 44).[210]

2.73 NSW Health have since reported that the implementation of all of these recommendations has been completed.[211] However, the Committee considers that remote, rural and regional health needs have not been sufficiently prioritised within government decision-making and that there is a need to establish a Remote, Rural and Regional Health Commissioner position, as discussed below.

Some action has been taken to prioritise rural health needs within government

Minister for Regional Health

2.74 The NSW Government state that they are committed to prioritising regional health through 'strong governance and leadership'. In 2021, a Minister for Regional Health was appointed with responsibility for regional hospitals and health services in NSW. The regional portfolio has since been maintained, and the Regional Health Minister position is currently held by the Hon. Ryan Park MP, who is also the Minister for Health.[212] Additionally, a Deputy Secretary for Regional Health was appointed in July 2023 'to ensure regional health issues remain front and centre of the decision-making process within the Ministry of Health'.[213]

2.75 While stakeholders expressed support for the creation of the Minister for Regional Health position,[214] the Committee also heard about the position's limitations.[215] For example, Australian Paramedics Association NSW raised concerns about the Regional Health Minister concurrently holding the position of Health Minister. They stated that this would divide the Minister's attention, and

[210] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 178, 182-183.

[211] *Progress Report*, September 2024, pp 79-82, 94.

[212] *Progress Report*, September 2024, p 79.

[213] NSW Health, *NSW Government announces appointment of Regional Health Deputy Secretary*, media release, 6 July 2023, viewed 8 April 2024.

[214] Submission 31, Chris O'Brien Lifehouse, p 14; Submission 34, p 15; Submission 96, p 8; Submission 107, Australian College of Rural and Remote Medicine, p 1.

[215] Submission 76, Australian Paramedics Association (NSW), pp 4-5; Submission 92, p 6.

that there are conflicts of interest between the overall health system and the regional health system.[216]

2.76 The Rural Doctors Association of NSW noted that while the Minister of Regional Health can escalate issues, their ability to enact change is restricted by the Treasury and by the autonomy of LHDs within NSW Health's devolved governance structure. Similarly, they queried the practical utility of the Regional Health Deputy Secretary role, in terms of authority to enact change.[217]

2.77 The Committee considers that establishing an independent Commissioner role would provide remote, rural and regional health with its own permanent standing, in a role that is independent of Cabinet. The proposed position is discussed later in this section.

Health in All Policies Framework

2.78 Recommendation 44 was for the NSW Government to adopt a Health in All Policies framework, similar to the policy in South Australia, including 'a requirement that all decisions of government are assessed to determine the impact on human and environmental health to ensure a whole-of-government ownership of health outcomes'.[218]

2.79 NSW Health has since completed a review of the Health in All Policies Framework. However, based on the review's findings, NSW Health stated that it will embed 'principles of a Health in All Policies approach through existing statewide, regional and local mechanisms' rather than adopting the framework as it was initially implemented in South Australia.[219]

2.80 The review included an evidence check by the Agency for Clinical Innovation to support developing, reviewing, measuring, and evaluating Health in All Policies and similar approaches.[220] It also included recommendations for embedding this approach, which were endorsed by the Ministry of Health's Executive in June 2024.[221] However, it is unclear what these recommendations are or how are they promote whole-of-government ownership of health outcomes.

2.81 NSW Health stated that it will consult with the Premier's Department, Treasury and the Cabinet Office on 'further opportunities for embedding the principles and key components of effective partnerships across the NSW Government.'[222]

---

[216] Submission 76, p 5.

[217] Submission 92, p 6.

[218] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 182-183.

[219] *Progress Report*, September 2024, p 94; Submission 106, p 21.

[220] Agency for Clinical Innovation, Evidence check: Health in All Policies and similar approaches, October 2024.

[221] Submission 106, p 21; *Progress Report*, September 2024, p 94.

[222] Submission 106, p 21; *Progress Report*, September 2024, p 94.

2.82 While there was support for this recommendation,[223] stakeholders did not notice significant progress.[224] Manna Institute reiterated the need for a framework of this kind, noting the need to work across government portfolios instead of relying on communities to identify and address their own health needs.[225]

NSW Regional Health Strategic Plan

2.83 NSW Health published the *Final Progress Review of the Rural Health Plan: Towards 2021* in May 2022. They stated that insights from the review were used to develop the *NSW Regional Health Strategic Plan 2022-32* (the Plan), which was published in February 2023. According to NSW Health, the new Plan seeks to address issues raised in the PC2 report and was informed by extensive consultation with consumers and NSW Health staff.[226]

2.84 NSW Health explained that throughout its 10-year timeframe, the Plan will be regularly monitored and reviewed. Part of this work involves conducting evaluations at three, five and ten years. NSW Health stated that findings from these evaluations will be published to increase visibility of the Plan and accountability for NSW Health in implementing it.[227] NSW Health have also published a Progress Snapshot for 2022-2023, which shows initial progress against the 19 targets set for the first three years of the Plan.[228]

2.85 The next Progress Snapshot was due for release in late 2024.[229] However, at the time of writing, this does not appear to be available.

2.86 Rural Doctors Network (RDN) expressed support for the Plan and provided a range of insights as constructive feedback. As part of this feedback, RDN stated that continual reporting against PC2 recommendations could affect resourcing for executing the Plan:

> [there is a] risk of confusion, and dilution of resources, resulting from continued calls for reporting against the Rural Health Inquiry recommendations versus focused delivery of the NSW Regional Health Strategic Plan 2022-32 which was designed with significant community and stakeholder consultation to respond to the Rural Health Inquiry recommendations.[230]

2.87 The Committee acknowledges that remote, rural and regional health priorities have and will continue to shift beyond what was recommended in the PC2 report. As outlined below, we are of the view that a Remote, Rural and Regional Health Commissioner position will assist in advocating for current rural health needs and progressing relevant priorities. This role will ensure that the intention of both

---

[223] Submission 34, p 15; Submission 41, Can Assist (Cancer Assistance Network), p 3; Submission 74, Australian College of Nurse Practitioners, p 4; Submission 87, Manna Institute, p 2.

[224] Submission 3, p 5; Submission 76, p 4.

[225] Submission 87, p 2.

[226] Submission 106, p 20; *Progress Report*, September 2024, pp 80-81; NSW Health, NSW Regional Health Strategic Plan 2022-2032, viewed 3 April 2025.

[227] *Progress Report*, September 2024, pp 80-81.

[228] *Progress Report*, September 2024, pp 81-82; NSW Health, *Regional Health Strategic Plan 2022-2032 – Progress Snapshot 2022-23*, November 2023.

[229] *Progress Report*, September 2024, p 82.

[230] Submission 90, p 2.

NSW Health-developed plans and the recommendations of independent inquiries are met.

A NSW Remote, Rural and Regional Health Commissioner would help to prioritise rural health needs

2.88 The Committee is of the view that establishing a NSW Remote, Rural and Regional Health Commissioner role could help to ensure that RRR needs are appropriately considered and prioritised as part of broader health reform.

2.89 As noted earlier in this chapter, even when communities are engaged or consulted, their input may not be reflected in tangible health reform. In some instances, local consultation may also identify issues that cannot be addressed without broader reform. For example, Mr Matthew Clancy, Chair, Culcairn Local Health Advisory Committee, noted that despite regular contact between his committee, the LHD and PHN, issues fall through the gaps as responsibilities across health organisations are unclear.[231]

2.90 Ms Monika Wheeler, Chief Executive Officer, Healthy North Coast, stated that there is 'still a long way to go' to ensure that patient needs are driving health reform. She emphasised the importance of embedding a 'consumer voice' in health service design and evaluation.[232]

2.91 Local communities are also experiencing consultation fatigue and are being engaged repeatedly without noticing any outcomes as a result.[233] As Associate Professor Sarah Wayland, Senior Researcher, Manna Institute, observed:

> People feel that people come to them and ask for the solutions, and then they never hear the outcome of that, other than another focus on, "Tell us again, because we didn't hear it the first time."[234]

2.92 Noting these ongoing challenges, the Committee recommends the establishment of a NSW Remote, Rural and Regional Health Commissioner (or similar office holder) to ensure that remote, rural and regional health needs are adequately considered in government decision-making.

2.93 We are of the view that an ongoing, dedicated and independent office holder, like a Remote, Rural and Regional Health Commissioner, will be able to drive the necessary reform and bring attention to persistent and emerging health challenges in RRR NSW. Consideration should be given to how this role can amplify and support the work of the current LHAC network, particularly in light of the recommendations the Committee has made in this chapter.

2.94 This position may be informed, in part, by the functions and scope of the National Rural Health Commissioner role, described below.

---

[231] Mr Clancy, Evidence, 12 December 2024, p 37.

[232] Ms Wheeler, Evidence, 12 December 2024, p 7.

[233] Associate Professor Sarah Wayland, Senior Researcher, Manna Institute, Transcript of Evidence, 12 December 2024, p 58; Ms Leanne Nisbet, PhD Candidate, Faculty of Medicine and Health, University of New England, Transcript of Evidence, 12 December 2024, p 58.

[234] Associate Professor Wayland, Evidence, 12 December 2024, p 58.

The National Rural Health Commissioner

The National Rural Health Commissioner (the Commissioner) leads the Office of the National Rural Health Commissioner (the Office) and is supported by two deputy commissioners. The Commissioner is an independent statutory office holder appointed under the *Health Insurance Act 1973*. They must have rural health experience, and can serve in the role for up to two years.[235]

Established in 2017, the Office provides policy advice to the minister responsible for rural health and supports reform in primary health care, workforce and training. As part of its statutory requirements, the Office prepares an annual report for the Minister for Regional Health to present in Parliament.[236]

2.95 However, in addition to performing an advocacy role, the Committee is of the view that a state-based Remote, Rural and Regional Health Commissioner should be empowered to hold NSW Health accountable in implementing recommendations to improve RRR health.

2.96 Over the course of the Committee's three inquiries, it has become clear that there are many areas within RRR health that require continued oversight to ensure that sufficient progress is made. We explore these persistent challenges further in Chapter Three, and make an additional recommendation to clarify the powers and functions of the proposed NSW Remote, Rural and Regional Health Commissioner role.

[235] Australian Government Department of Health and Aged Care, The Commissioner and Deputies, viewed 9 April 2025.

[236] Australian Government Department of Health and Aged Care, About the Office of the National Rural Health Commissioner, viewed 9 April 2025.

Chapter Three – Persistent issues and final observations

3.1 In its 2022 report, Portfolio Committee No. 2 (PC2) made 44 recommendations for health reform in remote, rural and regional NSW. Of these 44 recommendations, the NSW Government supported 41 recommendations (in full or in principle) and noted three.[237]

3.2 While this Committee has examined progress against these recommendations over the course of three separate inquiries, each with their own distinct areas of focus, there are a number of persistent issues that have consistently been raised across these inquiries. These include workforce shortages, working conditions, workplace culture, and collaboration between NSW Health and non-governmental organisations.

3.3 This final chapter of the report begins by discussing these persistent issues. It then examines the overall progress made against the PC2 recommendations, and how this compares to the progress reported by NSW Health, noting that the intent of many PC2 recommendations remains unfulfilled. A summary table outlining the Committee's views of the completed PC2 recommendations (Table 1) is included at the end of this chapter.

3.4 Finally, we outline a recommended pathway for reform, including mechanisms for continued oversight, to ensure that addressing remote, rural and regional (RRR) health needs remains a priority in government decision-making.

Workforce issues and workplace culture

Finding 9

Despite the recommendations made by Portfolio Committee No. 2, there are persistent issues with workforce shortages, working conditions and workplace culture in remote, rural and regional NSW.

In its 2022 report, Portfolio Committee No. 2 (PC2) made numerous recommendations that focused on improving staffing shortages, working conditions and workplace culture in public health facilities across RRR NSW. This included reviewing the conditions and remuneration for various health professions, in addition to increasing nursing and midwifery staffing numbers, ensuring that paramedics are distributed evenly across RRR NSW, and building the Aboriginal health workforce.[238]

[237] NSW Government, *Response to Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, September 2022, p 4.

[238] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, pp xvi-xx.

3.5 In each of our three inquiries, the Committee has heard about persistent shortages in the RRR health workforce since the PC2 report was tabled.

3.6 The Committee acknowledges that the NSW Government has committed to addressing recruitment and retention issues through the Rural Health Workforce Incentive Scheme (the Incentive Scheme). However, there are several other areas where there have been only modest or underwhelming improvements to the workforce challenges experienced in RRR NSW.

3.7 This section begins by outlining the persistent workforce shortages and poor working conditions in RRR health facilities. It then puts forward recommendations to make the Incentive Scheme a permanent and more effective mechanism, reduce NSW Health's reliance on locum doctors, and improve workplace culture through comprehensive leadership training.

Workforce shortages have persisted across remote, rural and regional NSW

3.8 The Committee's first two reports examined a number of health and medical professions that experienced staff shortages across RRR NSW. These included general practice, Aboriginal health, maternity, paediatrics, mental health and allied health professions.[239]

3.9 During the current inquiry, we heard that there continues to be a general shortage of health care professionals in RRR NSW.[240] These shortages may be more pronounced in regions such as far western NSW, which face 'significant workforce shortages', in addition to limited access to health services and a growing chronic disease burden.[241]

3.10 Specifically, staffing shortages in the following health professions continue to be of significant concern:

- general practice[242]
- rural generalism, where training places 'remain undersubscribed'[243]
- obstetrics and gynaecology, where staff shortages have reached a crisis point in particular regions[244]

[239] Select Committee on Remote, Rural and Regional Health, *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, report 1/58, Parliament of New South Wales, August 2024, pp 4-16; Select Committee on Remote, Rural and Regional Health, *The implementation of recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW*, report 2/58, Parliament of New South Wales, March 2025, pp 9-17, 56-59.

[240] Submission 103, Royal Flying Doctor Service (South Eastern Section), p 4.

[241] Mr Brad Porter, Chief Executive Officer, Western NSW Primary Health Network, Transcript of evidence, 12 December 2024, p 2.

[242] Submission 91, The Royal Australian College of General Practitioners (RACGP) Rural, p 3; Submission 96, Inverell Health Forum, p 3.

[243] Submission 92, Rural Doctors Association of NSW, p 6.

[244] Submission 34, Narrabri Shire Council, pp 8-9; Submission 84, Australian Salaried Medical Officers' Federation NSW, p 6.

- paramedicine, which may be experiencing a 'deleterious' decline in staff retention across regional NSW[245]
- psychiatry, in which a critical statewide shortage is more pronounced in rural and regional areas.[246]

3.11 As discussed in Chapter One of this report, several stakeholders described a severe shortage of doctors in areas of rural NSW.[247] We also heard that there has been limited evidence of improvements in the recruitment or retention of doctors.[248] This includes shortages of doctors who can supervise trainees, which then limits the number of training positions that can be offered by regional hospitals.[249]

3.12 Beyond the limitations in patient care, doctor shortages continue to have other negative impacts. As the Committee has observed previously, workforce shortages are part of a challenging cycle where having unfilled positions creates poor working conditions for existing staff.[250] In turn, this makes working in RRR facilities less appealing and makes recruitment more difficult. Ms Fiona Davies, CEO, Australian Medical Association (AMA) NSW, told us that 'where there are healthcare shortages, doctors, nurses and other healthcare workers may choose to remain in metropolitan hospitals.'[251]

3.13 NSW Health have indicated a number of actions that they have taken to address the workforce crisis. In addition to expanding the Rural Generalist Single Employer Pathway (discussed in Chapter One), these actions include:

- the Rural Preferential Recruitment Program, which supports junior doctors spending their first two years of work in a rural location
- the NSW Area of Need Program, which makes it easier for employers to recruit International Medical Graduates in areas experiencing workforce shortage
- the NSW Rural Resident Medical Officer Cadetship Program, which currently supports 48 cadetships for medical students who agree to work in a rural hospital after they graduate.[252]

---

[245] Submission 76, Australian Paramedics Association (NSW), p 2.

[246] Dr Kathryn Drew, Member, Australian Salaried Medical Officers' Federation NSW and Director of Medical Services, Mental Health, Alcohol and Other Drugs Services, Northern NSW Local Health District, Transcript of evidence, 12 December 2024, p 50.

[247] Submission 6, Parkes Shire Council, p 1; Submission 96, p 3; Submission 92, p 5; Submission 91, p 3; Councillor Louise O'Leary, Transcript of evidence, 13 December 2024, p 3; Answers to questions on notice, Parkes Shire Council, 13 December 2024, p 1; Cr Louise O'Leary, Parkes Shire Council, Transcript of evidence, 13 December 2024, p 3.

[248] Submission 84, p 5; Submission 93, Charles Sturt University, p 4.

[249] Submission 44, Australian Medical Association NSW, pp 2-3.

[250] *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, August 2024, p 50.

[251] Ms Fiona Davies, Chief Executive Officer, Australian Medical Association NSW, Transcript of evidence, 12 December 2024, p 43.

[252] Answers to questions on notice, NSW Health, 24 January 2025, p 3.

3.14 A key recommendation of the PC2 report involved the development of a 10-year recruitment and retention strategy for the rural and remote medical and health workforce, in collaboration between the NSW and Australian governments (Recommendation 11).[253] In their submission, NSW Health identified a number of workforce plans and strategies that are in place or being developed. These include the NSW Health Workforce Plan 2022-2032, the National Medical Workforce Strategy 2021-2031 and national strategies that aim to address workforce issues in fields such as nursing, mental health and suicide prevention, and maternity services.[254]

3.15 The Committee also notes that the final report of the Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners ('the Independent Review') was endorsed by National Cabinet in April 2023. The Independent Review recommended a number of actions that could increase usage of internationally-trained medical and health professions, while ensuring quality of care is maintained for communities across Australia (particularly in rural and remote areas).[255]

3.16 NSW Health have advised that the Australian Health Practitioner Regulation Agency delivered the Expedited Registration Pathway for International Qualified General Practitioners in October 2024, which resulted from the Independent Review. This Pathway is expected to halve the registration timeframe for internationally qualified GPs.[256]

3.17 The Committee acknowledges that the NSW Government is taking action in response to these workforce crises, including through the Rural Health Workforce Incentive Scheme (discussed further below). However, it is clear to us that results from these NSW and Australian government plans have yet to materialise.

3.18 Several stakeholders have disputed exactly how much progress has been made in addressing regional workforce shortages. For example, AMA submitted that 'anecdotal evidence indicates a concerning decline in workforce availability, funding and overall service delivery' in RRR NSW.[257] Similarly, Australian Salaried Medical Officers' Federation NSW submitted that 'little progress' has been made on recruitment and retention.[258]

3.19 Charles Sturt University told the Committee that, since NSW Health manages the largest health system in Australia, it 'should be a leader, not a follower' on workforce planning, development and investment.[259] Similarly, the Committee believes that particular actions being partly reliant on the Australian Government should not become an excuse for NSW Health's delay, inaction or failure to implement the PC2 recommendations in the spirit in which they were intended.

---

[253] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, p xvi.

[254] Submission 106, NSW Health, p 7.

[255] R Kruk AO, *Independent review of Australia's regulatory settings relating to overseas health practitioners – Final report*, Commonwealth of Australia, 2023, p 16.

[256] Submission 106, pp 10-11.

[257] Submission 44, p 2.

[258] Submission 84, p 1.

[259] Submission 93, p 2.

Working conditions and pay are continuing to impact recruitment and retention

3.20 In its first report, the Committee argued that improvements to pay and working conditions were a vital element in improving workforce recruitment and retention. We recommended that NSW Health review remuneration for health professionals, with a view to improving pay for parity with other states and territories.[260] The NSW Government response supported this recommendation in principle, but without providing a course of action as to how it would do this.[261]

3.21 During the current inquiry, stakeholders continued to emphasise that the effectiveness of recruitment and retention strategies will be limited if there are inadequate improvements to remuneration, staff satisfaction, wellbeing and safety.[262] For example, Mr Craig Gross, Professional Officer, NSW Nurses and Midwives' Association, told the Committee:

> …we see the efforts that Local Health Districts within regional, rural and remote facilities are making to improve the recruitment and retention of nursing and midwifery staff through incentives and the like. The concern remains that without significant improvements to pay, working conditions and workplace culture for our members, we won't see genuine improvements that retain skilled workers and serve the needs of our rural communities.[263]

3.22 Stakeholders reported that there has been limited progress in improving remuneration, and cross-border disparities in remuneration and conditions continue to make recruitment and retention difficult.[264] For example, Mr Coda Danu-Asmara, Industrial Officer, Australian Paramedics Association NSW (APA), told the Committee that losing staff in NSW, due to better pay elsewhere, is a 'large issue among the paramedic cohort'.[265]

3.23 The Committee acknowledges that there have been some clear improvements to remuneration in recent years. For example, the Rural Doctors Association of NSW (RDA) noted that the three new items added to the Rural Doctors Settlement Package – which allow GP Visiting Medical Officers (VMOs) to be remunerated for discharge summaries and medication reconciliations – 'have been well received'.[266] RDA added that an item that remunerates GP VMOs for 'agreed, planned supervision of junior doctors' is now included in the Settlement Package and is being 'monitored for use'.[267]

---

[260] *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, August 2024, pp 26-28.

[261] NSW Government, *Response to Inquiry into the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, February 2025, p 8.

[262] Submission 88, NSW Nurses and Midwives' Association, pp 4, 6; Submission 84, pp 16, 18; Answers to supplementary questions, Australian College of Nurse Practitioners, 15 January 2025, p 2.

[263] Mr Craig Gross, Professional Officer, NSW Nurses and Midwives' Association, Transcript of evidence, 12 December 2024, p 44.

[264] Submission 84, p 17; Ms Davies, Evidence, 12 December 2024, p 51.

[265] Mr Coda Danu-Asmara, Industrial Officer, Australian Paramedics Association NSW (APA), Transcript of evidence, 12 December 2024, p 46.

[266] Submission 92, p 7; *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, pp 26-27.

[267] Submission 92, p 8; NSW Health, 2024/25 Rural Doctors Settlement Package Rates, viewed 15 April 2025.

3.24 In our first report, we also acknowledged the pay increase for paramedics in NSW and removal of the public sector wages cap in the 2023-24 Budget.[268]

3.25 However, these positive developments are offset by the long-running pay disputes between NSW Health and key employees. For example, in evidence given in November 2023, the NSW Nurses and Midwives' Association (NMA) told us that NSW staff are being lost to other states due to uncompetitive pay.[269] At the time of writing, the NMA's campaign for a 15 per cent pay rise for nurses and midwives is still ongoing.[270]

3.26 In our second report, we highlighted the mass resignation of senior psychiatrists across the NSW public health system.[271] As of February 2025, one-third of the resigned staff specialists had been rehired as VMOs on higher pay.[272] The Industrial Relations Commission's arbitration hearing between Australian Salaried Medical Officers' Federation NSW (ASMOF) and NSW Health on this issue began in March 2025.[273]

3.27 The Committee also notes an additional doctors' pay dispute between ASMOF and NSW Health, which has recently led to wider industrial action and potential impacts on the provision of care in NSW public hospitals.[274] This is further indication that not enough progress is being made to improve working conditions and remuneration for doctors in NSW.

3.28 The doctors' strike calls for pay that is competitive with other states, as well as appropriate remuneration for overtime and on-call work. The union is also calling for a commitment from NSW Health to avoid unsafe or excessive hours, provide safe and healthy workplaces, and improving workplace culture.[275] During our hearings in 2024, we heard that these issues lead to 'attrition of the doctor-in-training workforce' and an 'exodus to other states'.[276]

3.29 These challenges are not limited to RRR NSW, and they involve significant budgetary considerations. The Committee acknowledges the Minister for Health and Regional Health's concerns that industrial action has the potential to create patient safety concerns.[277] However, we firmly believe that these remuneration

---

[268] *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, pp 27-28.

[269] Inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to workforce, workplace culture and funding for remote, rural regional health, Mr Michael Whaites, Assistant General Secretary, New South Wales Nurses and Midwives' Association, Transcript of evidence, 27 November 2023, p 5.

[270] New South Wales, Legislative Assembly, *Parliamentary Debates*, 20 March 2025.

[271] *The implementation of recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW*, pp 57-58.

[272] ABC News, *One-third of New South Wales' resigning psychiatrists rehired as visiting medical officers*, viewed 25 February 2025.

[273] The Royal Australian and New Zealand College of Psychiatrists, *Statement on NSW Health-ASMOF IRC Arbitration*, 17 March 2025, viewed 15 April 2025.

[274] ASMOF NSW, *Doctors launch new campaign as industrial action begins across NSW*, 8 April 2025, viewed 15 April 2025.

[275] *Doctors launch new campaign as industrial action begins across NSW*, 8 April 2025, viewed 15 April 2025.

[276] Dr Chris Selvaraj, Federal DiT Delegate, NSW Branch Councillor, ASMOF NSW and SET5 (Accredited) General Surgical Trainee, Murrumbidgee Local Health District, Transcript of evidence, 12 December 2024, p 45.

[277] NSW Government, *Doctors' strike*, media release, 7 April 2025, viewed 15 April 2025.

issues will not go away until the NSW Government improves pay for those key health workers, whose legitimate concerns have not been addressed through tangible changes to remuneration and working conditions. Without any meaningful workplace culture improvements, NSW Health will continue to risk losing staff to other states or to the private health sector. We discuss workplace culture later in this chapter.

The Rural Health Workforce Incentive Scheme should be permanently retained

Recommendation 11

That NSW Health retain the Rural Health Workforce Incentive Scheme as a permanent mechanism for growing the regional health workforce.

3.30 The Rural Health Workforce Incentive Scheme (the Incentive Scheme) has been a central component of NSW Health's response to the wholescale shortages across the health workforce in remote, rural and regional NSW. The Incentive Scheme was implemented in 2022, and provides incentives such as an allowance, additional personal leave, funding for professional development or relocation bonuses. Health workers can receive up to $20 000, in order to 'attract, recruit, and retain health workers in positions with hard-to-fill and critical vacancies' across RRR NSW.[278]

3.31 NSW Health submitted that, as of October 2024, there were 3146 health workers who were receiving a recruitment incentive package under the Incentive Scheme, and 11 429 who were receiving a retention package.[279] In data submitted to the Special Commission of Inquiry into Healthcare Funding, NSW Health reported that approximately $20 million has been spent on recruitment incentives and approximately $55 million on retention incentives, as of July 2024.[280]

3.32 The Committee has examined the Incentive Scheme in each of its three inquiries, and views it as a positive intervention within the remote, rural and regional health workforce. We commend the NSW Government for its willingness to invest in measures that will attract new workers and keep existing workers in the RRR health system.

3.33 However, as part of making the Incentive Scheme a permanent recruitment and retention mechanism, the Committee urges NSW Health to be more flexible with its scope and application. We are of the view that NSW Health should consider refining the scheme to better reflect the organisational reality of working in RRR health, where public facilities and services work in tandem with non-government health providers, community organisations, private facilities and the tertiary education sector. Access to incentives for non-governmental organisations, including Aboriginal Community Controlled Health Organisations (ACCHOs), is discussed later in this chapter.

---

[278] Submission 106, p 10.

[279] Submission 106, p 10.

[280] NSW Ministry of Health, *Workforce data report*, prepared for Special Commission of Inquiry into Healthcare Funding, Exhibit H – Tab H.005.024, MOH.0010.0377.0037, 17 July 2024.

3.34 Additionally, Manna Institute described how worker incentive schemes, 'as well as schemes to attract students to universities, or support internships or clinical placements', do not have consistent funding across the health workforce.[281] There may be room for the Incentive Scheme to incorporate people undertaking training in social work, mental health nursing and other allied health professions.

3.35 Charles Sturt University also raised the issue of students on aged care work placements who are essentially performing unpaid work. Notwithstanding the joint responsibilities of the NSW and Australian governments in supporting aged care provision, the NSW Nurses and Midwives' Association's argument that aspects of workplace learning should be 'regarded as work, with appropriate remuneration' is worth exploring further.[282] As the Committee observed in its first report, the study-to-work pipeline in RRR areas is a critical element of addressing workforce shortages.[283] An incentive scheme focused solely on existing NSW Health employees risks creating a siloed approach to achieving long-term sustainability of the RRR health workforce.

3.36 The Committee also acknowledges that the Australian Government could play an important role in managing the current mix of state-based incentive schemes. In light of Victoria's $40 000 incentives for junior doctors entering GP training, the Australian Medical Association NSW called for the Australian Government to introduce a 'nationally consistent incentive payment' that reduces disparities across jurisdictions.[284]

3.37 Advocacy from the NSW Government could be valuable in ensuring that the Australian Government is able to support NSW Health's efforts in addressing doctor shortages in RRR NSW. As noted above, reliance on the Australian Government for action on some elements of workforce strategy should not be an excuse for a lack of progress or innovation on NSW Health's part.

Recommendation 12

That NSW Health publish quarterly data from each Local Health District that indicates how many staff were recruited, how many were retained, and how many resigned or transferred to a different public health service or facility. This data should also include information on staff specialties and roles, their level of employment, and which facility they work in.

3.38 While the Committee is supportive of the Incentive Scheme, we believe that NSW Health needs to be more transparent in communicating the impacts of this program. Specifically, more data should be publicly available to indicate where improvements in staffing volumes are being made in RRR NSW. We recommend that NSW Health publish quarterly data on staff recruitment and retention, particularly where the Incentive Scheme has been used.

---

[281] Answers to questions on notice, Manna Institute, 20 December 2024, p 1.

[282] Submission 93, p 8.

[283] *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, pp 33-37.

[284] Submission 44, p 2.

3.39 In particular, data should be published that indicates how many staff were recruited and retained, and how many resigned or transferred to a different public health facility, for each Local Health District (LHD) in NSW. This should include both rural, regional and metropolitan LHDs, in order to illustrate movements between public health facilities across the state. This will help to clarify whether gains in one regional LHD amount to losses in another.

3.40 This data should also show staff roles, specialties and their level of employment (such as degree of seniority or trainee status), as well as which facilities staff are being recruited to or retained in. The Committee notes that LHDs often encompass vast geographical areas, and it is plausible that recruitment and retention efforts are more successful in larger regional centres (such as in the coastal areas of the Hunter New England or Mid North Coast LHDs) than they are in Multi-Purpose Services and other small facilities in rural and remote communities.

3.41 Dr Rachel Christmas, NSW President, Rural Doctors Association of NSW and GP VMO Obstetrician, Temora NSW, told the Committee that it would be helpful for stakeholders to know more about how and where health workers are being recruited and retained.

> … overall, we are hearing that there are record numbers recruited to rural health, and this is good. I would like to know what that breakdown is in terms of rural, remote and regional—because I think there is a tendency to put that all in the one basket—and to know how the incentives are actually bringing new people into rural medicine and rural health provision not just in medicine. How is that movement into that sector going? Where are they coming from? Are they actually coming from the private sector, rurally, into the public sector, or is it actually bringing new recruitment in from elsewhere? That breakdown would be interesting to see.[285]

3.42 Australian Salaried Medical Officers' Federation NSW (ASMOF) also stated that it is unclear whether progress is being made as a result of the Incentive Scheme. They submitted that NSW Health's data currently 'lacks critical details'. For example, information is not available on the qualifications of new and retained workers, which specialties they work in, or which areas of NSW they were recruited to or retained in.[286]

3.43 The Committee notes that workforce statistics are available in NSW Health's annual reporting. In the *NSW Health 2023-24 Annual Report*, data indicates a consistent (if modest) improvement across 'Medical', 'Nursing', 'Allied Health' and other broad staffing categories, in most regional and rural LHDs. However, this data is presented as 'full-time equivalent' (FTE) staff and does not include information on specialisation or practice level, for example.[287]

3.44 In answers to questions taken on notice, Dr Chris Selvaraj, Federal DiT Delegate, NSW Branch Councillor, ASMOF, raised the issue of Ministry of Health workforce data, in relation to locum expenditure (discussed further below). Dr Selvaraj

---

[285] Dr Rachel Christmas, NSW President, Rural Doctors Association of NSW and GP VMO Obstetrician, Temora NSW, Transcript of evidence, 12 December 2024, p 13.

[286] Submission 84, p 10.

[287] NSW Health, *2023-24 Annual Report*, pp 292-296.

argued that metrics such as FTE 'obfuscate and manipulate honest interpretation of medical workforce issues in NSW, rather than simple metrics such as headcount, vacancies/locum positions filled, or actual costs of locums in each LHD.'[288]

3.45 The Committee is of the view that the Incentive Scheme is generally having a positive impact in RRR NSW. However, more data on its implementation and impact should be published, particularly with a view to improving the clarity of information that health stakeholders and the wider public can access.

3.46 We believe that greater transparency and accountability, in the form of better publicly available data, will contribute towards restoring trust in NSW Health's management of the state's public health system.

Over-reliance on locum doctors has continued

Recommendation 13

That NSW Health urgently progresses its work to address the cost impacts of over-reliance on locum doctors, including by completing its scoping work on an internal locum agency and establishing a locum vendor management system within six months.

3.47 In our first report, the Committee was deeply concerned about the remote, rural and regional health system's over-reliance on locum doctors, and the associated costs and patient impacts. While we recommended that NSW Health prioritise long-term solutions to staff shortages, we also noted that greater regulation of the locum market may reduce the impacts of this over-reliance.[289]

3.48 During the current inquiry, the Committee heard further evidence on the impacts of using locums extensively. Stakeholders highlighted that the regional health system continues to be over-reliant on locum doctors, with many vacancies in regional hospitals being filled by these temporary staff.[290]

3.49 Based on data submitted to the Special Commission of Inquiry into Healthcare Funding, it is clear that the use of locums in rural and regional Local Health Districts (LHDs) has increased significantly in recent years. Overall, the use of medical locums (as a proportion of the medical workforce) increased from 7.21 per cent in 2019/20 to 9.26 per cent in 2023/24. In 2023/24, locum use was more pronounced in the following LHDs:

- Southern NSW LHD (67.56 per cent of the medical workforce)
- Far West LHD (41.49 per cent of the medical workforce)

[288] Answers to questions on notice, Dr Chris Selvaraj, Australian Salaried Medical Officers' Federation NSW, 24 January 2025, pp 1-2.

[289] *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, pp 23-26.

[290] Submission 34, p 7; Submission 84, pp 7-8; Dr Selvaraj, Evidence, 12 December 2024, p 49; Dr Drew, Evidence, 12 December, p 50; Professor Sally Hall Dykgraaf, Head Rural Clinical School, Australian National University, Transcript of evidence, 12 December 2024, p 54.

- Western NSW LHD (18.46 per cent of the medical workforce)
- Northern NSW LHD (17.76 per cent of the medical workforce).[291]

3.50 Stakeholders described the significant costs of using locums to such an extent.[292] Across the NSW public health system, the overall cost of medical locums has increased from approximately $142 million in 2020/21 to $270 million in 2023/24.[293]

3.51 While locums are an important supporting mechanism in the public health system, over-use of locums can lead to patients not having continuity or consistency of care.[294] For example, in specialties such as psychiatry, locum usage can be 'incredibly disruptive and does not provide the best care.'[295] Widespread use of locums also complicates supervision of doctors-in-training, where these temporary staff may not have the qualifications or motivation to oversee trainees.[296]

3.52 Additionally, locum use within a region can disrupt the availability of general practice care. For example, local practices may be unable to match the high rates of pay offered in local hospitals, which limits their ability to attract locum GPs. According to Royal Australian College of General Practitioners (RACGP) Rural, a locum can cost a general practice more than $2000 per day.[297]

3.53 Having locums that can work in both hospital and general practice can reduce the workload for GPs, improve community access to GPs and reduce emergency department presentations. However, the Rural Doctors Association of NSW told the Committee that there are not enough locums performing this dual role of hospital and general practice care.[298]

3.54 The disparities in pay between locums and full-time staff continue to create discontent and a sense of unfairness for local doctors in rural and regional facilities.[299] Members of RACGP Rural have reported that local GPs experience job dissatisfaction in RRR areas, in part because the additional shifts they take at hospitals to relieve workforce shortages are paid at a lesser rate compared to locum GPs.[300]

---

[291] NSW Ministry of Health, *Workforce data report*, prepared for Special Commission of Inquiry into Healthcare Funding, Exhibit H – Tab H.005.024, MOH.0010.0377.0025, 17 July 2024.

[292] Dr Selvaraj, Evidence, 12 December 2024, p 49; Ms Davis, Evidence, 12 December 2024, p 46.

[293] NSW Ministry of Health, *Workforce data report*, prepared for Special Commission of Inquiry into Healthcare Funding, Exhibit H – Tab H.005.024, MOH.0010.0377.0025, 17 July 2024.

[294] Submission 34, p 8; Submission 44, p 3; Submission 84, p 8; *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, pp 25-26.

[295] Dr Drew, Evidence, 12 December, p 50; Submission 84, p 8.

[296] Submission 44, p 3; Professor Dykgraaf, Evidence, 12 December 2024, p 54.

[297] Submission 91, p 4.

[298] Submission 92, p 3; Dr Christmas, Evidence, p 18.

[299] Dr Selvaraj, Evidence, 12 December 2024, p 49; Dr Lesley Barron, Member, ASMOF NSW and General Surgeon, Medical Director of Surgical Services, John Hunter Hospital, Transcript of evidence, 12 December 2024, p 50; *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, p 25.

[300] Submission 91, p 4.

3.55 The NSW Government response to our first report noted that, 'one of the drivers of locum use is a shortage of doctors nationally and internationally.'[301] The Committee does not dispute that this is a factor, and firmly believes that addressing other drivers of doctor shortages, such as uncompetitive pay, poor workplace culture and working conditions, will contribute to reducing the need for widespread locum utilisation.

3.56 However, we believe that expediting action on an internal locum agency and a locum vendor management system will at least reduce the cost burden imposed by locum use on the health budget. We heard that while consultation surrounding the NSW Health-administered locum pool has commenced, the locum pool 'has not been fully explored nor resolved.'[302]

3.57 We therefore recommend that NSW Health progresses its planned actions with the utmost of urgency. By November 2025, NSW Health should have an internal locum agency and a locum vendor management system in place. These measures to improve the reliability and reduce the cost of locum use should not come at the expense of longer-term solutions to workforce shortages.

Workplace culture, leadership and cultural safety remain persistent issues

Recommendation 14

That NSW Health urgently implement a comprehensive, face-to-face, mandatory leadership training program for managers in the remote, rural and regional health system. This program should prioritise non-clinical leadership skills and include performance development measures that align with NSW Health's Culture and Staff Experience Framework.

3.58 In our first report, we recommended that NSW Health urgently implement the NSW Health Culture Framework to address persistent workforce culture issues. This included 'a commitment to training managers in leadership skills, and the development of accountability measures to ensure that NSW Health's workplace culture reforms are delivering tangible benefits for staff'.[303]

3.59 The report also highlighted suggestions from Dr Charlotte Hall, Human Factors Consultant and Medical Educator, who proposed that Local Health District (LHD) executives and staff receive training in 'non-technical' skills to bring about changes in behaviour and, therefore, culture. This included training in leadership, communication, and emotional intelligence.[304]

3.60 The Committee acknowledges that the NSW Health Culture and Staff Experience Framework was finalised and published in September 2024. The Framework

[301] NSW Government, *Response to Inquiry into the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, February 2025, p 7.

[302] Submission 92, p 7.

[303] *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, p 42.

[304] *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, p 49.

identifies nine key areas that impact staff experience and drive culture. It is also supported by a resource hub of online tools and reference materials.[305]

3.61 However, we note that a key component of our recommendation was the commitment to training managers in leadership skills, which the government response has not addressed. Additionally, the Framework lacks accountability measures to ensure that workplace culture reforms are delivering tangible benefits.

3.62 During the current inquiry, we heard that significant culture issues remain within LHDs and there has been little observable progress in workplace culture over the last 12 months. Stakeholders cited cost-cutting, toxic culture, weak managerial accountability frameworks, and lack of support as key barriers to improving workplace culture.[306]

3.63 Stakeholders also queried the effectiveness of complaint-handling mechanisms, and reported minimal visibility of the Grievances and Concerns Portals that were launched in 2021 and 2023.[307]

3.64 The Committee notes that effective leadership skills are critical to improving culture. As the NSW Health Culture and Experience Framework states:

> …leaders have the most influence in shaping their team's culture through the behaviours they display, accept, reinforce and reward, and through what they avoid saying or overlook.[308]

3.65 However, we also note that these soft skills are not necessarily taught in clinical training, and health system managers that progress through the clinical ranks may not have had the opportunity to develop these skills.

3.66 On this basis, the Committee recommends that NSW Health urgently implement a mandatory, comprehensive leadership training program that includes:

- an emphasis on sophisticated soft skills, including emotional intelligence, empathy, communication, and interpersonal skills
- mentored development for staff
- performance development measures that align with NSW Health's Culture and Staff Experience Framework
- face-to-face delivery of training.

3.67 While the Committee acknowledges that online leadership programs are currently offered through the Health Education and Training Institute, we are of the view that a robust, face-to-face training program will better facilitate the

[305] NSW Government, *Response to Inquiry into the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, February 2025, p 15; NSW Health, Culture and Staff Experience Framework, September 2024, p 10.

[306] Submission 84, p 15; Submission 92, p 6; Submission 108, Name suppressed, p 3.

[307] Submission 84, p 15; Submission 108, Name suppressed, p ii.

[308] NSW Health, *Culture and Staff Experience Framework*, September 2024, p 11.

development of soft skills in leadership. We also believe that this leadership program should be mandatory for all people leaders within the remote, rural and regional health system to ensure a consistent approach to improving workplace culture.

Collaboration with non-governmental organisations

Finding 10

Non-governmental organisations continue to fill gaps in health service provision, despite not being sufficiently resourced or included in statewide approaches to recruitment and retention in remote, rural and regional NSW.

Recommendation 15

That the NSW Government prioritise incentives for recruitment and retention in non-governmental organisations (NGOs), either through targeted incentive mechanisms for NGOs, or by amending the *Health Services Act 1997* to include staff from NGOs that are working in partnership with NSW Health or providing services directly to communities in remote, rural and regional NSW.

3.68 Across all three of its inquiries, the Committee has heard about the critical role that non-governmental organisations (NGOs) play within the RRR health system, and the way in which they are increasingly relied upon to fill gaps in service provision.

3.69 For example, during our second inquiry on specific services and specialist care, we heard that not-for-profits like Royal Far West are helping to plug paediatric service gaps and meet increased demand, despite not being sufficiently funded to do so. We recommended that NSW Health work with key stakeholders, including non-government service providers, to explore options for addressing paediatric service gaps in rural areas through networked models of care, with a focus on developmental care.[309]

3.70 Additionally, our second inquiry found that not-for-profit cancer care organisations such as Cancer Council NSW and Can Assist are increasingly relied upon to cover the out-of-pocket costs associated with travel for regional cancer care. These organisations also play a critical role in subsidising and supplementing limited community transport services for cancer patients in RRR NSW. On this basis, we recommended that the NSW Government provide additional funding for community transport providers, through the Community Transport Program and NGO Grants Program, and work with relevant providers to address any funding gaps for community transport services across RRR NSW.[310]

3.71 However, the issue raised most consistently across all of our inquiries is that NGOs are unable to access incentives for staff recruitment and retention under the Rural Health Workforce Incentive Scheme. Our first report recognised the vital, complementary role that non-governmental organisations play in the RRR

[309] *The implementation of recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW*, pp 26-27.

[310] *The implementation of recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW*, pp 84-85.

health system, and recommended that the Incentive Scheme be broadened so that NGOs that service RRR communities directly, or in partnership with NSW Health, are able to access incentives under the scheme.[311]

3.72 This recommendation was not supported in the government response to our first report, which explained that 'modifying the Incentive Scheme to enable access by non-government organisations is outside the scope of the *Health Services Act 1997* (NSW)'. The response also noted that the 'intent and purpose' of the Incentive Scheme is to incentivise staff to work for NSW Health.[312]

3.73 However, the issue was raised again in our second inquiry. In advocating for the expansion of the Incentive Scheme to Aboriginal Community Controlled Health Organisation (ACCHO) staff, the Aboriginal Health and Medical Research Council submitted that:

> ACCHOs are essential primary health providers of the public health system. Without strong, secure primary health services, patients will present directly to hospitals. ACCHOs should be able to access state-level workforce incentive packages given their role in preventing hospitalisations and reducing presentations to NSW Health facilities. Not only is preventative health care essential, but it also ensures that hospitals are not overburdened to maintain reliable and responsive health systems.[313]

3.74 In our second report, we recommended that the NSW Government prioritise incentives to specifically support the growth of the Aboriginal community-controlled health sector, either through targeted incentive mechanisms for ACCHOs, or by amending the *Health Services Act 1997* to include ACCHO staff working in partnership with NSW Health or providing services directly to Aboriginal communities.[314]

3.75 The Royal Flying Doctor Service (RFDS) reiterated these concerns during the Committee's current inquiry, with respect to NGOs more broadly, and called for 'equal access to incentives for public and not-for-profit healthcare providers delivering emergency, essential and preventive healthcare services in rural and remote locations'.[315]

3.76 The Committee remains of the view that NGOs (including ACCHOs) delivering services in partnership with NSW Health should be included in state-level approaches to recruitment and retention. In addition to our previous recommendation regarding ACCHOs, we recommend that the NSW Government prioritise incentives for NGOs more broadly, either through targeted incentive mechanisms, or by amending the *Health Services Act 1997* to include staff that

---

[311] *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, August 2024, pp 4-6.

[312] NSW Government, *Response to Inquiry into the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, February 2025, p 4.

[313] Inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW, Submission 66, Aboriginal Health and Medical Research Council, p 6.

[314] *The implementation of recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW*, p 70.

[315] Submission 103, p 7.

are working in partnership with NSW Health or providing services directly to communities. This change would also recognise the significant role that NGOs play in the remote, rural and regional health system.

Collaboration with the Aboriginal community controlled health sector remains a challenge

Finding 11

Genuine collaboration between Local Health Districts and Aboriginal Community Controlled Health Organisations is still not occurring across remote, rural and regional NSW, which is impacting the provision of culturally safe care for Aboriginal communities.

3.77 Across the Committee's inquiries, we have consistently heard that Local Health Districts (LHDs) are not working in genuine partnership with Aboriginal Community Controlled Health Organisations (ACCHOs).

3.78 In our second report, which focused specifically on the delivery Aboriginal health services, we discussed the importance of genuine partnership and co-design between regional LHDs and the Aboriginal community-controlled sector. We found that genuine and effective collaboration between LHDs and ACCHOs remains a challenge, even where partnership agreements have been formalised, as LHDs are often making unilateral decisions about Aboriginal health care.[316]

3.79 For example, during the site visits for that inquiry, LHD executives described positive relationships and meetings with local ACCHOs. However, ACCHO staff told us that these meetings were high level and, in reality, action and communication at the service level was limited.[317]

3.80 These concerns were reiterated during the current inquiry. For example, the North Coast PHN, Healthy North Coast, described a positive partnership with the six local ACCHOs on the North Coast, including Bulgarr Ngaru Medical Aboriginal Corporation. This partnership recognises that ACCHOs are 'the experts in Aboriginal health', and purports to deliver 'comprehensive and culturally responsive health care' across the region.[318]

3.81 However, Bulgarr Ngaru submitted that 'this partnership [with the LHD and PHN] has so far led to little in the way of changes to the way NSW Health services are planned or delivered'.[319]

3.82 Bulgarr Ngaru also told us that Northern NSW LHD does not engage well with ACCHOs in the planning and delivery of Aboriginal health services:

---

[316] *The implementation of recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW*, pp 72-73.

[317] *The implementation of recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW*, p 74.

[318] Submission 94, Healthy North Coast (North Coast Primary Health Network), p 11.

[319] Submission 3, Bulgarr Ngaru Medical Aboriginal Corporation, p 4.

> The LHD is part of a partnership forum, but this activity has not translated into any transparency on the part of the LHD nor any partnership-like activity in their service planning or delivery.[320]

3.83 Without effective partnerships between LHDs and ACCHOs, continuity of care – and the delivery of culturally safe care – can be impacted for Aboriginal communities. We urge NSW Health to implement the various recommendations made in our second report to strengthen governance and partnerships in delivering Aboriginal health services. These include prioritising incentives for the Aboriginal community-controlled health sector, engaging with ACCHOs and PHNs using genuine principles of co-design, and embedding Aboriginal community representation within LHD boards.[321]

Mechanisms for continued oversight

Finding 12

The intent of many Portfolio Committee No.2 recommendations has not been fulfilled, despite NSW Health reporting that the implementation of these recommendations has been completed.

Recommendation 16

That the Minister for Regional Health report to NSW Parliament every six months on the progress of recommendations made by the Select Committee on Remote, Rural and Regional Health to ensure continued accountability and oversight of health access and outcomes in remote, rural and regional NSW.

3.84 During this inquiry, a number of stakeholders queried the extent of progress reported against PC2 recommendations, and identified a lack of oversight regarding ongoing implementation of these recommendations.[322]

3.85 In its Progress Report, NSW Health reported that it had completed 25 of the 44 PC2 recommendations, with the remaining 19 recommendations 'in progress' as at 30 June 2024.[323]

3.86 However, the Committee undertook its own review of the actions reported against these 'completed' recommendations and is concerned that the intent of many PC2 recommendations remains unfulfilled. Of the 25 'completed' recommendations, we consider there to be sufficient evidence of progress against only six recommendations. A summary table outlining the Committee's views of the completed PC2 recommendations is included at Table 1 at the end of this chapter.

---

[320] Submission 3, p 4.

[321] *The implementation of recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW*, pp 70-75.

[322] Submission 18, Culcairn Local Health Advisory Committee, p 3; Mr Matthew Clancy, Chair, Culcairn Local Health Advisory Committee, Transcript of evidence, 12 December 2024, p 31; Submission 107, Australian College of Rural and Remote Medicine, p 1.

[323] NSW Health, *Progress Report: Parliamentary inquiry into health outcomes and access to health and hospital services in Rural, Regional and Remote New South Wales*, September 2024, pp 4-6.

3.87 The Committee is particularly concerned about the progress reported against four PC2 recommendations. These include:

- Recommendation 7 - there is no evidence of clear governance arrangements or a strategic plan to specifically improve doctor workforce issues, as noted in Chapter One of this report
- Recommendation 24 – the Committee is concerned about the extent of progress that can be made in implementing innovative and effective palliative care models across RRR NSW, in the absence of a palliative care taskforce (as per Recommendation 23)
- Recommendation 26 - widespread implementation of Midwifery Continuity of Care models has not been achieved in NSW, as noted in our second report[324]
- Recommendation 27 - there is limited evidence of plans to re-open maternity services that have closed across RRR NSW, as noted in our second report.[325]

3.88 In addition, we believe that NSW Health is not approaching some of the recommendations with an appropriate sense of urgency. For example, the recommendation to expedite the review of the nursing and midwifery workforce is not on track for completion until 2027.[326] As Charles Sturt University identified, without a clear forward plan, it will be difficult for the NSW Government to determine the appropriate staffing and funding levels for services, including for education and training.[327]

3.89 To ensure that reform is achieved, the Australian College of Rural and Remote Medicine called for the establishment of an assurance and oversight process, including the introduction of a regular 'report card' or similar mechanism. They suggested that this should outline whether and how well the recommendations are being implemented, along with measurable outcomes.[328]

3.90 The Committee shares this view, and believes that continued oversight is needed to ensure continued accountability and oversight of health access and outcomes in RRR NSW. We recommend that the Minister for Regional Health report to NSW Parliament every six months on the progress of recommendations made by this Committee. We also recommend additional oversight mechanisms, as discussed below.

[324] *The implementation of recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW*, pp 18-19.

[325] *The implementation of recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW*, pp 4, 9.

[326] *Progress Report*, September 2024, p 6.

[327] Submission 93, p 4.

[328] Submission 107, p 1.

Targeted performance audits may provide another mechanism for accountability

Recommendation 17

That the Minister for Health request that the Auditor-General undertake performance audits, and that the NSW Government provide additional funding to the Audit Office of NSW for the purposes of undertaking these performance audits, in relation to:

- **remote, rural and regional maternity services**
- **workplace culture and leadership training within NSW Health**
- **remote, rural and regional health workforce planning**
- **the Rural Health Workforce Incentive Scheme.**

The Auditor-General reports to the Parliament of NSW and is responsible for financial and performance audits that help Parliament hold government accountable for its use of public resources.

Audits are conducted under the *Government Sector Audit Act 1983* and the *Local Government Act 1993*, but the Treasurer, a minister or both Houses of Parliament can also request the Auditor-General to perform an audit.[329]

3.91 The Committee notes that the Audit Office of NSW provides another potential mechanism for accountability, in relation to NSW Health's remote, rural and regional health program, beyond this inquiry.

3.92 The Audit Office conducts performance audits to assess whether the activities of government entities are being carried out effectively, economically, efficiently and in compliance with relevant laws. The activities examined by a performance audit may include a government program, project or service.[330]

3.93 Where NSW Government agencies are audited, the results of each performance audit are reported to the head of the agency, the responsible minister, the Treasurer, and NSW Parliament. Audited agencies then have the opportunity to provide a formal response to the audit, which is included in the Auditor-General's report to Parliament.[331]

3.94 The Committee notes that the Audit Office's Annual Work Program 2024-27 already includes a number of planned health audits that may be relevant to the scope of our inquiries. These include audits focusing on oversight of Visiting Medical Officers (2025-27), health workforce planning (2025-27) and palliative care (2025-27).[332]

[329] Audit Office of NSW, Annual work program 2024-27 - Our role, viewed 24 April 2025.

[330] Audit Office of NSW, Annual work program 2024-27 - Our role, viewed 24 April 2025.

[331] Audit Office of NSW, Annual work program 2024-27 - Our role, viewed 24 April 2025.

[332] Audit Office of NSW, Annual work program 2024-27 - Three-year performance audit program 2024-2027, viewed 24 April 2025.

3.95 We consider that there is scope for future performance audit work to focus explicitly on health programs that impact on remote, rural and regional NSW. We are also of the view that separate audits may be necessary to ensure further accountability for the focus areas that we have highlighted in this report.

3.96 We recommend that the Minister for Health request that the Auditor-General undertake performance audits in relation to persistent issues in remote, rural and regional health, as provided for under section 27B of the *Government Sector Audit Act 1983*. These include RRR maternity services, workplace culture and leadership training, RRR health workforce planning, and the ongoing implementation of the Rural Health Workforce Incentive Scheme.

3.97 Noting the resourcing implications of conducting additional audits, we also recommend that the NSW Government provide additional funding to the Audit Office of NSW for the purposes of undertaking these performance audits. However, the Committee acknowledges that the Auditor-General is an independent officer of Parliament, and is of the view that the Audit Office should have discretion as to its work program and the audits it chooses to prioritise.

An independent statutory office of the NSW Remote, Rural and Regional Health Commissioner should be established

Recommendation 18

That, further to Recommendation 10 of this report, the NSW Government introduce legislation to create the independent statutory office of the NSW Remote, Rural and Regional Health Commissioner. The Commissioner's functions should focus on overseeing NSW Health's implementation of reforms for the improvement of remote, rural and regional health care, and should include (but not be limited to) advocating for communities and reporting to Parliament on remote, rural and regional health policy. The Commissioner should have statutory powers to:

- **evaluate and report to Parliament on any remote, rural and regional health programs and policies enacted by the NSW Government**
- **support the implementation of proposed enhancements to governance operations, both within NSW Health and in relation to other entities, to facilitate remote, rural and regional health reform**
- **support the implementation of NSW Government policies, programs and strategies for remote, rural and regional health care and service provision**
- **obligate the NSW Government to respond to any recommendations made by the Commissioner.**

3.98 As discussed in Chapter Two of this report, the Committee considers that remote, rural and regional (RRR) health needs have not been sufficiently prioritised within government-decision making. To address this, we recommended that a NSW Remote, Rural and Regional Health Commissioner role be established to ensure that these needs are appropriately considered and prioritised.

3.99 In addition to providing advocacy and advice, as per Recommendation 10, we are of the view that a state-based Remote, Rural and Regional Health Commissioner should be empowered to hold NSW Health accountable in implementing recommendations to improve RRR health. This may entail a greater degree of independence, with the proposed Commissioner reporting directly to Parliament rather than to the Minister for Health and Regional Health.

3.100 The Committee also notes that, due to NSW Health's devolved governance structure, it is often unclear whether the Ministry of Health or Local Health Districts are responsible for implementing recommendations. We are of the view that a Remote, Rural and Regional Health Commissioner should be empowered to support the implementation of any proposed enhancements to governance arrangements within NSW Health to ensure greater clarity and accountability, and to facilitate reform.

3.101 NSW has a world-class public health system that strives to meet community needs through a commitment to excellence in care, treatment and research. However, as we conclude this report, we must emphasise how many inquiries have been (or are being) conducted in relation to the NSW public health system in recent years. These include:

- the PC2 rural health inquiry, and its recent inquiries into birth trauma and community mental health[333]
- three inquires of this Select Committee[334]
- four state and federal parliamentary inquiries and six non-parliamentary inquiries into mental health since 2017[335]
- the Special Commission of Inquiry into Healthcare Funding.[336]

3.102 This high volume of inquiries reflects the deeply entrenched issues that affect the provision of health care in NSW. As this Committee has observed on numerous occasions, issues affecting the wider health system are also far more pronounced in RRR NSW. Unless ambitious and sustained action is taken to fulfill the intent of the recommendations made in these inquiries, the health of remote, rural and regional communities in NSW will continue to decline.

3.103 We recommend that the NSW Government introduce legislation to create an independent statutory office of the NSW Remote, Rural and Regional Health Commissioner. The Commissioner's functions should focus on overseeing NSW

---

[333] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022; Select Committee on Birth Trauma, *Birth Trauma*, report no. 1, Parliament of NSW, May 2024; Portfolio Committee No. 2, *Equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW*, report 64, Parliament of NSW, June 2024.

[334] Select Committee on Remote, Rural and Regional Health, *The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, report 1/58, Parliament of New South Wales, August 2024; Select Committee on Remote, Rural and Regional Health, *The implementation of recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW*, report 2/58, Parliament of New South Wales, March 2025.

[335] NSW Health, Request for additional information, TAB B and C, pp 8-22.

[336] NSW Government, The Special Commission of Inquiry into Healthcare Funding, viewed 24 April 2025.

Health's implementation of reforms for the improvement of remote, rural and regional health care, and should include (but not be limited to) advocating for regional communities and reporting to Parliament on remote, rural and regional health policy. We hope that the establishment of this statutory position helps to maintain accountability beyond this inquiry and facilitate much needed health reform for remote, rural and regional communities in NSW.

3.104 A summary of key priorities and next steps that the Committee urges the NSW Government to take is included below.

Key priorities and next steps

Changes to governance

- Establishment of a NSW Remote, Rural and Regional Health Commissioner, as per Recommendations 10 and 18 of this report.
- Funding and implementation of the health precinct model, as per Recommendation 6 of this report.
- Prioritisation of incentives to support the growth of the Aboriginal community-controlled sector, and genuine partnerships with Aboriginal Community Controlled Health Organisations, as per Recommendations 20 and 21 of the Committee's second report.
- Shared governance arrangements between Local Health Districts and Primary Health Networks in service agreements, to support effective collaboration, information sharing and joint planning at the local level, as per Recommendation 4 of this report.

Specific focus areas

- Development of a statewide, publicly accessible rural obstetric plan for maintaining and re-establishing hospital birthing services, as per Recommendation 1 of the Committee's second report.
- Implementation of a mandatory, face-to-face leadership training program to address persistent workplace culture issues within NSW Health, as per Recommendation 14 of this report.
- Funding to pilot innovative and multidisciplinary models of primary care service delivery, as per Recommendation 5 of this report.

Monitoring mechanisms

- Request for performance audits and additional funding for the Audit Office of NSW to undertake these audits, as per Recommendation 17 of this report, with a focus on:
    - remote, rural and regional maternity services
    - workplace culture and leadership training within NSW Health
    - remote, rural and regional health workforce planning
    - the Rural Health Workforce Incentive Scheme.
- Reporting to NSW Parliament every six months on the progress of recommendations, as per Recommendation 16 of this report.

Table 1: Committee views of completed Portfolio Committee No. 2 recommendations

	Recommendation	Committee view	Committee comments
1	That NSW Health review the current funding models for all rural and regional Local Health Districts in order to identify any service delivery gaps and provide any recommendations for funding increases.	Area of moderate concern	Although the review of the Small Hospitals Funding Model has been completed and published, the recommendations from this review still need to be implemented, as discussed in this report. The Committee also notes that the NSW Government is still working with the Australian Government to develop a new addendum to the National Health Reform Agreement, and the Special Commission of Inquiry into healthcare funding is ongoing.
2	That the NSW Government review the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) as a matter of priority, with a view to: • increasing the current reimbursement rates for accommodation and per kilometre travel • expanding the eligibility criteria, with consideration given to people participating in medical trials, those that hold private health insurance and those that are referred to treatment centres that are not geographically closest to them due to the urgency of the treatment required • streamlining the application process to make it easier for patients to access the scheme • undertaking on an ongoing basis a public awareness program of the scheme across the state in communities and among health professionals who can then inform patients.	Sufficient evidence of progress	Significant improvements have been made to the Isolated Patients Travel and Accommodation Assistance Scheme to increase subsidies and make financial assistance available for a broader number of services, as noted in the Committee's second report.
3	That NSW Health, the rural and regional Local Health Districts and Transport for NSW work collaboratively to ensure, where feasible, more frequent and appropriately timed affordable transport services are available to support people to attend medical appointments in rural, regional and remote areas.	Area of moderate concern	A number of actions are ongoing or not yet completed, and we are concerned that the intent of the recommendation remains unfulfilled, as noted in the Committee's second report.

	Recommendation	Committee view	Committee comments
4	That NSW Health review the funding available for air transport.	Area of moderate concern	NSW Health is yet to publish its review of air transport funding and the outcomes of this review are unclear, as noted in the Committee's second report.
5	That NSW Health and the rural and regional Local Health Districts actively engage with local community groups and charities to understand the services and resources they provide, and to ensure that where possible and appropriate, service gaps are filled by government.	Sufficient evidence of progress	NSW Health conducted a review of the role of charities and community groups in supporting health in 3 regions, and a position paper was published in June 2024, outlining the findings and recommendations of this work. Some inquiry participants also reported improved engagement, as noted in this report.
6	That on the two-year anniversary of the tabling of this report, Portfolio Committee No. 2 – Health undertake an inquiry and report on the progress and developments that have been made to address the matters raised by this inquiry.	N/A	N/A
7	That the NSW Government urgently engage with the Australian Government at a ministerial level to: • establish clear governance arrangements and a strategic plan to deliver on the health reforms recommended in this report to improve doctor workforce issues • progress those initiatives that both levels of government have identified as meritorious, but where progress has been slow or non-existent.	Area of significant concern	There is no evidence of clear governance arrangements or a strategic plan to specifically improve doctor workforce issues, as noted in this report.
8	That the NSW Government investigate ways to support the growth and development of the primary health sector in rural, regional and remote areas, and support the sector's critical role in addressing the social determinants of health and reducing avoidable hospitalisations for the citizens of New South Wales.	Area of moderate concern	NSW Health report that LHDs have supported their Primary Health Networks to develop regional place-based needs assessments. However, it is unclear if there is a focus on addressing the social determinants of health outcomes and reducing avoidable hospitalisations. Stakeholders also continue to report a lack of support from NSW Health in the primary care space, as noted in this report.

	Recommendation	Committee view	Committee comments
9	That NSW Health work with the Australian Government and the Primary Health Networks to expedite the implementation of a single employer model for GP trainees across rural, regional and remote New South Wales.	Sufficient evidence of progress	The Rural Generalist Single Employer Pathway has been established, with 21 rural generalist trainees commencing in 2024. The pathway is being expanded over a 4-year trial period (2024-2027), with 80 positions available per year, and eight regional LHDs participating, as noted in this report.
18	That in addition to peer group B hospitals, NSW Health employ a geriatric nurse in all peer group C hospitals. Where a geriatric nurse is not employed, NSW Health develop and provide staff members with annual training in geriatric care to ensure an ageing population is given the best health care when visiting a health care facility.	Area of moderate concern	As noted in the Committee's second report, it is unclear whether any progress has been made regarding the employment of geriatric nurses in all peer group C hospitals.
20	That NSW Health, as part of its review of the nursing and midwifery workforce: • develop stronger partnerships with the university sector to more proactively engage local people and support them through rurally and regionally based education, training and professional development to become qualified nurses and midwives • develop partnerships between rural, regional and metropolitan Local Health Districts to devise programs for nurses and midwives who are either early career, specialised or are experienced to practice in rural and remote locations • implement professional, financial and career enhancement incentives for nurses and midwives who work in rural and remote locations.	Area of moderate concern	As noted in the Committee's first report, there are still numerous, substantial shortfalls in a number of key health professions across remote, rural and regional NSW, including midwives, despite the range of scholarships and financial assistance packages that are offered to nursing and midwifery students in RRR areas. It is also unclear whether NSW Health has developed 'stronger partnerships with the university sector...'. The Committee noted in its second report that students in RRR communities may have difficulty accessing Bachelor of Midwifery programs close to their homes, with limited opportunities for distance education.
21	That NSW Health working with the Commonwealth and all relevant service providers investigate strategies to ensure public patients being treated in regional cancer centres can access private-public services while reducing out-of-pocket costs.	Sufficient evidence of progress	Significant progress has been made in reducing out-of-pocket costs for public-private cancer services in some regional areas, as noted in the Committee's second report.

	Recommendation	Committee view	Committee comments
24	That NSW Health and the rural and regional Local Health Districts expand the Far West NSW Palliative and End-of-Life Model of Care to other rural and remote settings across New South Wales.	Area of significant concern	As noted in the Committee's second report, NSW Health report that many LHDs have implemented alternative, locally adapted models, including in Northern, Western and Southern NSW LHDs, but there are mixed views on how accessible these models are. The Committee is also concerned about the extent of progress that can be made on this recommendation, in the absence of a palliative care taskforce (Recommendation 23).
25	That Portfolio Committee No. 2 – Health consider undertaking an inquiry into mental health, including into mental health services in rural, regional and remote New South Wales in the future.	N/A	
26	That the NSW Government implement the midwifery continuity of care model throughout rural, regional and remote New South Wales.	Area of significant concern	As noted in our second report, stakeholders did not agree that this recommendation had been implemented in practice, as widespread implementation of MCoC models has not been achieved in NSW. The implementation of MCoC models should be prioritised, as recommended.
27	That the rural and regional Local Health Districts, and those metropolitan Local Health Districts that take in regional areas of the state, review their maternity services in order to develop plans for midwifery, GP Obstetrics, specialist Obstetrics and newborn services.	Area of significant concern	As noted in our second report, we are deeply concerned that there is limited evidence of plans to re-open services that have closed across remote, rural and regional NSW. We recommended a statewide plan to address the intent of this recommendation.
32	That NSW Health and the Local Health Districts improve the cultural safety of health services and facilities by engaging with Aboriginal Elders and local communities to: • revise and incorporate local content into cultural awareness training such as Respecting the Difference: Aboriginal Cultural Training • listen to their experiences of the healthcare system and seek guidance around what cultural safety strategies should be applied in their areas	Area of moderate concern	As noted in our second report, it is unclear to what extent NSW Health's cultural awareness training has been informed by local communities and their experiences of the healthcare system. The Committee notes that seeking guidance around what cultural safety strategies should be applied was a key aspect of this recommendation.

	Recommendation	Committee view	Committee comments
	• include prominent Acknowledgements of Country in all NSW Health facilities as a starting point.		
36	That the NSW Government maintain a Regional Health Minister in cabinet and provide that Minister with appropriate authority to address issues raised in the inquiry and future issues that affect the rural, regional and remote health system and its communities.	Area of moderate concern	The Minister for Regional Health position has been retained since it was first appointed in 2021. It is currently held by the Hon. Ryan Park MP, who is also the Minister for Health. The Committee is of the view that the intention of this recommendation would be further supported through the creation of a Rural Health Commissioner position, as recommended in this report.
37	That NSW Health complete and publish the final evaluation of the NSW Rural Health Plan: Towards 2021 before finalising the next rural health plan for New South Wales.	Sufficient evidence of progress	As noted in this report, an evaluation of the Rural Health Plan was published in May 2022. It informed the NSW Regional Health Strategic Plan 2022-2032, which was published in February 2023.
38	That the NSW Government ensure that the development of the next Rural Health Plan: • acknowledges that rural and remote health systems are fundamentally different to urban and regional city health systems • includes genuine consultation with rural and remote communities • contains realistic, measurable and quantifiable goals in terms of tangible health outcomes • provides the funding and support required to deliver against those goals.	Sufficient evidence of progress	As noted in this report, the NSW Regional Health Strategic Plan 2022-2032 was designed with significant community and stakeholder consultation and will be evaluated every three, five and 10 years.
39	That NSW Health and the rural and regional Local Health Districts upgrade and enhance their collaborative work with the Primary Health Networks to: • ensure that high quality health services for rural, regional and remote New South Wales are cooperatively planned and successfully delivered	Area of moderate concern	As discussed in this report, actions appear to be in progress, rather than completed. For example the Joint Statement between NSW Health, PHNs and the Australian Government is being implemented over the next two years.

	Recommendation	Committee view	Committee comments
	• drive innovative models of service delivery, including those recommended elsewhere in this report.		
41	That the NSW Government establish an independent office of the Health Administration Ombudsman to receive and review concerns about the administrative conduct of management of Local Health Districts and NSW Health from staff, doctors, patients, carers and the public. The Health Administration Ombudsman is to be empowered to review administrative decisions of NSW Health and Local Health District management, including but not limited to, alleged coverups of medical errors or deaths, false or misleading data, inaccurate communications and/or media reporting, Visiting Medical Officer accreditation decisions, staff blacklisting, and bullying or harassment of whistle-blowers. Additionally, the Health Administration Ombudsman is to provide an annual report to Parliament and the public.	Area of moderate concern	As the NSW Ombudsman noted in its submission to our second inquiry, and as noted in our second report, the Health Administration Ombudsman role is consistent with the existing statutory functions of the NSW Ombudsman. The NSW Ombudsman has since established the role of Deputy Ombudsman, Health Administration and a Health Administration branch to support the proposed role and functions.[1] However, it is unclear whether the new Health Administration branch is helping to address concerning workforce culture issues, which was the intention of this recommendation. It is also unknown if and how this branch will be publicly reporting on its work.
42	That the rural and regional Local Health Districts: • review, reinvigorate and promote the role of Local Health Advisory Committees to ensure genuine community consultation on local health and hospital service outcomes, and health service planning • investigate methods of better informing communities about the services that are available to them, and publish additional data such as wait times and minimum service standards for the facilities within their remit.	Area of moderate concern	Although parts of this recommendation are broadly complete or in progress, some RRR communities are unable to provide open feedback on health services through Local Health Advisory Committees, as noted in this report. The status of publishing minimum service standards for LHD facilities is also unknown.
43	That the rural and regional LHDs work with rural and remote communities to develop Place-Based Health Needs Assessments and	Area of moderate concern	NSW Health report that all regional PHNs have developed place-based needs assessments, but as noted in this report, the nature and/or

[1] NSW Ombudsman Annual Report 2023-2024, pp 24, 60.

	Recommendation	Committee view	Committee comments
	Local Health Plans in collaboration with the Department of Regional NSW, local government, education, human services, community services, community and First Nations organisations and local health providers that are responsive to the variations in determinants, lifestyle and disease burden for each community and its population.		extent to which these assessments have progressed appears to vary and we are concerned that these assessments may lack input from local stakeholders.
44	That the NSW Government adopt a Health in All Policies framework (similar to the policy in South Australia) to ensure that the health of people in New South Wales is central to government decision making, and which recognises that community physical and mental health is a responsibility of all Ministers and Departments of government. Further, such a framework should include a requirement that all decisions of government are assessed to determine the impact on human and environmental health to ensure a whole-of-government ownership of health outcomes for people living in New South Wales.	Area of moderate concern	As discussed in this report, NSW Health has reviewed the 'Health In All Policies' framework, but will embed the principles of this framework through existing statewide, regional and local mechanisms. rather than adopting the framework as it was initially implemented in South Australia. The review included recommendations aimed at embedding this approach, but it is unclear what these recommendations are.

Appendix One – Terms of reference

This inquiry was self-referred on 11 September 2024.

That the Select Committee on Remote, Rural and Regional Health inquire into and report on the progress of and issues relating to the implementation of Portfolio Committee No. 2 recommendations relating to health outcomes and access to health and hospital services, including:

1) Cross-jurisdictional cooperation between the New South Wales and Australian governments, in particular:

    a) Long-term strategic planning to improve health services and health outcomes in remote, rural and regional areas, including in relation to primary health (including Recommendations 1, 7, 8 and 11)

2) Collaboration between NSW Health and Australian Government bodies on particular initiatives, services or training programs (including Recommendations 9, 10, 14, 21, 22 and 39)

3) NSW Government consultation with health stakeholders and communities in remote, rural and regional New South Wales, in particular:

    a) Improving communication between communities and health services (including Recommendations 5, 42), and

    b) Developing place-based health plans (including Recommendation 43)

4) NSW Government action to prioritise the health of regional communities in government decision making (including Recommendations 36, 37 and 44).

5) Any updates or final observations relating to the progress of implementing any Portfolio Committee No. 2 recommendations that the Select Committee has considered in its previous inquiries.

Appendix Two – Conduct of inquiry

Establishment of the Committee

On 11 May 2023, the Legislative Assembly resolved, on the motion of the Hon. Ron Hoenig MP (Leader of the House and Minister for Local Government), to appoint a Legislative Assembly Select Committee on Remote, Rural and Regional Health. The House required the Committee to report on the implementation of recommendations made by the Legislative Council Portfolio Committee No. 2 in its 'Health outcomes and access to health and hospital services in rural, regional and remote New South Wales' report (the Portfolio Committee No. 2 report).

Adoption of the inquiry

On 11 September 2024, the Committee resolved to conduct an inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities.

Call for submissions

The Committee issued a media release on 19 September 2024 and wrote to key stakeholders inviting them to make a submission to the inquiry. The Committee also advertised the call for submissions on social media. On 1 November 2024, the Committee informed stakeholders that it had extended the submissions deadline on 15 November 2024.

A total of 112 submissions were received from local councils, community health care providers, peak bodies, professional colleges, NSW Health and members of the public. A list of submissions is at Appendix Three. Submissions are available on the Committee webpage.

Public hearings

The Committee held two public hearings at Parliament House on 12 and 13 December 2024. Representatives from Primary Health Networks, peak bodies and unions, academic institutions, local councils, and NSW Health appeared as witnesses in person and via videoconference.

A list of witnesses is at Appendix Four. Transcripts of evidence taken at the hearings are available on the Committee's webpage.

Appendix Three – Submissions

No.	Author
1	Confidential
2	Ms Lyndal Breen
3	Bulgarr Ngaru Medical Aboriginal Corporation
4	Mr Rod Pryor
5	Ms Voren O'Brien
6	Parkes Shire Council
7	Medical Error Action Group
8	Mr Steven Ross
9	Confidential
10	Ms Amanda Whiles
11	Confidential
12	Mr Matthew Baskerville
13	Can Assist Orange
14	Ms Penny Abbington-Blanch
15	Confidential
16	Confidential
17	Mrs Rosemarie Griffiths
18	Culcairn Local Health Advisory Committee (LHAC)
19	Community Transport Organisation Ltd
20	Confidential
21	Confidential
22	Mrs Kerry Warner
23	Mrs Amanda Large
24	Mrs Marian Imrie
25	Mrs Danielle Hollow
26	Confidential
27	Mr Ashley Cooper
28	Mr Paul Hartnett
29	Confidential
30	Mrs Debra Kerr
31	Chris O'Brien Lifehouse
32	Ms Megan Lincoln

No.	Author
33	Mr Gordon McDonnell
34	Narrabri Shire Council
35	Mr Stephen Taverner
36	Ms Kathryn Ryan
37	Ms Biruta Kass
38	Mrs Linda Bennett
39	Ms Samantha Cosgrove
40	Mrs Louise Bligh
41	Can Assist (Cancer Assistance Network)
42	Central NSW Joint Organisation
43	Murrumbidgee Primary Health Network
44	AMA New South Wales
45	Ms Sharelle Fellows
46	Ms Jess Ewin
47	Mrs Anne Boyd
48	Mrs Carmelina Leotta
49	Mr Peter Leotta
50	Confidential
51	Ms Jacinta Green
52	Confidential
53	Mr Alan Talbot
54	Confidential
55	Mr Graham Mercer
56	Ms Marea Lerade
57	Miss Joanne O'Loughlin
58	Ms Caitlin O'Sullivan
59	Mrs Sharon Morrow
60	Confidential
61	Mrs Toni Morrison
62	Mrs Justine MacLennan
63	Mr Peter Clarke
64	Lithgow City Council
65	Mr Steve Fitzgerald
66	Name suppressed
67	Mrs Kathryn Pearson

No.	Author
68	Confidential
69	Mr Matthew Azzopardi
70	Ms Wendy Borchert
71	Mr Christopher Pearson
72	Mrs Linda Edwards
73	Orange Push for Palliative
74	Australian College of Nurse Practitioners (ACNP)
75	The Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
76	Australian Paramedics Association (NSW)
77	Berrigan Shire Council
78	Royal Far West
79	Mid North Coast Local Health District (MNCLHD) Local Health Advisory Committee
80	Mrs Belinda O'Gorman
81	Confidential
82	National Rural Health Alliance
83	Mr Michael Sweeney
84	The Doctors Union (ASMOF NSW)
85	Confidential
86	Cr Melanie McDonell
87	Manna Institute
88	NSW Nurses and Midwives' Association
89	Ms Maxine Most
90	NSW Rural Doctors Network (RDN)
91	The Royal Australian College of General Practitioners (RACGP) Rural
92	Rural Doctors Association of NSW
93	Charles Sturt University
94	Healthy North Coast (North Coast Primary Health Network)
95	Local Government NSW
96	Inverell Health Forum
97	Dr Edward Christian
98	Confidential
99	Ms Marea Ruddy
100	Ms Karen Carter
101	Dr Nevin Kollannoor Chinnan

No.	Author
102	Pharmaceutical Society of Australia
103	Royal Flying Doctor Service (South Eastern Section)
104	Ms Sarah Elliott - Troy
105	Dr D Robinson
106	NSW Health
107	Australian College of Rural and Remote Medicine (ACRRM)
108	Name suppressed
109	A Allan
110	Exercise and Sports Science Australia (ESSA)
111	Dr Emma Rush, Dr Monica Short, Dr Nicola Ivory, Dr Ella Dixon, Michelle Bonner and Sarah Ansell (Charles Sturt University research team)
112	Little Wings

Appendix Four – Witnesses

12 December 2024
Parliament House, Macquarie Room, Sydney, NSW

Witness	Position and Organisation
Mr Damian Thomas	Directory Advocacy, Local Government NSW
Associate Professor Michael Curtin	Head of School, Allied Health, Exercise and Sports Science, Charles Sturt University, Faculty of Science and Health
Professor Megan Smith PhD GAICD	Executive Dean, Faculty of Science and Health, Charles Sturt University, Faculty of Science and Health
Ms Susanne (Susi) Tegen	Chief Executive Officer, National Rural Health Alliance
Ms Margaret Deerain	Director, Policy and Strategy Development, National Rural Health Alliance
Mr Richard Colbran	Chief Executive Officer, NSW Rural Doctors Network (RDN)
Mr Mike Edwards	Chief Operating Officer, NSW Rural Doctors Network (RDN)
Ms Annette Lenstra	Sector Advancement Manager, NSW Rural Doctors Network (RDN)
Mr Craig Gross	Professional Officer, New South Wales Nurses and Midwives' Association
Ms Frances Usherwood	Primary Care Sector Co-Ordinator, New South Wales Nurses and Midwives' Association
Mr Brad Porter	Chief Executive Officer, Western NSW Primary Health Network
Dr Ian Kamerman	Representative, The Royal Australian College of General Practitioners (RACGP) Rural
Ms Monika Wheeler	Chief Executive Officer, Healthy North Coast (North Coast Primary Health Network)
Dr Adrian Gilliland	GP & HNC Chair, Healthy North Coast (North Coast Primary Health Network)
Mr Josh Gaynor	Culcairn Local Health Advisory Committee (LHAC)
Mr Matthew Clancy	Culcairn Local Health Advisory Committee (LHAC)

Ms Sharelle Fellows	Community representative
Ms Fiona Davies	Chief Executive Officer, AMA New South Wales
Professor Sally Hall Dykgraaf	Head Rural Clinical School, Australian National University (ANU), Rural Clinical School
Associate Professor Sarah Wayland	Senior Researcher, Manna Institute
Adjunct Associate Professor Leanne Boase	Chief Executive Officer, Australian College of Nurse Practitioners (ACNP)
Mr Coda Danu-Asmara	Industrial Officer, Australian Paramedics Association (NSW)
Mr Tim McEwen	Delegate, Australian Paramedics Association (NSW)
Dr Chris Selvaraj	SET5 (Accredited) General Surgical Trainee, NSW, Murrumbidgee Local Health District, ASMOF NSW State Councillor, Australian Salaried Medical Officers' Federation NSW
Dr Kathryn Drew	Director of Medical Services, Mental Health, Alcohol and Other Drugs Services, Northern NSW Local Health District, Australian Salaried Medical Officers' Federation NSW
Dr Lesley Barron	General Surgeon John Hunter Hospital and Medical Director of Surgical Services , Australian Salaried Medical Officers' Federation NSW
Mr Stewart Gordon	Chief Executive Officer, Murrumbidgee Primary Health Network
Ms Narelle Mills	Executive Integration and Partnerships, Murrumbidgee Primary Health Network
Ms Melissa Collins	Executive Policy, Strategy & Innovation, Murrumbidgee Primary Health Network
Ms Leanne Nisbet	PhD candidate, Faculty of Medicine and Health, University of New England
Dr Rachel Christmas	President, GP VMO Obstetrician, Temora NSW, Rural Doctors Association of NSW
Dr Sue Velovski	Committee member, General Surgeon, Northern NSW, Rural Doctors Association of NSW
Cr Phyllis Miller OAM	Vice President, Local Government NSW
Mrs Rebecca Sedgman	Policy Advisor, Australian College of Nurse Practitioners (ACNP)

13 December 2024
Parliament House, Jubilee Room, Sydney, NSW

Witness	Position and Organisation
Mayor Julia Cornwell McKean	Mayor, Berrigan Shire Council
Mrs Karina Ewer	Chief Executive Officer, Berrigan Shire Council
Cr Darrell Tiemens	Mayor, Narrabri Shire Council
Ms Donna Ausling	Director Planning and Sustainability, Narrabri Shire Council
Mr Luke Sloane	Deputy Secretary, Regional Health, NSW Health
Mr Scott McLachlan	Deputy Secretary, Health System Strategy and Patient Experience, NSW Health
Mr Greg Westenberg	Executive Director, Government Relations, Strategy and Violence Prevention, NSW Health
Ms Jill Ludford	Chief Executive, Murrumbidgee Local Health District, NSW Health
Ms Tracey Maisey	Chief Executive, Northern NSW Local Health District, NSW Health
Mr Shaun Elwood	Director, Lithgow City Council
Mayor Neil Westcott	Parkes Shire Council
Deputy Mayor Marg Applebee	Parkes Shire Council
Cr Louise O'Leary	Parkes Shire Council
Cr Steven Ring	Deputy Mayor, Lithgow City Council

Appendix Five – Extracts from minutes

Meeting no. 15
TIME & DATE: 10:01 AM, WEDNESDAY 11 SEPTEMBER 2024
LOCATION: WEBEX

Members present
Via Webex: Dr Joe McGirr (Chair), Ms Liza Butler, Ms Trish Doyle, and The Hon Leslie Williams.

Apologies
Ms Janelle Saffin (Deputy Chair), Mrs Tanya Thompson, and Mr Clayton Barr.

Officers present
Leon Last, Matthew Johnson, Sukhraj Goraya, Madelaine Winkler, Nicolle Gill, and Karena Li.

Agenda item

1. **Confirmation of minutes**
   Resolved on the motion of Ms Doyle, seconded by Ms Butler: That the minutes of the meeting of 2 August 2024 be confirmed.

2. **Adoption of a third inquiry**
   The Committee considered terms of reference for an inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities.

   Resolved on the motion of Mrs Williams, second by Ms Doyle:

   - That the Committee conduct an inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities, in accordance with the draft terms of reference.
   - That the secretariat circulate a list of stakeholders to members, and that members have 3 business days after receiving that list to provide further input.
   - That the Committee call for submissions and advertise the inquiry on the Committee's webpage.
   - That the closing date for submissions be 1 November 2024.
   - That key stakeholders identified by the Committee be informed of the inquiry and invited to make a submission.
   - That the Chair issue a media release and promotional video announcing the inquiry.

3. ***

4. **Correspondence**

   ***

5. **Next meeting**

   The meeting adjourned at 10:06am, until a time and date to be determined.

Meeting no. 16

TIME & DATE: 3.01PM, 29 NOVEMBER 2024
LOCATION: ROOM 1136 AND WEBEX VIDEOCONFERENCE

Members present

Dr Joe McGirr (Chair) (via Webex), Ms Janelle Saffin (Deputy Chair) (via Webex), Mr Clayton Barr (via Webex), Ms Liza Butler (via Webex), Ms Trish Doyle (via Webex), Mrs Tanya Thompson and The Hon. Leslie Williams (via Webex).

Apologies

Ms Janelle Saffin (Deputy Chair), Mrs Tanya Thompson, and Mr Clayton Barr.

Officers present

Matthew Johnson, Carly McKenna, Sukhraj Goraya, Madelaine Winkler and Karena Li.

Agenda item

1. **Confirmation of minutes**

   Resolved on the motion of Ms Doyle: That the minutes of the meeting of 11 September 2024 be confirmed.

2. **Committee's third inquiry (PC2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities)**
   2.1 Extension of submission deadline

   The Committee agreed to publicly extend the submission deadline to Friday 15 November 2024, following the secretariat's email of 31 October 2024. A further extension was granted to NSW Health until Friday 29 November 2024.
   Resolved on the motion of Mrs Williams: That the Committee note its agreement via email that:

   - The submission deadline be extended to 15 November 2024,
   - The Chair issue a media release announcing the extension of the deadline for submissions, and
   - The relevant details be updated on the Committee's website.

2.2 Publication of submissions

The Committee considered publishing submissions for its inquiry into the implementation of PC2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities.

***

Resolved on the motion of Ms Saffin, seconded by Mr Barr:

- That Submissions 1, 9, 11, 15, 16, 20, 21, 26, 29, 50, 52, 54, 60, 68, 81, 85 and 98 be accepted and kept confidential to the Committee;
- That Submission 66 be accepted and published with name withheld on the Committee's webpage; and
- That Submissions 2 – 8, 10, 12 – 14, 17 – 19, 22 – 25, 27 – 28, 30 – 49, 51, 53, 55 – 59, 61 – 65, 67, 69 – 80, 82 – 84, 86 – 97, 99 – 107 be accepted by the Committee and published in full on the Committee's webpage.

3. Correspondence

***

4. Rural Health Inquiry Progress Report

The Committee noted that NSW Health published its Rural Health Inquiry Progress Report on 17 September 2024.

5. *

6. General business

The Committee discussed its work programme for 2025, including potential site visits in relation to its third inquiry.

***

7. Next meeting

The meeting adjourned at 3:17pm until 8:45am on 12 December at Parliament House.

Meeting no. 17

TIME & DATE: 8:47AM, THURSDAY 12 DECEMBER 2024

LOCATION: MACQUARIE ROOM, PARLIAMENT HOUSE AND VIDEOCONFERENCE

Members present

Dr Joe McGirr (Chair), Ms Janelle Saffin (Deputy Chair), Mr Clayton Barr (via Webex), Ms Liza Butler (via Webex), Ms Trish Doyle, Mrs Tanya Thompson (via Webex) and The Hon. Leslie Williams (via Webex).

Officers present

Matthew Johnson, Carly McKenna, Sukhraj Goraya, Madelaine Winkler, Nicolle Gill and Karena Li.

Agenda item

1. **Confirmation of minutes**

   Resolved, on the motion of Mrs Thompson: That the minutes of the meeting of 29 November 2024 be confirmed.

2. **Inquiry into PC2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities**

   2.1. Publication of submissions

   The Committee considered the publication of submissions with proposed redactions. Discussion ensued.

   Resolved, on the motion of Mr Barr: That Submissions 45, 47, 49, 96 and 99 be published with redactions on the Committee's webpage.

3. **Pre-hearing procedural resolutions**

   The Committee considered the notice of hearing and witnesses.
   Resolved, on the motion of Mrs Thompson:

   - That the Committee invites the witnesses listed in the notice of the public hearing for Thursday 12 December 2024 to give evidence in relation to the inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities.
   - That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 12 December 2024, in accordance with the Legislative Assembly's resolution of 9 May 2023; and the Assembly's guidelines for coverage of proceedings for parliamentary committees administered by the Legislative Assembly.
   - That the Committee adopt the following process in relation to supplementary questions:
     - Members to email any proposed supplementary questions for witnesses to the secretariat by 4pm, Monday 16 December 2024;
     - Secretariat to then circulate all proposed supplementary questions to Committee, with members to lodge any objections to the questions by 4pm, Wednesday 18 December 2024.
   - That witnesses be requested to return answers to any questions taken on notice and supplementary questions by Friday 24 January 2025.

   The Chair adjourned the meeting at 8:57am.

4. Public hearing

Witnesses and the public were admitted. The Chair opened the public hearing at 9:01am and made a short opening statement.

Ms Monika Wheeler, Chief Executive Officer, Healthy North Coast (North Coast Primary Health Network), was affirmed and examined via videoconference. Dr Adrian Gilliland, General Practitioner and Chair, Healthy North Coast (North Coast Primary Health Network), was sworn and examined via videoconference.
Mr Brad Porter, Chief Executive Officer, Western NSW Primary Health Network, was affirmed and examined via videoconference.
Mr Stewart Gordon, Chief Executive Officer, Ms Narelle Mills, Executive, Integration and Partnerships, and Ms Melissa Collins, Executive, Policy, Strategy & Innovation, Murrumbidgee Primary Health Network, were affirmed and examined via videoconference.
Mr Porter, Mr Gordon and Dr Gilliland each made an opening statement.
The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

Ms Margaret Deerain, Director, Policy and Strategy Development, and Ms Susanne Tegen, Chief Executive Officer, National Rural Health Alliance, were sworn and examined via videoconference.
Mr Richard Colbran, Chief Executive Officer, Rural Doctors Network, was sworn and examined.
Mr Mike Edwards, Chief Operating Officer, and Ms Annette Lenstra, Sector Advancement Manager, Rural Doctors Network, were affirmed and examined.
Dr Rachel Christmas, President of Rural Doctors Association New South Wales (NSW), General Practitioner and Visiting Medical Officer Obstetrician, Temora NSW, was affirmed and examined via videoconference. Dr Sue Velovski, Committee member of Rural Doctors Association New South Wales (NSW) and General Surgeon, was sworn and examined via videoconference.
Mr Colbran, Dr Christmas and Ms Tegen each made an opening statement.
The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair adjourned the public hearing at 11:03am.

5. Deliberative meeting

The Committee commenced a deliberative meeting at 11:18am.

Resolved, on the motion of Ms Doyle: That the Committee invites Mrs Rebecca Sedgman to give evidence in relation to the inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to cross-jurisdictional health reform and government

consultation with remote, rural and regional communities at the Committee's public hearing on 12 December 2024.

The Chair adjourned the meeting.

6. Public hearing

The Chair resumed the public hearing at 11:19am.

Dr Ian Kamerman, Representative of the National and NSW.ACT Rural Faculty councils, Royal Australian College of General Practitioners (RACGP) Rural, was affirmed and examined.
Adjunct Associate Professor Leanne Boase, Chief Executive Officer, and Mrs Rebecca Sedgman, Policy Advisor, Australian College of Nurse Practitioners were affirmed and examined via videoconference.
Mrs Sedgman made an opening statement.
The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair adjourned the public hearing at 12:11pm.

The Chair resumed the public hearing at 1:18pm.

Mr Matthew Clancy, Chair, and Mr Joshua Gaynor, Member, Culcairn Local Health Advisory Committee, were sworn and examined via videoconference.
Ms Sharelle Fellows, Community Representative, was affirmed and examined via videoconference.
Ms Fellows and Mr Clancy each made an opening statement.
The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

Councillor Phyllis Miller OAM, Vice President, Local Government New South Wales, was sworn and examined via videoconference. Mr Damian Thomas, Directory Advocacy, Local Government New South Wales, was affirmed and examined via videoconference.
Councillor Miller made an opening statement.
The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair adjourned the public hearing at 2:42pm.

The Chair resumed the public hearing at 3:01pm.

Mr Craig Gross, Professional Officer, and Ms Frances Usherwood, Primary Care Sector Co-Ordinator, New South Wales Nurses and Midwives' Association, were affirmed and examined.
Ms Fiona Davies, Chief Executive Officer, Australian Medical Association New South Wales, was affirmed and examined.
Mr Coda Danu-Asmara, Industrial Officer, Australian Paramedics Association (New South Wales), was affirmed and examined via videoconference. Mr Tim McEwen, Delegate, Australian Paramedics Association (New South Wales), was sworn and examined.
Dr Chris Selvaraj, SET5 (Accredited) General Surgical Trainee, NSW, Murrumbidgee Local Health District and State Councillor, Australian Salaried Medical Officers' Federation New South Wales, was affirmed and examined. Dr Kathryn Drew, Director of Medical Services, Mental Health, Alcohol and Other Drugs Services, Northern NSW Local Health District, and Dr Lesley Barron, General Surgeon, John Hunter Hospital and Medical Director of Surgical Services, Australian Salaried Medical Officers' Federation New South Wales, were affirmed and examined via videoconference.
Ms Davies, Mr Gross, Mr Danu-Asmara and Dr Selvaraj each made an opening statement.
The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

Professor Sally Hall Dykgraaf, Head of Rural Clinical School, Australian National University, was affirmed and examined via videoconference.
Associate Professor Sarah Wayland, Senior Researcher, Manna Institute, was affirmed and examined.
Associate Professor Michael Curtin, Head of School of Allied Health, Exercise and Sports Science, Faculty of Science and Health, and Professor Megan Smith, Executive Dean, Faculty of Science and Health, Charles Sturt University, were affirmed and examined via videoconference.
Ms Leanne Nisbet, PhD Candidate, Faculty of Medicine and Health, University of New England, was affirmed and examined via videoconference.
Associate Professor Wayland made an opening statement.
The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair closed the public hearing at 4:53pm.

7. Post-hearing deliberative meeting

The Committee commenced a deliberative meeting at 4:58pm.

7.1. Redaction to corrected transcript of public evidence

Ms Doyle requested that a comment she made *** be redacted from the corrected transcript of today's hearing.
Discussion ensued.
Resolved, on the motion of Mrs Williams: That the comment by Ms Doyle be redacted from the corrected transcript of public evidence given today.

7.2. Publication orders

Resolved, on the motion of Mr Barr: That the corrected transcript of public evidence given today be authorised for publication and uploaded on the Committee's webpage.

8. Next meeting

The meeting adjourned at 5:00pm until 8:45am on 13 December at Jubilee Room, Parliament House.

Meeting no. 18

TIME & DATE: 8:49AM, FRIDAY 13 DECEMBER 2024
LOCATION: JUBILEE ROOM, PARLIAMENT HOUSE AND VIDEOCONFERENCE

Members present

Dr Joe McGirr (Chair), Mr Clayton Barr (via Webex), Ms Liza Butler (via Webex), Ms Trish Doyle, Mrs Tanya Thompson (via Webex) and The Hon. Leslie Williams (via Webex)

Officers present

Matthew Johnson, Carly McKenna, Sukhraj Goraya, Madelaine Winkler, Nicolle Gill and Karena Li.

Members present

Ms Janelle Saffin (Deputy Chair).

Officers present

Matthew Johnson, Carly McKenna, Sukhraj Goraya, Madelaine Winkler, Nicolle Gill and Karena Li.

Agenda item

1. Pre-hearing procedural resolutions

The Committee considered the notice of hearing and witnesses.

Resolved, on the motion of Ms Doyle:

- That the Committee invites the witnesses listed in the notice of the public hearing for Friday 13 December 2024 to give evidence in relation to the inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities.
- That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 13 December 2024, in accordance with the Legislative Assembly's resolution of 9 May 2023; and the Assembly's guidelines for coverage of proceedings for parliamentary committees administered by the Legislative Assembly.

- That the Committee adopt the process for questions on notice and supplementary questions for the hearing of 13 December 2024, as agreed to during the meeting of 12 December 2024.

The Chair adjourned the meeting at 9:04 am.

2. Public hearing

Witnesses and the public were admitted. The Chair opened the public hearing at 9:07am and made a short opening statement.

Mayor Darrell Tiemens, Narrabri Shire Council, was sworn and examined. Ms Donna Ausling, Director of Planning and Sustainability, Narrabri Shire Council, was affirmed and examined.

Mayor Julia Cornwell McKean, Berrigan Shire Council, was affirmed and examined via videoconference. Mrs Karina Ewer, Chief Executive Officer, Berrigan Shire Council, was affirmed and examined via videoconference.

Councillor Louise O'Leary, Parkes Shire Council, was affirmed and examined via videoconference. Mayor Neil Westcott, Parkes Shire Council, was sworn and examined via teleconference.

Deputy Mayor Steven Ring, and Mr Shaun Elwood, Director, People and Places, Lithgow City Council, were affirmed and examined via videoconference.

Mayor Tiemens, Mayor Cornwell McKean, Councillor O'Leary and Deputy Mayor Ring each made opening statements.

The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair adjourned the public hearing at 10:07 am.

The Chair resumed the public hearing at 10:27 am.

Mr Luke Sloane, Deputy Secretary, Rural and Regional Health, NSW Health, was affirmed and examined. Mr Greg Westenberg, Executive Director, Government Relations, Strategy and Violence Prevention, NSW Health, was sworn and examined. Ms Jill Ludford, Chief Executive, Murrumbidgee Local Health District, NSW Health, was sworn and examined via videoconference. Ms Tracey Maisey, Chief Executive, Northern NSW Local Health District, NSW Health, was affirmed and examined via videoconference.

The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.

The Chair closed the public hearing at 12:11 pm.

3. Post-hearing deliberative meeting

The Committee commenced a deliberative meeting at 12:12 pm.

3.1. Publication orders

Resolved, on the motion of Ms Butler: That the corrected transcript of public evidence given today be authorised for publication and uploaded on the Committee's webpage.

3.2. Process in relation to supplementary questions

The Committee considered an amendment to the process relating to supplementary questions that was previously agreed to.

Resolved, on the motion of Mr Barr: That the Committee provide proposed supplementary questions for witnesses to the secretariat within 24 hours of receiving the uncorrected transcripts of evidence of the Committee's hearings on 12 and 13 December 2024.

4. General business

The Committee discussed its plans for the following year.

5. Next meeting

The meeting adjourned at 12:27 pm until a time and date to be determined.

Meeting no. 19

TIME & DATE: 9:01AM, MONDAY 17 MARCH 2025

LOCATION: ROOM 1136, PARLIAMENT HOUSE AND VIDEOCONFERENCE

Members present

Dr Joe McGirr (Chair), Mr Clayton Barr, Ms Liza Butler (via Webex), Mr Justin Clancy, Ms Trish Doyle (via Webex) and Mrs Tanya Thompson.

Apologies

Ms Janelle Saffin (Deputy Chair).

Officers present

Matthew Johnson, Carly McKenna, Sukhraj Goraya, Joan Douce, Yann Pearson and Nicolle Gill.

Agenda item

1. Confirmation of minutes

Resolved, on the motion of Mrs Thompson: That the minutes of the meetings of 12 December and 13 December 2024 be confirmed.

2. Membership changes

The Committee noted:

- the extract from the Legislative Assembly Votes and Proceedings, no 91, entry no 6, advising of the resignation of Mrs Leslie Williams

- the extract from the Legislative Assembly Votes and Proceedings, no 94, entry no 10, appointing Mr Justin Clancy MP to the Committee, in place of Mrs Williams:

6 ELECTORAL DISTRICT OF PORT MACQUARIE

The Speaker advised the House that on 31 January 2025 he had received a letter from Leslie Gladys Williams resigning her seat as member for the electoral district of Port Macquarie.

10 COMMITTEE MEMBERSHIP

(2) Justin Clancy be appointed to serve on the Select Committee on Remote, Rural and Regional Health.

3. NSW Government response to inquiry into the implementation of PC2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health

3.1. NSW Government response

The Committee discussed the NSW Government responses to the Committee's report on the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health.

4. ***

5. Inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities

5.1. Answers to questions on notice and supplementary questions

The Committee considered the publication of answers to questions on notice and supplementary questions received from the following organisations:

- Mayor Neil Westcott, Parkes Shire Council, received on 13 December 2024
- Manna Institute, received on 20 December 2024
- Western NSW Primary Health Network, received on 9 January 2025
- Royal Australian College of General Practitioners, received on 13 January 2025
- Australian College of Nurse Practitioners, received on 15 January 2025
- Healthy North Coast (North Coast Primary Health Network), received on 20 January 2025
- Rural Doctors Network, received on 22 January 2025

5.2. Clarification of evidence in transcript

The Committee considered correspondence from the following witnesses seeking to clarify their evidence in the published transcripts:

- Letter from Ms Narelle Mills, Executive Integration and Partnerships, Murrumbidgee Primary Health Network, received on 19 December 2024
- Letter from Ms Luke Sloane, Deputy Secretary, Rural and Regional Health, NSW Ministry of Health, received on 20 January 2025.

Resolved, on the motion of Mr Barr: That the Committee accept and publish all witness correction letters listed above and footnote the transcript to link

5.3. Late submissions

The Committee considered the publication of late submissions from:

- *** received on 3 February 2025
- A. Allan, received on 12 February 2025
- Exercise and Sports Science Australia (ESSA), received on 6 March 2025.

Resolved, on the motion of Mr Clancy:

- That the Committee accept and publish the late submission from *** (108), with name suppressed, with proposed redactions
- That the Committee accept and publish the late submission from Mr Allan (109) with proposed redactions
- That the Committee accept and publish the late submission from ESSA (110) with contact details redacted.

6. Correspondence

***

7. *

8. General Business

The Committee discussed its forward work plan.

9. Next meeting

The meeting adjourned at 10:51am until 12 May 2025.

Unconfirmed minutes of Meeting no. 20

TIME & DATE: 10:35 AM, MONDAY 12 MAY 2025

LOCATION: ROOM 1254, PARLIAMENT HOUSE AND VIDEOCONFERENCE

Members present

Dr Joe McGirr (Chair), Mr Clayton Barr, Mr Justin Clancy, Ms Trish Doyle.

Apologies
Ms Janelle Saffin (Deputy Chair), Ms Liza Butler, Mrs Tanya Thompson.

Officers present
Matthew Johnson, Carly McKenna, Sukhraj Goraya, Joan Douce, Yann Pearson and Nicolle Gill.

Agenda item

1. **Confirmation of minutes**
   Resolved, on the motion of Mr Barr: That the minutes of the meeting of 17 March 2025 be confirmed.

2. **Inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities**

   2.1 Late submissions
   The Committee considered the publication of late submissions.
   Resolved, on the motion of Ms Doyle: That the Committee accept and publish the late submission from Dr Emma Rush, Dr Monica Short, Dr Nicola Ivory, Dr Ella Dixon, Michelle Bonner and Sarah Ansell (Charles Sturt University research team) (111) with contact details redacted.
   Resolved, on the motion of Mr Clancy: That the Committee accept and publish the late submission from Little Wings (112) with contact details redacted.

   2.2 Answer to question on notice
   The Committee considered the publication of a late answer to a question on notice.
   Resolved, on the motion of Mr Clancy: That the Committee accept the answer to a question on notice by the Rural Clinical School, Australian National University and publish it on its webpage.

   2.3 Correspondence
   The Committee considered the publication of correspondence from the National Rural Health Alliance.
   Resolved, on the motion of Ms Doyle: That the Committee publish the letter received from the National Rural Health Alliance to the Chair, dated 13 March 2025, on its webpage.

   2.4 Resolution permitting recording of meeting
   Resolved, on the motion of Mr Clancy: That the Committee agrees to record the meeting for the purposes of committee staff preparing the minutes and report amendments, and that the recording be deleted once the report is tabled.

   2.5 Consideration of Chair's draft report
   The Chair informed the Committee of his meeting with the Auditor-General and staff from the Audit Office of NSW, in relation to the current inquiry.

The Committee considered the Chair's draft report, circulated via email on Monday 5 May 2025.

Resolved, on the motion of Mr Barr: That the draft report be considered chapter by chapter.

The Committee considered Chapter One of the report.
Resolved, on the motion of Mr Barr: That Recommendation 2 of the report be amended to in insert the words 'and remote' after 'rural'.
Resolved, on the motion of Mr Clancy: That Chapter One, as amended, stand as part of the report.

The Committee considered Chapter Two of the report.
Resolved, on the motion of Mr Barr: That the following words be omitted from paragraph 2.26: 'There has also been 'significant community concern' about a lack of transparent consultation on the development of the new Albury Wodonga hospital, including the departure from the plan for a single-site greenfield hospital. We acknowledge that this is a cross-border region and effective community engagement by health services would need to occur in partnership with the Victorian Department of Health.'
Resolved, on the motion of Mr Barr: That a new paragraph 2.26 be inserted with the following words: 'Local Government NSW cited challenges for Albury-Wodonga Health being a cross-border health service and for Cootamundra-Gundagai where there is both state agencies and federal agencies seeking to engage with the community. We acknowledge this and that effective community engagement by health services needs to occur in partnership with Commonwealth and other state health agencies in these situations.'
Resolved, on the motion of Ms Doyle: That the words 'Rural and Regional Health Commissioner' be replaced with 'Remote, Rural and Regional Health Commissioner' throughout Chapter Two.
Resolved, on the motion of Mr Barr: That Chapter Two, as amended, stand as part of the report.

The Committee considered Chapter Three of the report.
Resolved, on the motion of Ms Doyle: That the words 'Rural and Regional Health Commissioner' be replaced with 'Remote, Rural and Regional Health Commissioner' throughout Chapter Three.
Resolved, on the motion of Mr Clancy: That Chapter Three, as amended, stand as part of the report.

Resolved, on the motion of Ms Doyle:
1. That the draft report as amended be the report of the Committee and that it be signed by the Chair and presented to the House.
2. That the Chair and committee staff be permitted to correct stylistic, typographical and grammatical errors.

3. That, once tabled, the report be posted on the Committee's webpage.

2.6 Consideration of alternative report cover

The Committee considered adopting an alternate cover for its final report.

Resolved, on the motion of Mr Barr: That the attached proposed cover be the cover of the Committee's report.

3. Proposed outgoing correspondence

The Committee considered potential correspondence for key stakeholders, in relation to recommendations made in the Committee's final report.

***

***

***

4. General business

***

The Committee thanked committee staff for their work during its three inquiries.

The meeting adjourned at 11:21am.