Committee on Community Services

LEGISLATIVE ASSEMBLY

Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025

Report 2/58 – November 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 77 2

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	Mr Clayton Barr MP
Deputy Chair	Ms Trish Doyle MP
Members	Ms Liza Butler MP Mrs Helen Dalton MP Ms Donna Davis MP Mrs Tanya Thompson MP Ms Felicity Wilson MP
Contact details	
Telephone	(02) 9230 3054
E-mail	communityservices@parliament.nsw.gov.au
Website	https://www.parliament.nsw.gov.au/communityservices

Chair's foreword

The question regarding the suitability of the current Hunter New England Local Health District structure is not a new one. It appears to have been questioned for almost as long as the district has existed. Importantly, this is not a consequence free question to pose, as it has created turmoil and uncertainty for both staff and communities right across the regions.

It is my personal hope that this inquiry has finally provided the opportunity for all concerns and challenges to be aired such that the question can once and for all be dealt with.

The Hunter New England Local Health District is a geographically large one. It has a large population to serve. The district is unique as far as health districts go, in that it has both regional and metropolitan elements to it – with most of the executive of the district based in the metropolitan city of Newcastle. Combined, these factors have been at the heart of almost every argument made about why the district needs to be split into two separate health districts.

Contrary to these arguments are the realities that the district is neither the most expansive geographically, nor the largest by population. In addition, during this inquiry, a number of submissions by those working in the health system highlighted that the unique regional and metropolitan characteristics of the district allow smoother and simpler referral pathways, as well as the reality that outreach specialist services into the regions only happen because it is all the one health district.

The various submissions received during this inquiry, along with the transcripts of the public hearings, are well worth reading for a thorough understanding of the various factors explored and considered. Also worthy of consideration is the absence of submissions from much of the health district, which could be interpreted to suggest that many are content with the delivery of health services.

The disparities in health outcomes for regional communities is not in question. Various sets of data, independent studies, and NSW Parliamentary inquiries show that health outcomes for regional communities are poorer than those experienced by metropolitan communities. There are many reasons for this and it is not simply a matter of blaming the provision of health services. Take for example the scale of road trauma in the regions, or the socioeconomics that contribute to lifestyle factors, or the distances that people often live from the nearest town centres, or the nature of the work undertaken in our regional communities, or the limited access to commercial gyms, social sporting teams and sport facilities.

Health services cannot be perfectly positioned, perfectly staffed and perfectly resourced to meet the needs of every event, injury or illness for every citizen of NSW. Apart from not having a boundless amount of money to spend on health nor a boundless supply of health workers, we also have many health facilities that have a historical reason for existence and not a strategic one. None of this is intended to be a criticism of anyone who wants the best of all things from their local health centre, but it is important to grapple with what the safest and most abundant delivery of services looks like in the context of limited resources.

During the inquiry we heard, from the communities that participated, that they firmly believed that if decision making were located physically closer to their nearest health facility, different

decisions would be made and services would become more abundant and staffing would be fulsome.

We also heard, by contrast, from many of the health workers that participated in the inquiry, that workforce is a significant challenge right across NSW and Australia and the Hunter New England Local Health District, in its current form, provides good links to ensure that each patient is properly referred to the best site for treatment of their health needs, creating a healthier and safer outcome for patients.

Further to this, we also heard that splitting the district into two separate districts would see a disconnection between specialist services that are often in larger cities, where volume of patients underpins their existence, and that some of these specialist services that currently perform outreach to the regions would most likely cease that travel, leaving those isolated regional communities worse off.

Of significant note, the inquiry was told that a newly formed health district would be required, by law, to establish its own administrative and executive arm that could come at a recurrent cost of some $111 million, which would have to be taken from front line activities, further reducing the provision of health services.

In the end, this inquiry makes just a single recommendation: that consideration of the Private Members Bill proceed to debate in the House. It is now for the 93 members of the NSW Legislative Assembly to decide the question.

I do sincerely hope that members will consider the contents of this report.

Based on the balance of all that I was exposed to during this inquiry, I cannot support the separation of the Hunter New England Local Health District. I am left with a firm belief that separation would lead to a decline in health services and health outcomes, not an improvement. I do however believe that there is always room for improvement and I urge the Hunter New England Local Health District to continue to strive for equity and excellence in all that they do.

It has been my absolute pleasure to work with my parliamentary colleagues and the Committee staff during this inquiry. Yet again, we have taken Parliament to the bush and we have reaped the rewards of making ourselves as available as was practical. I also thank the Hansard team that travelled with us to record the spoken words of our hearings and the audio-visual teams in the various locations that made it possible for the wider public to watch the inquiry as it unfolded.

Most of all I thank the general public who, invited to participate in this process, rose to the occasion and gave us their frank and fearless advice.

Clayton Barr MP
Chair

Recommendations

That the Parliament of NSW proceeds to consider the Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025, including stakeholder input into this inquiry.

Chapter One – Health services and outcomes in Hunter New England

Summary

Many stakeholders were of the view that health services in the Hunter New England Local Health District have declined. Some perceived there to be a disparity in healthcare and outcomes between the district's Hunter and New England North West regions. There was mixed evidence on whether splitting the district would address or exacerbate health inequity.

The Health Services Amendment (Splitting of the Hunter New England Health District) Bill

Recommendation 1

That the Parliament of NSW proceeds to consider the Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025, including stakeholder input into this inquiry.

1.1 The Committee heard conflicting evidence on the Health Services Amendment (Splitting of the Hunter New England Health District) Bill (the Bill) and whether passing it would improve healthcare for affected communities in the Hunter and New England North West regions. This report outlines stakeholder input on the potential benefits and risks of passing the Bill. The Committee recommends that the Houses take these stakeholder views into account when considering the Bill.

1.2 We note that in recent years there have been several parliamentary inquiries and subsequent recommendations to improve remote, rural and regional health in NSW.[1]

1.3 The Bill was introduced by Roy Butler MP, Member for Barwon, on 20 February 2025. If passed the Bill would amend the *Health Services Act 1997* (the Act) to dissolve the Hunter New England Local Health District and form a Hunter Local Health District and a New England North West Local Health District.[2]

1.4 The Act would also be amended to enable the transfer of the Hunter New England Local Health District's assets, rights and liabilities to either the Hunter or

[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; Select Committee on Remote, Rural and Regional Health, *Implementation of Portfolio Committee No. 2 recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, report 1/58, Parliament of NSW, August 2024; Select Committee on Remote, Rural and Regional Health, *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*, report 2/58, Parliament of NSW, March 2025; Select Committee on Remote, Rural and Regional Health, *The implementation of Portfolio Committee No. 2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities*, report 3/58, Parliament of NSW, May 2025.

[2] Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025, sch 1[2].

New England North West Local Health District.[3]

1.5 In his second reading speech, Mr Butler noted that Hunter New England is the only local health district with a metropolitan based administration providing services to rural and remote areas. He stated that the district's geographical size was 'too large' for its administration and splitting the district would be a return to 'a country health district looking after its own'.[4]

The Hunter New England Local Health District

1.6 The Hunter New England Local Health District (the district) was formed in 2005 when NSW transitioned from the area health service model and combined the Hunter, New England and Lower Mid North Coast regions into a single local health district.[5]

1.7 Like other local health districts (LHDs), it is established under the *Health Services Act 1997* and is responsible for managing public hospitals and health institutions and delivering health services in a defined geographical area.

1.8 The district spans 131,785 km^2 and is the third largest LHD in geographical size, after the Far West LHD and Western NSW LHD.[6] It covers 25 local government areas and is the only LHD in NSW that has a major metropolitan centre, several large regional centres, smaller rural centres and remote communities.[7] Figure 1 shows a map of the district and its health facilities.

[3] Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025, sch 1[2].

[4] New South Wales, Legislative Assembly, *Parliamentary Debates*, 20 February 2025, pp 1, 3 (Mr Roy Butler, Member for Barwon).

[5] Submission 30, Hunter New England Local Health District, p 3.

[6] NSW Health, Hunter New England, viewed 3 September 2025; NSW Health, Far West, viewed 3 September 2025; NSW Health, Western NSW, viewed 3 September 2025.

[7] NSW Government, About Hunter New England Local Health District, viewed 8 September 2025.

Figure 1 Map of Hunter New England Local Health District health facilities[8]

1.9 In 2021, there were 962,390 residents in the LHD, including 71,983 Aboriginal and Torres Strait Islander people. Its population is expected to grow to 1.039 million by 2031.[9]

1.10 The district has the largest population among NSW's rural and regional LHDs. Its population size is comparable to metropolitan LHD populations in Sydney.[10]

[8] Submission 30, Hunter New England Local Health District, p 12.

[9] NSW Health, Hunter New England, viewed 3 September 2025; NSW Government, About Hunter New England Local Health District, viewed 8 September 2025.

[10] Submission 31, NSW Health, p 2; Examples of comparable metropolitan districts include the South Eastern Sydney LHD, South Western Sydney Local Health District and Northern Sydney Local Health District (NSW Health, South Eastern Sydney, viewed 3 September 2025; NSW Health, Northern Sydney, viewed 3 September 2025; NSW Health, South Western Sydney, viewed 3 September 2025).

Health outcomes

The district has poorer health outcomes compared to state and national averages

1.11 Some participants highlighted that Hunter New England residents have poorer health outcomes when compared to NSW averages.[11] For example, cancer incidence and mortality rates in the district are higher than the general NSW population.[12] There is also a higher prevalence of chronic disease, with six in ten people living with a long-term health condition, compared to the NSW average of one in two people.[13]

1.12 Brenna Smith, Manager, Community Cancer Information and Support Services, Cancer Council NSW, stated that the district has some of the worst cancer survival rates in NSW.[14] When compared to the national average, cancer survival rates are:

- 31 per cent lower in Cessnock (Hunter region)
- 27 per cent lower in Taree (Mid North Coast region)
- 27 per cent lower in Armidale and 24 per cent lower in Narrabri (New England region).[15]

1.13 Several stakeholders pointed to the adverse health outcomes faced by Australia's remote, rural and regional communities, including worse cancer outcomes, a shorter life expectancy and higher burden of chronic disease.[16] We heard that the healthcare challenges in the Hunter New England LHD are not unique, and also exist in other regional parts of NSW.[17]

A number of factors influence health outcomes

1.14 ACON submitted that a lack of services leads to poorer health outcomes.[18] The limited availability of health services in the district is discussed in the next section.

1.15 Noting the connection between poverty and poorer health outcomes, Ben

[11] Submission 58, NSW Council of Social Service, p 2; Brenna Smith, Manager, Community Cancer Information and Support Services, Cancer Council NSW, Transcript of evidence, 20 August 2025, p 21.

[12] Submission 86, Cancer Council NSW, p 2.

[13] Ben McAlpine, Director of Policy and Advocacy, NSW Council of Social Service, Transcript of evidence, 20 August 2025, pp 1, 3.

[14] Brenna Smith, Manager, Community Cancer Information and Support Services, Cancer Council NSW, Transcript of evidence, 20 August 2025, p 21.

[15] Brenna Smith, Transcript of evidence, 20 August 2025, p 21.

[16] Submission 32, Country Women's Association of NSW, p 3; Submission 86, Cancer Council NSW, p 1; Councillor Russell Webb, Mayor, Tamworth Regional Council, Transcript of evidence, 13 August 2025, p 12; Brenna Smith, Transcript of evidence, 20 August 2025, p 21; Bradley Gellert, Manager, Policy and Advocacy, Cancer Council NSW, Transcript of evidence, 20 August 2025, p 22; Fiona Davies, Chief Executive Officer, Australian Medical Association (NSW), Transcript of evidence, 20 August 2025, p 43.

[17] Submission 67, Australian Medical Association (NSW), p 2; Bronwyn Dunston, State Secretary, Country Women's Association of NSW, Transcript of evidence, 20 August 2025, pp 18-19; Fiona Davies, Transcript of evidence, 20 August 2025, p 46.

[18] Submission 57, ACON, p 1.

McAlpine, Director of Policy and Advocacy, NSW Council of Social Service (NCOSS), said that there are high rates of poverty in the district.[19] Mr McAlpine stated that half of Hunter New England residents who live below the poverty line cannot afford medication or travel to access healthcare.[20]

1.16 Cancer Council NSW observed that factors influencing worse cancer outcomes in parts of the district include lower participation rates for screening programs, and a higher rate of cancer risks such as smoking and risky alcohol consumption.[21] Bradley Gellert, Manager, Policy and Advocacy, Cancer Council NSW, also noted that barriers affecting access to healthcare, such as fewer services, cost and the need to travel long distances to access treatment, contribute to worse cancer outcomes.[22]

1.17 Elyse Cain, Policy Lead, NCOSS, stated that some unique, long-term health impacts in the district are a result of the region being affected by climate disasters and emergencies.[23]

Health services

There is a perception that health services are declining

1.18 Many stakeholders believed that there has been a decline in health and hospital services in the district.[24] This decline was reported in both smaller towns and larger cities in the New England North West region, including Armidale, Glen Innes, Inverell, Moree, Narrabri, Tenterfield and Tamworth.[25]

Limited availability of services

1.19 Inquiry participants pointed to strained, limited, or a lack of local health services

[19] Ben McAlpine, Transcript of evidence, 20 August 2025, p 1.

[20] Ben McAlpine, Transcript of evidence, 20 August 2025, p 1.

[21] Bradley Gellert, Transcript of evidence, 20 August 2025, p 22; Answers to questions on notice, Cancer Council NSW, 3 September 2025, p 1.

[22] Bradley Gellert, Transcript of evidence, 20 August 2025, p 22.

[23] Elyse Cain, Policy Lead, NSW Council of Social Service, Transcript of evidence, 20 August 2025, p 3.

[24] Submission 3, Mrs Diana Burtenshaw, p 1; Submission 6, Ms Carol Sparks, p 1; Submission 25, Kaz Madigan, pp 1-2; Submission 27, Tenterfield Shire Council, p 2; Submission 34, Ms Karen Orman, pp 1, 3-4; Submission 46, Ms Kathleen Denniss, p 1; Submission 55, Dr Eric Baker, p 1; Submission 59, Mrs Oddette Avery, p 1; Submission 76, Narrabri Shire Council, p 3; Submission 85, Tamworth Regional Council, p 1; Submission 94, NSW Farmers Association - Wee Waa Branch, p 1; Submission 101, Moree Plains Shire Council, p 1; Andrew Bowen, Secretary and Treasurer, Wee Waa Chamber of Commerce, Transcript of evidence, 12 August 2025, p 10; Leah Daley, General Manager, Gwydir Shire Council, Transcript of evidence, 12 August 2025, p 27; Richard Schwager, Treasurer, NSW Farmers Association, Wee Waa Branch Transcript of evidence, 12 August 2025, p 31; John Fogarty, Transcript of evidence, 12 August 2025, p 31; Councillor Russell Webb, Transcript of evidence, 13 August 2025, pp 11, 17; Councillor Kate Dight, Mayor, Inverell Shire Council, Transcript of evidence, 22 August 2025, p 1; Councillor Bronwyn Petrie, Mayor, Tenterfield Shire Council, Transcript of evidence, 22 August 2025, pp 8, 10-11; Councillor Darrell Tiemens, Mayor, Narrabri Shire Council, Transcript of evidence, 22 August 2025, p 9.

[25] Submission 3, Mrs Diana Burtenshaw, p 1; Submission 6, Ms Carol Sparks, p 1; Submission 27, Tenterfield Shire Council, p 2; Submission 34, Ms Karen Orman, pp 1, 3-4; Submission 59, Mrs Oddette Avery, p 1; Submission 68, Name suppressed, p 1; Submission 94, NSW Farmers Association - Wee Waa Branch, p 1; Submission 101, Moree Plains Shire Council, p 1; Andrew Bowen, Transcript of evidence, 12 August 2025, p 10; Leah Daley, Transcript of evidence, 12 August 2025, p 27; Richard Schwager, Transcript of evidence, 12 August 2025, p 31; John Fogarty, Transcript of evidence, 12 August 2025, p 31; Councillor Kate Dight, Transcript of evidence, 22 August 2025, p 1; 22 August; Councillor Bronwyn Petrie, Transcript of evidence, 22 August 2025, pp 8, 10-11; Councillor Darrell Tiemens, Transcript of evidence, 22 August 2025, p 9.

in the district, including specific services such as maternity and palliative care.[26] Stakeholders shared stories about the personal effect of limited health services including women giving birth on the side of the road or in their cars, and family members dying alone and/or far from home.[27]

1.20 We heard that limited access to primary care services has put pressure on the district's emergency departments (EDs).[28] NCOSS advised that 37 per cent of people in the New England North West and Mid North Coast regions presented at an ED because their GP was unavailable. This is higher than the NSW average of 23 per cent.[29]

1.21 Challenges with accessing emergency hospital services were also reported, with multiple accounts of the district's hospitals going on bypass.[30] The Australian Medical Association NSW (AMA NSW) said that Tamworth Hospital, one of the major hospitals in the district, was on bypass for more than 14 days in 2024.[31] Hospital bypass is when an ambulance is diverted to another hospital because the closest or most suitable hospital has exceeded capacity.[32]

1.22 While noting positive developments in the district's delivery of mental health services, Warren Isaac, Member of the NSW Nurses and Midwives' Association, noted that a number of early intervention mental health services that were established under the area health service model had been cut.[33]

---

[26] Submission 32, Country Women's Association of NSW, p 3; Submission 51a, Name suppressed, p 1; Submission 58, NSW Council of Social Service, p 2; Submission 67, Australian Medical Association (NSW), p 1; Submission 68, Name suppressed, p 1; Submission 83, Ron Thorp, p 1; Submission 87, Name suppressed, p 1; Submission 100, Rural Doctors Association of NSW, p 2; Submission 101, Moree Plains Shire Council, p 1; Clifford Toomey, Chair, Wee Waa Aboriginal Land Council, Transcript of evidence, 12 August 2025, p 5; Kate Kahl, Member, Save Wee Waa Hospital Committee, Transcript of evidence, 12 August 2025, p 17; Councillor Tiffany Galvin, Mayor, Gwydir Shire Council, Transcript of evidence, 12 August 2025, p 25; Heather Franke, Secretary and Delegate, Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association, Transcript of evidence, 13 August 2025, pp 2-3; Councillor Russell Webb, Transcript of evidence, 13 August 2025, p 12; Ben McAlpine, Transcript of evidence, 20 August 2025, pp 1, 3; Elyse Cain, Transcript of evidence, 20 August 2025, p 3; Emma Hardy, Professional Officer, NSW Nurses and Midwives' Association, Transcript of evidence, 20 August 2025, pp 7, 9; Bronwyn Dunston, Transcript of evidence, 20 August 2025, pp 14-15, 18; Sandy Harrison, Country Women's Association, Murrurundi Branch, Transcript of evidence, 20 August 2025, pp 15-17; Fiona Davies, Transcript of evidence, 20 August 2025, p 41.

[27] Submission 51a, Name suppressed, p 1; Submission 59, Mrs Oddette Avery, p 1; Submission 68, Name suppressed, p 1; Submission 87, Name suppressed, p 1; Robyn Keefe, Chief Executive Officer, Wee Waa Aboriginal Land Council, Transcript of evidence, 12 August 2025, p 3; Kate Kahl, Transcript of evidence, 12 August 2025, p 17.

[28] Submission 16, Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association, p 1; Submission 58, NSW Council of Social Service, p 2; Ms Heather Franke, Transcript of evidence, 13 August 2025, p 3.

[29] Submission 58, NSW Council of Social Service, p 2; Ben McAlpine, Transcript of evidence, 20 August 2025, p 3; Elyse Cain, Transcript of evidence, 20 August 2025, p 3.

[30] Submission 32, Country Women's Association of NSW, p 3; Submission 67, Australian Medical Association (NSW), p 1; Submission 101, Moree Plains Shire Council, p 1; Kate Kahl, Member, Save Wee Waa Hospital Committee, Transcript of evidence, 12 August 2025, pp 17, 22; Emma Hardy, Transcript of evidence, 20 August 2025, p 7; Fiona Davies, Transcript of evidence, 20 August 2025, p 41; Councillor Susannah Pearse, Mayor, Moree Plains Shire Council, Transcript of evidence, 22 August 2025, p 2; Susan Sargent, Transcript of evidence, 22 August 2025, p 19.

[31] Submission 67, Australian Medical Association (NSW), p 1; Fiona Davies, Transcript of evidence, 20 August 2025, p 41.

[32] Australian College for Emergency Medicine, *Position Statement: Ambulance Ramping and Diversion*, November 2022, 1 October 2025, p 3.

[33] Warren Isaac, Member, NSW Nurses and Midwives' Association, Transcript of evidence, 20 August 2025, p 11.

1.23 Some stakeholders reported long wait times for health services.[34] We also heard several examples of hospitals and EDs in the New England region not having doctors for varying periods of time,[35] and relying on locum and/or telehealth doctors.[36] Multiple inquiry participants noted that limited access to health services in the district's regions is impacted by workforce shortages. This issue is discussed in chapter two.

Long distance patient transfers and transport issues

1.24 Many stakeholders discussed patients travelling long distances for up to hundreds of kilometres to access health services, including maternity, specialised and emergency care.[37] There were reports of patients from the New England region needing to travel to John Hunter Hospital in Newcastle to receive healthcare, including when services at Tamworth Hospital were full or on bypass.[38]

1.25 Moree Plains Shire Council stated that its region relies heavily on John Hunter Hospital, which is about six hours away for patients from their community.[39] The Council and Narrabri Shire Council reported instances of double and triple 'diversions' when regional hospitals are on bypass, and patients are redirected to different hospitals before being admitted.[40]

1.26 Luke Sloane, Deputy Secretary of Rural and Regional Health at NSW Health, told us that if patients are transferred, it is to access higher level care that is related to their clinical acuity.[41]

1.27 Moree Plains Shire Council stated that for residents in Mungindi, Boggabilla and Toomelah, travelling over 600 kilometres to access care at John Hunter Hospital

---

[34] Submission 11, Name suppressed, p 1; Submission 16, Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association, p 1; Submission 55, Dr Eric Baker, pp 2-3; Christian Petersen, Founder and Program Manager, RiverBank Youth Works Ltd, Transcript of evidence, 12 August 2025, p 10.

[35] Submission 5, Miss Navanka Fletcher, p 1; Submission 11, Name suppressed, p 1; Submission 16, Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association, p 1; Submission 34, Karen Orman, p 1; Submission 62, Name suppressed, p 3; John Fogarty, Transcript of evidence, 12 August 2025, p 31; Councillor Susannah Pearse, Transcript of evidence, 22 August 2025, p 2.

[36] Submission 16, Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association, p 1.

[37] Submission 3, Mrs Diana Burtenshaw, p 1; Submission 5, Miss Navanka Fletcher, p 1; Submission 7, Mr Sid Brummell, p 1; Submission 60, Name suppressed, p 1; Submission 75, Australian Paramedics Association (NSW), p 1; Submission 86, Cancer Council NSW, p 2; Kate Kahl, Transcript of evidence, 12 August 2025, pp 17, 19; Leah Daley, Transcript of evidence, 12 August 2025, pp 26, 28; Heather Franke, Transcript of evidence, 13 August 2025, p 2; Emma Hardy, Transcript of evidence, 20 August 2025, p 7; Councillor Bronwyn Petrie, Transcript of evidence, 22 August 2025, p 8; Councillor Darrell Tiemens, Transcript of evidence, 22 August 2025, p 11.

[38] Submission 75, Australian Paramedics Association (NSW), p 1; Submission 85, Tamworth Regional Council, p 1; Leah Daley, Transcript of evidence, 12 August 2025, p 26; Councillor Tiffany Galvin, Transcript of evidence, 12 August 2025, p 28; Heather Franke, Transcript of evidence, 13 August 2025, p 2; Emma Hardy, Transcript of evidence, 20 August 2025, p 7; Councillor Susannah Pearse, Transcript of evidence, 22 August 2025, pp 2, 5; Councillor Darrell Tiemens, Transcript of evidence, 22 August 2025, p 11; Councillor Bronwyn Petrie, Transcript of evidence, 22 August 2025, p 13.

[39] Submission 101, Moree Plains Shire Council, p 1.

[40] Submission 101, Moree Plains Shire Council, p 1; Councillor Darrell Tiemens, Mayor, Narrabri Shire Council, Transcript of evidence, 22 August 2025, p 11.

[41] Luke Sloane, Deputy Secretary of Rural and Regional Health, NSW Health, Transcript of evidence, 22 August 2025, p 48.

in Newcastle hinders access to consistent support, follow up care and family.[42] The Council said that this contributes to poorer health outcomes and compounds 'existing rural and Indigenous disadvantage'.[43]

1.28 There were also perceptions that the Hunter New England LHD is working to centralise health services in Newcastle,[44] downgrade non-metropolitan hospitals,[45] or close remote hospitals.[46]

1.29 Stakeholders raised various issues related to patients being transferred and transported to non-local hospitals, such as:

- Patients having to make their own way home, including late at night and when there is limited public transport available.[47]
- Aboriginal patients being displaced from Country when they are transferred to locations far from home.[48]
- Increased pressure on ambulances, which are limited and not available to their community for emergencies when transferring patients between hospitals.[49]

1.30 Inquiry participants said that travelling long distances for healthcare is costly and has a financial impact on patients with socio-economic disadvantage, puts patients at risk, and delays treatment.[50]

1.31 Due to challenges with travelling long distances to access healthcare, we heard about cases of patients triaging themselves during medical emergencies, including to services interstate,[51] and being deterred from or unable to seek any care.[52]

1.32 NSW Health reported that the Hunter New England LHD is able to meet 90 per

[42] Submission 101, Moree Plains Shire Council, p 1.

[43] Submission 101, Moree Plains Shire Council, p 1.

[44] Submission 34, Ms Karen Orman, p 4.

[45] Councillor Bronwyn Petrie, Transcript of evidence, 22 August 2025, p 13.

[46] Submission 47, Mrs Amanda Brown, p 1.

[47] Submission 40, Wee Waa Aboriginal Land Council, p 1; Submission 51a, Name suppressed, p 1; Submission 60, Name suppressed, p 1; Robyn Keefe, Transcript of evidence, 12 August 2025, p 2; Clifford Toomey, Transcript of evidence, 12 August 2025, p 2; Councillor Susannah Pearse, Transcript of evidence, 22 August 2025, pp 2, 5; Councillor Greg Sauer, Deputy Mayor, Tenterfield Shire Council, Transcript of evidence, 22 August 2025, p 9; Answers to supplementary questions, Edward Stubbins, 24 August 2025, p 2.

[48] Clifford Toomey, Transcript of evidence, 12 August 2025, p 2.

[49] Andrew Bowen, Transcript of evidence, 12 August 2025, p 12; Kate Kahl, Transcript of evidence, 12 August 2025, p 21; Reece Fredericks, Executive Committee Member, Australian Paramedics Association (NSW), Transcript of evidence, 20 August 2025, p 32; Answers to supplementary questions, Save Wee Waa Hospital Committee, 26 August 2025, p 1.

[50] Submission 32, Country Women's Association of NSW, p 3; Submission 83, Ron Thorp, p 1; Submission 101, Moree Plains Shire Council, p 1; Councillor Susannah Pearse, Transcript of evidence, 22 August 2025, p 5.

[51] Daniel Kahl, Member, Business Manager and Director, Merced Farming Pty Ltd, Transcript of evidence, 12 August 2025, p 34; Councillor Bronwyn Petrie, Transcript of evidence, 22 August 2025, p 11.

[52] Submission 40, Wee Waa Aboriginal Land Council, p 1; Carmel Schwager, Member, Save Wee Waa Hospital Committee, Transcript of evidence, 12 August 2025, p 18; Councillor Tiffany Galvin, Transcript of evidence, 12 August 2025, p 28.

cent of its population's public healthcare demand, with a fraction of patients receiving treatment in the Central Coast LHD (two per cent) and the Sydney Children's Hospital Network (one per cent). NSW Health noted that this is higher than other districts. For example, 88 and 87 per cent of public healthcare demand is met in the Western NSW and Illawarra Shoalhaven LHDs, respectively.[53]

1.33 NSW Health indicated that the New England North West region can also meet patient demand with 83 per cent of Tamworth and Armidale residents being treated at their local hospitals. Six per cent of New England patients require health services from John Hunter Hospital in Newcastle.[54]

Community concerns about telehealth services

1.34 Some stakeholders expressed concern about the limitations of telehealth services at regional and rural hospitals in the district, including:

- Instances of telehealth doctors being unable to diagnose patients, resulting in misdiagnoses or patients having to travel long distances to a different hospital for examination.[55]
- Metropolitan-based telehealth doctors having a limited understanding of regional communities.[56]
- Poor connectivity limiting access to this type of service.[57]

1.35 We heard that there is a low public perception of telehealth services, and people may avoid presenting at a hospital if they know that only telehealth services are available.[58]

1.36 However, we were also told that telehealth is useful,[59] may be adequate when used for follow-up, not initial, consultations,[60] and can decrease travel for patients to access specialised health services.[61]

Reduced operating hours for Wee Waa Hospital

1.37 Wee Waa is a rural town in northern NSW with a population of 2,034 – 19.2 per cent of which identifies as Aboriginal and/or Torres Strait Islander.[62] In May 2023, the Hunter New England LHD reduced Wee Waa Hospital's operating hours from

[53] Submission 31, NSW Health, p 2.

[54] Submission 31, NSW Health, p 2.

[55] Submission 5, Miss Navanka Fletcher, p 1; Submission 51, Name suppressed, p 1; Robyn Keefe, Transcript of evidence, 12 August 2025, p 4; Daniel Kahl, Transcript of evidence, 12 August 2025, p 32.

[56] Submission 20, Name suppressed, p 1; Dr Ian Kamerman, Secretary, Rural Doctors Association of NSW, Transcript of evidence, 20 August 2025, p 45.

[57] Bronwyn Dunston, Transcript of evidence, 20 August 2025, p 16; Councillor Susannah Pearse, Transcript of evidence, 22 August 2025, p 2.

[58] Daniel Kahl, Transcript of evidence, 12 August 2025, p 32; Jonathon Phelps, President, NSW Farmers Association, Wee Waa Branch, Transcript of evidence, 12 August 2025, p 32.

[59] Edward Stubbins, Transcript of evidence, 13 August 2025, p 3.

[60] John Fogarty, Transcript of evidence, 12 August 2025, p 32; Richard Schwager, Transcript of evidence, 12 August 2025, p 32.

[61] Dr Michelle Guppy, Transcript of evidence, 13 August 2025, p 4.

[62] Australian Bureau of Statistics, Wee Waa: 2021 Census All Persons QuickStats, viewed 24 September 2025.

24 hours to 8 am to 5:30 pm daily.[63] NSW Health stated that this was 'to ensure ongoing safe patient care'.[64] In the twelve months before this change, 1,494 patients presented to the hospital's ED – an average of 4.1 patients per day.[65]

1.38 We heard from many stakeholders who were against this decision[66] and argued that because of reduced health services:

- Wee Waa residents are relocating for better healthcare.[67]
- Residents have to travel out of town to other hospitals, which prevents access to healthcare due to dangerous conditions such as rough terrain, wildlife encounters,[68] flooding,[69] and limited public transport.[70]
- Ambulance services are stretched with limited availability.[71]
- Services have continued to decline[72] and there is a greater reliance on telehealth due to limited or no doctors at the hospital.[73]

Benefits of current health service delivery model

1.39 NSW Health stated that the district's current model enables the operational and effective delivery of inpatient, community based, and population health services.[74]

---

[63] NSW Health, Wee Waa Health Service | NSW Government, viewed 24 September 2025.

[64] Answers to supplementary questions, NSW Health, 23 September 2025, p 3.

[65] Answers to supplementary questions, NSW Health, 23 September 2025, p 3.

[66] Submission 35, Jenny Hatton, p 1; Submission 53, Kate Knight, p 1; Submission 54, Name suppressed, p 1; Submission 59, Oddette Avery, p 1; Submission 60, Name suppressed, p 1; Submission 65, Sonia Fogarty, pp 1-3; Submission 67, Australian Medical Association (NSW), p 1; Submission 68, Name suppressed, p 1; Submission 76, Narrabri Shire Council, pp 2-3; Submission 82, Merced Farming, p 1; Submission 89, Wee Waa Chamber of Commerce, p 1; Submission 93, John Fogarty, pp 1-2; Submission 94, NSW Farmers Association, Wee Waa Branch, pp 1-2; Submission 95, Save Wee Waa Hospital Committee, p 1; Submission 96, RiverBank Youth Works Ltd, p 1; Submission 97, Peter Carrett, pp 1-2; Submission 102, Australian Food and Fibre, p 1; Kate Kahl, Transcript of evidence, 12 August 2025, p 17.

[67] Submission 17, Name suppressed, p 1; Submission 46, Kathleen Denniss, p 1; Submission 59, Oddette Avery, p 1; Ethan Towns, Narrabri Shire Council, Transcript of evidence, 22 August 2025, p 12.

[68] Submission 60, Name suppressed, p 1; Submission 65, Sonia Fogarty, p 3; Submission 73, Wee Waa Hospital Auxiliary, p 1; Robyn Keefe, Transcript of evidence, 12 August 2025, p 3; Andrew Bowen, Transcript of evidence, 12 August 2025, 12.

[69] Submission 65, Sonia Fogarty, p 3; Submission 68, Name suppressed, p 1; ; Submission 76, Narrabri Shire Council, pp 2-3; Submission 95, Save Wee Waa Hospital Committee, pp 3-4; Submission 97, Peter Carrett, p 7; Carmel Schwager, Transcript of evidence, 12 August 2025, p 18;

[70] Submission 65, Sonia Fogarty, p 2; Submission 93, John Fogarty, pp 1-2; Submission 94, NSW Farmers Association, Wee Waa Branch, p 2.; Submission 96, RiverBank Youth Works Ltd, p 1; Submission 40, Wee Waa Aboriginal Land Council, p 1; Anne Weekes, Wee Waa Hospital Auxiliary, Transcript of evidence, 12 August 2025, pp 16, 19; Robyn Keefe, Transcript of evidence, 12 August 2025, pp 1, 2.

[71] Submission 94, NSW Farmers Association, Wee Waa Branch, p 2; Submission 95, Save Wee Waa Hospital Committee, pp 7-8; Submission 96, RiverBank Youth Works Ltd, p 1; Submission 97, Peter Carrett, p 1; Answers to supplementary questions, Save Wee Waa Hospital Committee, 26 August 2025, p 1.

[72] Submission 68, Name suppressed, p 1; Submission 94, NSW Farmers Association – Wee Waa Branch, p 1; Submission 95, Save Wee Waa Hospital Committee, p 2, 3; Submission 97, Peter Carrett, p 2.

[73] Submission 65, Sonia Fogarty, p 1; Submission 76, Narrabri Shire Council, p 16; Submission 95, Save Wee Waa Hospital Committee, p 3.

[74] Submission 31, NSW Health, p 2; Luke Sloane, Transcript of evidence, 22 August 2025, p 38.

1.40 The Hunter New England LHD said that it provides various specialist, outreach and virtual care services for patients, including:

- Outreach programs delivered in partnership with Aboriginal Medical Services, such as Little Ears, Deadly Care, a service that improves access to specialised ear, nose and throat care for Aboriginal children.
- Outreach oncology and cardiology services.
- Virtual stroke outpatient clinics.
- virtualKIDS, a statewide telehealth service for paediatric care that has predominant uptake in the district.[75]

1.41 Some stakeholders agreed that the district's current model enables crucial access to various outreach, outpatient, telehealth and specialist services, and to John Hunter Hospital as a tertiary, quaternary-level hospital and trauma centre.[76]

1.42 Some inquiry participants highlighted positives examples of health service delivery in the district, including for maternity care and outreach services.[77] For example, the AMA NSW referred to the John Hunter Hospital M3Team – a virtual clinic for women in the district who need specialised or higher-level maternity care.[78] We also heard that the district has recently been more responsive to local needs.[79]

Impact on health services and outcomes

1.43 There were differing views on whether passing the Bill would improve health equity and access to healthcare.

1.44 We heard that there is disparity in the district's facilities,[80] patient treatment outcomes,[81] and health services.[82] Some stakeholders indicated that this disparity exists between the Hunter and New England North West/inland regions.[83]

1.45 A number of inquiry participants with different positions on the Bill called for

[75] Submission 30, Hunter New England Local Health District, pp 5, 6, 10; Dr Paul Craven, Executive Director for Children and Young People and Families, Hunter New England Local Health District, Transcript of evidence, 22 August 2025, pp 44, 49; Dr Elizabeth Grist, Executive Director of Clinical Services and Nursing and Midwifery, Hunter New England Local Health District, Transcript of evidence, 22 August 2025, p 50.

[76] Submission 57, ACON, p 2; Submission 67, Australian Medical Association (NSW), p 3; Submission 91, Aboriginal Health and Medical Research Council of NSW, p 4; Dr Ian Kamerman, Transcript of evidence, 20 August 2025, p 47.

[77] Submission 57, ACON, p 3; Submission 77, NSW Nurses and Midwives' Association, p 5; Submission 98, Hunter Medical Research Institute, p 3; Dr Michelle Guppy, Transcript of evidence, 13 August 2025, p 4; Warren Isaac, Transcript of evidence, 20 August 2025, p 11; Dr Tania Day, Chair, Training and Accreditation Committee, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Transcript of evidence, 20 August 2025, p 35; Professor Frances Kay, Chief Executive Officer and Institute Director, Hunter Medical Research Institute, Transcript of evidence, 22 August 2025, p 24.

[78] Submission 67, Australian Medical Association (NSW), p 3.

[79] Dr Michelle Guppy, Transcript of evidence, 13 August 2025, p 5.

[80] Fiona Davies, Transcript of evidence, 20 August 2025, p 46.

[81] Submission 75, Australian Paramedics Association (NSW), p 1.

[82] Submission 27, Tenterfield Shire Council, p 2.

[83] Submission 27, Tenterfield Shire Council, p 2; Submission 75, Australian Paramedics Association (NSW), p 1.

health equity,[84] and suggested ways to improve outcomes for regional communities, the district or healthcare more broadly.[85]

Creating a structure that meets local communities' needs

1.46 Some stakeholders outlined a connection between the district's structure and worse outcomes for communities. There were concerns that:

- the district is 'not fit for purpose'[86] and disadvantages rural hospitals[87]
- its size causes poorer health outcomes[88]
- keeping the current structure will mean that health services continue to decline.[89]

1.47 We heard that creating a New England North West district would mean local decision making,[90] and restoring some control over health service provision to communities.[91]

1.48 Some inquiry participants asserted that the Hunter New England LHD does not appear to understand,[92] or is unable to adequately meet the health needs of remote, rural and regional communities.[93] Several stakeholders hoped or were of the view that a separate New England North West district would improve outcomes for communities by establishing an organisation that can better understand and serve local health needs.[94] Meeting the needs of local communities is discussed in detail in chapter four.

1.49 We heard perspectives that a new district would lead to policies and procedures

[84] Submission 55, Dr Eric Baker, p 3; Submission 58, NSW Council of Social Service, pp 1-2; Bronwyn Dunston, Transcript of evidence, 20 August 2025, p 18; Sandy Harrison, Country Women's Association, Murrurundi Branch, Transcript of evidence, 20 August 2025, p 18; Bradley Gellert, Manager, Policy and Advocacy, Cancer Council NSW, Transcript of evidence, 20 August 2025, p 22.

[85] For example: Ben McAlpine, Transcript of evidence, 20 August 2025, pp 1-2; Bradley Gellert, Transcript of evidence, 20 August 2025, pp 23-24; Reece Fredericks, Transcript of evidence, 20 August 2025, p 32; Fiona Davies, Transcript of evidence, 20 August 2025, pp 42, 45; Dr Ian Kamerman, Transcript of evidence, 20 August 2025, p 45; Councillor Susannah Pearse, Transcript of evidence, 22 August 2025, p 6; Councillor Bronwyn Petrie, Transcript of evidence, 22 August 2025, p 11; Dr Eric Baker, Transcript of evidence, 22 August 2025, p 16; Dr Michelle Guppy, Head of School, School of Rural Medicine, University of New England, Transcript of evidence, 22 August 2025, p 29; Dr David Scott, Chair, Tamworth Medical Staff Council, Transcript of evidence, 22 August 2025, p 32.

[86] Submission 89, Wee Waa Chamber of Commerce, p 1; Submission 95; Save Wee Waa Hospital Committee, pp 2, 14.

[87] Submission 11, Name suppressed, p 1.

[88] Submission 76, Narrabri Shire Council, p 2.

[89] Submission 94, NSW Farmers Association - Wee Waa Branch, p 2.

[90] Daniel Kahl, Transcript of evidence, 12 August 2025, p 37; Councillor Tiffany Galvin, Transcript of evidence, 12 August 2025, p 24.

[91] Submission 81, Gwydir Shire Council, p 1.

[92] Submission 8, Name suppressed, p 1.

[93] Submission 89, Wee Waa Chamber of Commerce, p 2; Submission 102, Australian Food & Fibre, p 1.

[94] Submission 8, Name suppressed, p 1; Submission 29, Mr Brian Leslie, p 1; Submission 82, Merced Farming Pty Ltd, p 1; Submission 93, Mr John Fogarty, p 2; Submission 96, RiverBank Youth Works Ltd, p 1; Submission 102, Australian Food & Fibre, p 1; Robyn Keefe, Transcript of evidence, 12 August 2025, p 6.

that are more aligned to rural and remote needs,[95] improved and tailored health service delivery,[96] and better use of underutilised health facilities.[97]

Strengthening local services

1.50 Some stakeholders from Wee Waa argued that enacting the Bill would restore regional health services, including 24/7 care and services that have been removed like maternity care.[98]

1.51 Kate Kahl, a member of the Save Wee Waa Hospital Committee, said that if health management improved, the capability of rural hospitals in the district would be increased. She explained that by providing hospital care locally the need for patient travel would be reduced and pressure on the broader health system and larger hospitals, like Tamworth Hospital, would be relieved.[99]

1.52 We were also told that passing the Bill would allow regional parts of the district to attract specialists and doctors.[100] While noting some concerns about the proposed separation, HealthWISE members from the New England and North West region emphasised that the split could be an opportunity to improve the availability of specialists.[101]

Disrupting clinical pathways and further limiting access to services

1.53 The Hunter New England LHD stated that it operates as an integrated network, ensuring patients across its expansive region have access to 'safe, timely and coordinated' care.[102] The LHD said that its model supports patient flow through structured referral pathways and shared clinical services across multiple areas of healthcare, including maternity, emergency and cancer care.[103]

1.54 The Hunter New England LHD submitted that its model provides access to complex and high-risk care, especially for vulnerable populations.[104] The LHD said that its delivery of specialist and outreach services is dependent on district-wide coordinated planning and the scale, infrastructure and clinical leadership of central health facilities like John Hunter Hospital and John Hunter Children's Hospital.[105]

1.55 The Hunter New England LHD warned that splitting the district would cause significant fragmentation and reduce the quality and consistency of healthcare by:

---

[95] Submission 8, Name suppressed, p 1.

[96] Submission 82, Merced Farming Pty Ltd, p 1.

[97] Submission 83, Ron Thorp, p 1.

[98] Submission 95, Save Wee Waa Hospital Committee, p 1; Robyn Keefe, Transcript of evidence, 12 August 2025, p 6.

[99] Kate Kahl, Transcript of evidence, 12 August 2025, pp 18, 21-22.

[100] Submission 8, Name suppressed, p 1.

[101] Submission 61, HealthWISE, p 2.

[102] Submission 30, Hunter New England Local Health District, p 5.

[103] Submission 30, Hunter New England Local Health District, p 5.

[104] Submission 30, Hunter New England Local Health District, p 6.

[105] Submission 30, Hunter New England Local Health District, p 6.

- disrupting referral and escalation pathways
- delaying access to specialist health services
- duplicating clinical governance structures and virtual care
- compromising coordinated clinical service planning and workforce flexibility.[106]

1.56 The Hunter New England LHD stated that fragmentation could impact outcomes for patients in the proposed New England North West district who need urgent medical attention, as it would impede timely access to John Hunter Hospital's retrieval teams and specialist trauma consultation.[107]

1.57 NSW Health observed that if the district separated, networked arrangements across district boundaries would be more difficult and the New England North West district would not have local access to cardiac, neurology or plastic surgery.[108] The Hunter New England LHD warned us that it would take years to re-establish current systems and services.[109]

1.58 Some inquiry participants had similar concerns that a split would cause or risk fragmentation,[110] and disrupt existing clinical networks and referral pathways.[111] Stakeholders expressed concern that separating the district would create additional barriers to healthcare,[112] and impact or risk reducing its accessibility.[113]

Impact on Tamworth Hospital and health disparities

1.59 We heard that a connection to John Hunter Hospital and Newcastle is beneficial and/or necessary for communities and healthcare staff in the district.[114] Stakeholders foreshadowed that if the district was split, the New England North West district would not have a tertiary referral centre as John Hunter Hospital would not be in its boundaries.[115]

1.60 Stakeholders said that this would mean high risk and high acuity patients in the New England North West would have to be transferred to a different district or to

[106] Submission 30, Hunter New England Local Health District, p 5.

[107] Submission 30, Hunter New England Local Health District, p 5.

[108] Submission 31, NSW Health, p 3.

[109] Submission 30, Hunter New England Local Health District, pp 5-6.

[110] Submission 56, Ms Susan Sargent, pp 2-3; Submission 67, Australian Medical Association (NSW), p 3; Submission 91, Aboriginal Health and Medical Research Council of NSW, p 5.

[111] Submission 67, Australian Medical Association (NSW), pp 1, 3; Submission 91, Aboriginal Health and Medical Research Council of NSW, p 5; Submission 100, Rural Doctors Association of NSW, pp 1, 3.

[112] Submission 71, Australian Salaried Medical Officer's Federation NSW, p 8.

[113] Submission 67, Australian Medical Association (NSW), p 1; Submission 56, Ms Susan Sargent, p 3; Submission 57, ACON, p 2.

[114] Submission 104, New England Division of General Practice, p 1; Councillor Russell Webb, Transcript of evidence, 13 August 2025, p 14; Reece Fredericks, Transcript of evidence, 20 August 2025, p 29; Dr Ian Kamerman, Transcript of evidence, 20 August 2025, p 47; Councillor Susannah Pearse, Transcript of evidence, 22 August 2025, p 2.

[115] Submission 56, Ms Susan Sargent, p 3; Submission 67, Australian Medical Association (NSW), p 2; Submission 77, NSW Nurses and Midwives' Association, p 5; Submission 91, Aboriginal Health and Medical Research Council of NSW, pp 4-5; Fiona Davies, Transcript of evidence, 20 August 2025, p 41.

Tamworth, which would be the largest hospital in their district.[116] We were warned there would be more pressure on Tamworth Hospital, which is already impacted by critical staffing shortages,[117] and does not have the full capability of a district's 'flagship' hospital or tertiary referral centre.[118]

1.61 We were told that separating the district would have significant consequences for communities,[119] particularly for residents in the New England North West region.[120]

1.62 The Aboriginal Health and Medical Research Council of NSW (AH&MRC) submitted that without increasing the capability of Tamworth Hospital, the proposed shift could raise clinical risk and put more pressure on an overburdened workforce.[121] The AH&MRC cautioned that the discrepancy between the hospital's capacity and patient needs is 'likely to widen health disparities and undermine the quality of care' for residents in the proposed New England North West district.[122]

1.63 Others raised similar concerns about the impact of a separation on regional residents.[123] Health unions cautioned that New England hospital services would be severely impacted,[124] and patient care and access to specialists in the regions would be impaired.[125] The AMA NSW submitted that coordinated outpatient and outreach services delivered by John Hunter Hospital and John Hunter Children's Hospital would be restricted.[126]

Risks for referral pathways and patient transfers

1.64 Some stakeholders stated that if the district separated there would be a need to safeguard communities by ensuring that patient referral pathways and telehealth support from tertiary hospitals were established and maintained.[127] We also heard that the funding and capability of hospital services in the New England

[116] Submission 71, Australian Salaried Medical Officer's Federation NSW, p 8; Submission 77, NSW Nurses and Midwives' Association, p 5; Submission 91, Aboriginal Health and Medical Research Council of NSW, p 5; Emma Hardy, Transcript of evidence, 20 August 2025, p 7.

[117] Submission 77, NSW Nurses and Midwives' Association, p 5.

[118] Submission 75, Australian Paramedics Association (NSW), p 2; Submission 91, Aboriginal Health and Medical Research Council of NSW, p 4.

[119] Submission 67, Australian Medical Association (NSW), p 1.

[120] Submission 16, Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association, p 1; Submission 71, Australian Salaried Medical Officer's Federation NSW, p 10; Submission 91, Aboriginal Health and Medical Research Council of NSW, p 5.

[121] Submission 91, Aboriginal Health and Medical Research Council of NSW, p 5.

[122] Submission 91, Aboriginal Health and Medical Research Council of NSW, p 5.

[123] Submission 16, Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association, p 1; Submission 71, Australian Salaried Medical Officer's Federation NSW, p 10; Reece Fredericks, Transcript of evidence, 20 August 2025, p 29.

[124] Submission 16, Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association, p 1.

[125] Submission 71, Australian Salaried Medical Officer's Federation NSW, p 10.

[126] Submission 67, Australian Medical Association (NSW), p 2.

[127] Submission 63, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, pp 1-2; Ben McAlpine, Transcript of evidence, 20 August 2025, p 3.

North West should be increased.[128]

1.65 Inquiry participants raised the following risks with developing health services in the New England region and cross district transfers:

- The Bill does not guarantee, or is unclear about, planned improvements to New England health services.[129]
- Establishing new health services will be redundant if they cannot be staffed.[130]
- Tamworth Hospital, due to its population size and limited funding and staff, will never be equipped to deliver highly specialised, tertiary services and there will be an ongoing need to refer out.[131]
- Patient transfers will be more difficult if transferring across districts.[132]

1.66 The Australian Salaried Medical Officers Federation of NSW (ASMOF) noted that John Hunter Hospital currently has a responsibility to accept patients from the New England region, even when it has limited capacity.[133] ASMOF members expressed concern about the 'loss of a collaborative spirit' between the two proposed districts and feared that new referral sites for the region could be an even greater distance away, necessitating further travel for patients.[134]

1.67 Professor Michelle Guppy, Secretary and Treasurer of the New England Division of General Practice, told us that referring patients to another district places patients at 'square one' and the 'bottom of the list' and will add complexity to referral pathways.[135]

1.68 While we were told that referral pathways across districts already exist,[136] Fiona Davies, Chief Executive Officer, AMA NSW, expressed concern that districts without tertiary hospitals struggle to operate self-sufficiently.[137] She noted that 25 per cent of patients in the Southern NSW Local Health District have to travel to the ACT for health services, as that district does not have level 6 tertiary adult or children's hospitals.[138]

---

[128] Coda Danu-Asmara, Senior Industrial Officer, Australian Paramedics Association (NSW), Transcript of evidence, 20 August 2025, pp 28-29.

[129] Submission 71, Australian Salaried Medical Officer's Federation NSW, p 8; Submission 75, Australian Paramedics Association (NSW), p 2.

[130] Submission 71, Australian Salaried Medical Officer's Federation NSW, p 8.

[131] Dr Michelle Guppy, Transcript of evidence, 13 August 2025, p 2; Dr Tony Sara, Secretary, Australian Salaried Medical Officers Federation NSW, Transcript of evidence, 20 August 2025, pp 27, 29.

[132] Susan Sargent, Transcript of evidence, 22 August 2025, p 19.

[133] Dr Tony Sara, Transcript of evidence, 20 August 2025, p 27.

[134] Submission 71, Australian Salaried Medical Officer's Federation NSW, pp 8, 10.

[135] Dr Michelle Guppy, Transcript of evidence, 13 August 2025, pp 4, 8.

[136] Councillor Bronwyn Petrie, Transcript of evidence, 22 August 2025, p 11; Dr David Scott, Transcript of evidence, 22 August 2025, p 34.

[137] Fiona Davies, Transcript of evidence, 20 August 2025, p 41.

[138] Fiona Davies, Transcript of evidence, 20 August 2025, p 41.

Inconsistent outcomes for Aboriginal communities

1.69 The AH&MRC submitted that separating the district would have 'uneven consequences' for Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal communities in the region.[139]

1.70 The AH&MRC stated that ACCHOs in southern and central areas of the district, such as Tamworth and parts of Armidale, would likely be negatively impacted as they depend on access to specialist and tertiary services in Newcastle.[140] ACCHOs in the New England North West region would no longer be directly aligned with John Hunter Hospital and referral relationships with specialist units would be disrupted, potentially causing delays for Aboriginal patients.[141]

1.71 In contrast, AH&MRC said ACCHOs based in the district's far west, like Moree and Tenterfield, have less affiliation to Newcastle and could benefit from a locally responsive administrative model.[142]

1.72 NCOSS and the Hunter New England LHD agreed that administrative change to the district could undermine access for Aboriginal communities.[143] NSW Health stated that it would take time and resources to rebuild community trust and duplicate current programs and infrastructure for these communities.[144]

1.73 The AH&MRC argued that significant investment to upgrade local health infrastructure and service capacity should be made before any structural change is considered.[145] They stressed that a split would likely result in strain on ACCHOs, and that without a tailored approach and safeguards, a separation would risk 'deepening inequities'.[146]

Other ways to improve health outcomes and service delivery

1.74 We heard that it is not clear how administrative and structural changes to the district will improve service levels,[147] and address workforce issues.[148] The Country Women's Association of NSW said that reform should be evidence-based and structural change should not progress unless it is proven to provide better health outcomes and access to services, and address workforce challenges.[149]

1.75 A number of stakeholders argued separating the district does not, or is unlikely to

[139] Submission 91, Aboriginal Health and Medical Research Council of NSW, p 3.

[140] Submission 91, Aboriginal Health and Medical Research Council of NSW, pp 3-4.

[141] Submission 91, Aboriginal Health and Medical Research Council of NSW, p 5.

[142] Submission 91, Aboriginal Health and Medical Research Council of NSW, p 4.

[143] Ben McAlpine, Transcript of evidence, 20 August 2025, pp 3-4; Submission 30, Hunter New England Local Health District, p 10.

[144] Answers to supplementary questions, NSW Health, 23 September 2025, p 2.

[145] Submission 91, Aboriginal Health and Medical Research Council of NSW, p 3.

[146] Submission 91, Aboriginal Health and Medical Research Council of NSW, pp 4-5.

[147] Submission 80, Inverell Shire Council, p 1.

[148] Dr Michelle Guppy, Transcript of evidence, 13 August 2025, p 2.

[149] Submission 32, Country Women's Association of NSW, p 2.

address,[150] and will exacerbate,[151] broader underlying challenges facing the health system, such as workforce shortages. To improve outcomes and healthcare delivery in the region, stakeholders called for these issues to be addressed as a priority.[152]

1.76 Mr Ben McAlpine said that while separating the district may address some of the district's health challenges through local administration, the disruption and cost involved could undermine the outcomes it seeks to achieve.[153] He observed that prioritising more targeted solutions to existing issues (for example, healthcare accessibility) 'will more efficiently and quickly improve health outcomes for everyone across the region'.[154]

[150] Submission 56, Ms Susan Sargent, p 3; Submission 71, Australian Salaried Medical Officer's Federation NSW, p 10; Submission 105, School of Rural Medicine University of New England, p 1; Bronwyn Dunston, Transcript of evidence, 20 August 2025, p 19; Fiona Davies, Transcript of evidence, 20 August 2025, p 41; Susan Sargent, Transcript of evidence, 22 August 2025, p 19.

[151] Submission 67, Australian Medical Association (NSW), p 1.

[152] Submission 67, Australian Medical Association (NSW), p 2; Submission 105, School of Rural Medicine, University of New England, p 1; Emma Hardy, Transcript of evidence, 20 August 2025, p 7; Susan Sargent, Transcript of evidence, 22 August 2025, p 19; Dr Michelle Guppy, Transcript of evidence, 22 August 2025, p 23.

[153] Ben McAlpine, Transcript of evidence, 20 August 2025, pp 1-2.

[154] Ben McAlpine, Transcript of evidence, 20 August 2025, p 1.

Chapter Two – Workforce shortage and recruitment

Summary

NSW is experiencing a shortage of health and medical professionals. This is impacting the provision of services in the Hunter New England LHD. Some inquiry participants argued that the workforce shortage and challenges may be addressed by splitting the Hunter New England LHD. However, most were concerned that a split would worsen the workforce shortage in the region. Some stakeholders noted that splitting the district could negatively affect the conduct of medical research.

Impact of statewide workforce shortage

2.1 We heard that the NSW health system is experiencing clinical workforce shortages.[155] Described by inquiry participants as a crisis, these shortages are especially pronounced in rural and remote areas.[156]

2.2 Many inquiry participants raised the issue of workforce shortages in the Hunter New England LHD.[157] Some stakeholders said workforce shortages limit access to local,[158] timely, and quality care.[159]

2.3 NSW Health acknowledged the challenges in recruiting and retaining clinical staff, and the Hunter New England LHD highlighted workforce shortages as its most pressing challenge.[160] We heard that as of 22 August 2025, the Hunter New

[155] Submission 67, Australian Medical Association (NSW) p 2; Submission 76, Narrabri Shire Council, p 13; Submission 105, School of Rural Medicine University of New England, p 1; Submission 106, Mr Edward Stubbins, p 1; Andrew Bowden, Secretary and Treasurer, Wee Waa Chamber of Commerce, Transcript of evidence, 12 August 2025, p 13; Cr Tiffany Galvin, Mayor, Gwydir Shire Council, Transcript of evidence, 12 August 2025, p 25; Heather Franke, Secretary and Delegate, Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association, Transcript of evidence, 13 August 2025, p 2; Bronwyn Dunston, State Secretary, Country Women's Association of NSW, Transcript of evidence, 20 August 2025, p 19; Dr Tony Sara, Secretary, Australian Salaried Medical Officers Federation NSW, Transcript of evidence, 20 August 2025, p 29; Dr Tania Day, Chair, Training and Accreditation Committee, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Transcript of evidence, 20 August 2025, p 34; Fiona Davies, Chief Executive Officer, Australian Medical Association (NSW), Transcript of evidence, 20 August 2025, p 41.

[156] Heather Franke, Transcript of evidence, 13 August 2025, p 2; Fiona Davies, Transcript of evidence, 20 August 2025, p 41.

[157] Submission 5, Miss Navanka Fletcher, p 1; Submission 11, Name suppressed, p 1; Submission 27, Tenterfield Shire Council, p 2; Submission 77, NSW Nurses and Midwives' Association, p 5; Submission 79, Uralla Shire Council p 1; Submission 92, Name suppressed, p 1; Submission 95, Save Wee Waa Hospital Committee, p 3; Submission 100, Rural Doctors Association of NSW, p 2; Submission 101, Moree Plains Shire Council p 1; Cr Tiffany Galvin, Transcript of evidence, 12 August 2025, p 25; Bronwyn Dunston, Transcript of evidence, 20 August 2025, p 14; Cr Susannah Pearse, Mayor, Moree Plains Shire Council, Transcript of evidence, 22 August 2025, p 2.

[158] Submission 11, Name suppressed, p 1; Submission 20, Name suppressed, p 1; Submission 68, Name suppressed, p 1; Submission 83, Ron Thorp, p 1.

[159] Submission 32, Country Women's Association of NSW, pp 2-3; Submission 87, Name suppressed, p 1.

[160] Submission 30, Hunter New England Local Health District, p 3; Submission 31, NSW Health, p 4.

England LHD was recruiting to fill 150 vacancies.[161]

2.4 Some stakeholders said that splitting the district may address the region's clinical workforce shortage.[162] The Save Wee Waa Hospital Committee suggested that while the clinical workforce shortage is a statewide problem, it could be addressed in New England North West through a region specific approach.[163] They attributed the understaffing in-part to managerial issues and the distance of the Newcastle based administration.[164]

2.5 However, several inquiry participants considered that splitting the district would not address the clinical workforce shortage.[165] This view was held by some stakeholders that both supported and opposed the Bill. For example, Narrabri Shire Council supported splitting the district, while acknowledging that rural areas will not attract health professionals if career and life opportunities are not incentivised.[166]

2.6 Stakeholders opposed to splitting the district argued that it would exacerbate the clinical workforce crisis.[167] NSW Health submitted that the loss of the district's networked and outreached models of care would reduce service provision for rural and regional communities in its catchment, and increase reliance on agencies and locums.[168]

2.7 The Aboriginal Health & Medical Research Council of NSW (AH&MRC) stated that splitting the district would put a strain on local Aboriginal Community Controlled Health Organisations (ACCHOs) who may have to provide complex care locally without more workforce support. This would increase the risk of burnout and staff turnover, compounding the workforce shortage.[169]

2.8 Inquiry participants called for resources to address the clinical workforce shortage, rather than splitting the district.[170] Others saw addressing the clinical workforce shortage as a prerequisite to splitting the district.[171]

2.9 The Australian Medical Association (NSW) (AMA NSW) highlighted the disparity

---

[161] Tracey McCosker, Chief Executive, Hunter New England Local Health District, Transcript of evidence, 22 August 2025, p 40.

[162];Submission 83, Ron Thorp, p 1; Submission 95, Save Wee Waa Hospital Committee, pp 12-13, 16.

[163] Submission 95, Save Wee Waa Hospital Committee, p 18.

[164] Submission 95, Save Wee Waa Hospital Committee, pp 12-13.

[165] Submission 31, NSW Health, p 4; Submission 67, Australian Medical Association (NSW), p 3; Submission 71, Australian Salaried Medical Officer's Federation (ASMOF) NSW, p 5; Submission 100, Rural Doctors Association of NSW, p 2; Submission 105, School of Rural Medicine University of New England, p 1; Submission 106, Mr Edward Stubbins, p 1; Bronwyn Dunston, Transcript of evidence, 20 August 2025, p 19; Fiona Davies, Transcript of evidence, 20 August 2025, p 41; Dr Michelle Guppy, Head of School, School of Rural Medicine, University of New England, Transcript of evidence, 22 August 2025, pp 27-28.

[166] Submission 76, Narrabri Shire Council pp 3-4.

[167] Submission 31, NSW Health, p 4; Submission 67, Australian Medical Association (NSW), p 3; Submission 71, Australian Salaried Medical Officer's Federation (ASMOF) NSW, p 5.

[168] Submission 31, NSW Health, p 4.

[169] Submission 91, Aboriginal Health and Medical Research Council of NSW, p 5.

[170] Submission 79, Uralla Shire Council, p 2; Submission 106, Mr Edward Stubbins, p 1.

[171] Submission 91, Aboriginal Health and Medical Research Council of NSW, p 8; Submission 101, Moree Plains Shire, p 2.

between the rural and remote population and medical workforce supply. Twenty-five per cent of the state's population lives in rural and remote areas, while these areas contain only 22 per cent of the state's general practitioner full-time equivalent workforce. The disparity is greater for non-GP specialists, with only 14 per cent in rural and remote areas.[172]

2.10 Fiona Davies, Chief Executive Officer, AMA NSW, said that workforce shortages, which are common in rural and regional areas, increase demands placed on individual staff:

> … New South Wales needs to deliver 40 per cent more activity per worker to meet forecast needs, and the workforce gap is estimated at nearly 6,000 practitioners. Workforce shortages are particularly prevalent across rural and regional areas, to which Hunter New England Local Health District is not exempt.[173]

2.11 The clinical workforce shortage has been observed by previous parliamentary inquires. In 2022, Portfolio Committee No 2 (PC2) found that 'there is a critical shortage of health professionals across rural, regional and remote communities resulting in staffing deficiencies in hospitals and health services'.[174]

2.12 The Select Committee on Remote, Rural and Regional Health reviewed the implementation of PC2's recommendations in 2024, concluding that significant shortfalls still exist in remote, rural and regional areas including in primary care, Emergency Department staff, midwives, obstetricians and GP proceduralists.[175]

Shortages of specific health and medical professionals

2.13 We heard about the impact of shortages of specific medical professionals in the district. Inquiry participants highlighted the shortage of anaesthetic services.[176] Narrabri Shire Council submitted that, in the context of obstetric and gynaecological services, the current anaesthetic service model is unsustainable, leading to concerns about continuity of care.[177]

2.14 We heard that the shortage of anaesthetic services is impacting the delivery of maternity services.[178] Dr Tania Day, Chair, Training and Accreditation Committee, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), told us that with a shortfall of anaesthetists you cannot run an operating theatre or birthing suite.[179]

2.15 Inquiry participants also told us that the shortage of maternity staff is putting

---

[172] Submission 67, Australian Medical Association (NSW), p 2.

[173] Fiona Davies, Transcript of evidence, 20 August 2025, p 41.

[174] Portfolio Committee no 2 - Health, Health outcomes and access to health and hospital services in rural, regional and remote New South Wales, report no 57, Parliament of New South Wales, p 138.

[175] Select Committee on Remote, Rural and Regional Health, Report 1 - 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, p 4.

[176] Submission 11, Name suppressed, p 1; Submission 101, Moree Plains Shire Council, p 1; Dr Tania Day, Transcript of evidence, 20 August 2025, p 34.

[177] Submission 76, Narrabri Shire Council, pp 14-15.

[178] Cr Kate Dight, Mayor, Inverell Shire Council, Transcript of evidence, 22 August 2025, pp 5-6.

[179] Dr Tania Day, Transcript of evidence, 20 August 2025, p 37.

pressure on maternity services.[180]

2.16 The AMA NSW reported that Muswellbrook Hospital's Emergency Department is struggling to provide maternity services as it cannot secure a GP-obstetrician.[181] Currently the Hospital has a Level 1 non-birthing maternity unit.[182] The hospital stopped offering birthing services in 2022.[183]

2.17 The Country Women's Association of NSW (CWA NSW) called for the implementation of midwifery-led continuity of care, where an expectant mother is supported by a known midwife through pregnancy, birth, and postnatal care. The CWA NSW noted that while the NSW Government supports midwifery-led continuity of care, it cannot succeed without adequate midwife numbers.[184]

2.18 NSW Health reported that the Hunter New England LHD has re-established maternity services in Glen Innes, with Glen Innes Hospital offering women continuity and personalised care from a known midwife, in partnership with a GP obstetrician.[185]

Recruiting and retaining staff

2.19 Stakeholders raised concerns about challenges with recruiting and retaining clinical staff.[186] Inquiry participants spoke of a lack of nurses and midwives in rural and remote communities,[187] and difficulties with recruiting and retaining general practitioners and specialists.[188]

2.20 Some inquiry participants argued that splitting the district would address recruitment challenges.[189] The Save Wee Waa Hospital Committee said that the proposed New England North West district would be better placed to develop tailored incentives to recruit rural practitioners.[190]

2.21 RANZCOG submitted that splitting the district is unlikely to negatively affect recruitment or retention. They suggested that a split may address the workforce gap as the New England North West district would be able to contract locums at

[180] Submission 67, Australian Medical Association (NSW) p 1; Submission 77, NSW Nurses and Midwives' Association, p 5; Heather Franke, Transcript of evidence, 13 August 2025, p 2; Dr Tania Day, Transcript of evidence, 20 August 2025, p 36; Fiona Davies, Transcript of evidence, 20 August 2025, pp 41-42.

[181] Submission 67, Australian Medical Association (NSW) p 1.

[182] Hunter New England Local Health District, Muswellbrook Hospital, viewed 24 September 2025.

[183] ABC News, *Push for inquiry into declining maternity services in rural and regional NSW*, 16 March 2025.

[184] Submission 32, Country Women's Association of NSW, p 3.

[185] NSW Health, *Progress Report: Parliamentary Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales*, 30 June 2024, p 60.

[186] Submission 58, NSW Council of Social Service (NCOSS), p 3; Submission 71, Australian Salaried Medical Officer's Federation (ASMOF) NSW, p 5; Submission 90, Health Services Union - NSW ACT QLD (HSU), p 1; Submission 91, Aboriginal Health and Medical Research Council of NSW, p 7.

[187] Submission 77, NSW Nurses and Midwives' Association, p 5.

[188] Submission 91, Aboriginal Health and Medical Research Council of NSW, p 7.

[189] Submission 8, Name suppressed, p 1; Submission 83, Ron Thorp, p 1; Submission 95, Save Wee Waa Hospital Committee, p 16.

[190] Submission 95, Save Wee Waa Hospital Committee, pp 15, 16, 18.

the market rate.[191]

2.22 However, other inquiry participants argued that splitting the district would not address workforce issues,[192] or would exacerbate them.[193]

2.23 The Australian Salaried Medical Officer's Federation NSW (ASMOF) submitted that uncompetitive pay and conditions in NSW cause recruitment and retention challenges, and that this could be addressed through award reform.[194] The view that better pay, rather than splitting the district, would address workforce challenges was shared by the NSW Nurses and Midwives' Association and the Health Services Union.[195]

2.24 Disparities in pay and conditions between NSW and Queensland were cited as driving recruitment and retention challenges in healthcare facilities in Northern NSW, with health professionals choosing to work in Queensland for higher pay and better working conditions.[196]

2.25 We also heard that splitting the district could impact training. ASMOF said that its members had expressed concern about the impact of a split on the district's trainee workforce. As rural and regional hospitals rely on secondments from Newcastle hospitals, regional areas may have challenges with recruitment if they were cut off from Newcastle.[197]

2.26 The Health Services Union observed that the Hunter New England LHD is in a unique position, as it can leverage its partnerships with universities and the Hunter Medical Research Institute (HMRI) to provide teaching and research opportunities to clinicians. This acts as an incentive to retaining senior health professionals in the district.[198] The HMRI submitted that 'a smaller, isolated district will struggle to recruit and retain clinical and research expertise'.[199]

Impact on funding and delivery of medical research

2.27 We heard that the district's structure has advantages for medical research, which would be lost if the district were split. The Hunter New England LHD observed that the district's span over metropolitan, regional and rural areas provides access to a diverse population and broad clinical settings. This enables large-scale research and gives the district 'a competitive edge in securing state and federal research funding'.[200]

---

[191] Submission 63, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), p 2.

[192] Submission 56, Ms Susan Sargent, p 4.

[193] Submission 71, Australian Salaried Medical Officer's Federation (ASMOF) NSW, p 5.

[194] Submission 71, Australian Salaried Medical Officer's Federation (ASMOF) NSW, pp 2, 5.

[195] Submission 77, NSW Nurses and Midwives' Association, p 5; Submission 90, Health Services Union - NSW ACT QLD (HSU), p 2.

[196] Submission 71, Australian Salaried Medical Officer's Federation (ASMOF) NSW, p 5; Submission 77, NSW Nurses and Midwives' Association, p 6.

[197] Submission 71, Australian Salaried Medical Officer's Federation (ASMOF) NSW, p 7.

[198] Submission 90, Health Services Union - NSW ACT QLD (HSU), p 2.

[199] Submission 98, Hunter Medical Research Institute, p 2.

[200] Submission 30, Hunter New England Local Health District, p 11.

2.28 The Hunter New England LHD has research partnerships with the University of Newcastle, the University of New England, and the HMRI. The Hunter New England LHD stated that splitting the district would weaken these connections, reducing research capacity.[201]

2.29 The Hunter New England LHD alerted us to research initiatives that would be affected by a split. These include programs focused on telehealth, Aboriginal models of care, nurse-led innovation, and outreach services. The LHD stated that the cohesion and scale lost in these programs due to a split would risk funding, delays, and project discontinuation.[202]

2.30 The HMRI, which conducts medical research and delivers research outcomes across the district, expressed strong opposition to the proposal to split the district.[203]

2.31 The HMRI was concerned that the creation of the New England North West district would dismantle existing research partnerships, pose challenges to funding, and limit access to patient data. The HMRI's research is supported by access to urban and regional health services, patient populations, and datasets. Splitting the district would reduce the HMRI's access to these regional components, limiting its ability to deliver research and health improvements that address the needs of regional communities.[204]

[201] Submission 30, Hunter New England Local Health District, p 11.

[202] Submission 30, Hunter New England Local Health District, p 11.

[203] Submission 98, Hunter Medical Research Institute, p 1.

[204] Submission 98, Hunter Medical Research Institute, p 2.

Chapter Three – Administration and funding of the Hunter New England Local Health District

Summary

Splitting the Hunter New England Local Health District would have a significant impact on operations, governance and funding, and cost an additional, recurrent amount of $111 million. There was a common perception that the district is under resourced. There were differing views on whether a split would benefit resourcing and funding for the district.

Financial cost of splitting the district

3.1 The Hunter New England LHD spends around $201 million annually on operational, governance and administrative expenses.[205] NSW Health and the Hunter New England LHD submitted that forming a new district would require duplicating or redistributing these functions at an additional recurring cost of $111 million.[206]

3.2 NSW Health stated that splitting the district would have significant cost implications and is likely to impact its budget for several years.[207] Specifically, it would incur various initial and ongoing costs, including setting up the new district and maintaining and managing separate information and communication technology systems and infrastructure. Funding would also be needed to duplicate:

- infrastructure
- medical and non-medical equipment
- contracts, agreements, and licenses
- administrative, executive, and clinical staffing positions.[208]

3.3 Some stakeholders questioned whether splitting the district would incur the estimated cost proposed by NSW Health and the Hunter New England Local Health District.[209] Bronwyn Petrie, Mayor of Tenterfield Shire Council, told us that if regional hospital services in the New England were not degraded, the cost of separating the district would not be as high.[210]

[205] Submission 30, Hunter New England Local Health District, p 7.

[206] Submission 30, Hunter New England Local Health District, p 7; Submission 31, NSW Health, p 3.

[207] Submission 31, NSW Health, p 3.

[208] Submission 31, NSW Health, p 3.

[209] Councillor Bronwyn Petrie, Mayor, Tenterfield Shire Council, Transcript of evidence, 22 August 2025, p 10; Councillor Darrell Tiemens, Mayor, Narrabri Shire Council, Transcript of evidence, 22 August 2025, p 12.

[210] Bronwyn Petrie, Transcript of evidence, 22 August 2025, p 10.

Impact on operations and governance

3.4 We heard that splitting the district would affect its information and communication technology (ICT) systems and require additional ICT staff.[211]

3.5 The Hunter New England LHD stated that creating a separate district would involve reconfiguring or duplicating a number of digital systems and risk data fragmentation.[212] NSW Health noted that the delivery of and investment in new applications, like the Single Digital Patient Record, would be compromised by delays if the district was divided.[213]

3.6 The Hunter New England LHD said that a centralised structure enables consistent policy implementation and benefits reporting and corporate governance across the district's facilities. In contrast, they noted that separating the district would create duplicate governance frameworks and risk creating variations in compliance, oversight and risk management.[214]

3.7 Similarly, some stakeholders indicated that new policies, guidelines,[215] and service agreements[216] would need to be created for the proposed New England North West district.

3.8 We heard that the impacts of the split would extend to other parts of NSW Health. For example, NSW Health stated that it would create resourcing pressures for Specialty Health Networks and pillar agencies, as newly established districts need additional centralised support and monitoring.[217] They also submitted that services like HealthShare NSW, which provides support services such as hospital meals and cleaning, would need to duplicate teams.[218]

3.9 Governance requirements for LHDs and other organisations that form part of NSW Health are set out in the Corporate Governance and Accountability Compendium.[219] At the public hearing, Luke Sloane, Deputy Secretary of Rural and Regional Health, drew attention to these Compendium requirements.[220] Mr Sloane said that an LHD board and executive would need to be maintained in both districts, as opposed to the suggestion that these functions could be moved from the Hunter to the proposed New England North West district.[221]

3.10 NSW Health stated that a split would also affect its ability to meet NSW public

---

[211] Submission 30, Hunter New England Local Health District, p 7; Submission 31, NSW Health, pp 3-4.

[212] Submission 30, Hunter New England Local Health District, p 7.

[213] Submission 31, NSW Health, pp 6-7.

[214] Submission 30, Hunter New England Local Health District, pp 7-8.

[215] Heather Franke, Secretary and Delegate, Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association, Transcript of evidence, 13 August 2025, p 2.

[216] Dr Tania Day, Chair, Training and Accreditation Committee, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Transcript of evidence, 20 August 2025, p 36.

[217] Submission 31, NSW Health, p 3.

[218] Submission 31, NSW Health, p 3; HealthShare NSW, About us, viewed 9 September 2025.

[219] NSW Health, Corporate Governance and Accountability Compendium, viewed 29 September 2025.

[220] Luke Sloane, Deputy Secretary of Rural and Regional Health, NSW Health, Transcript of evidence, 22 August 2025, p 42.

[221] Luke Sloane, Transcript of evidence, 22 August 2025, pp 41-42.

sector targets to reduce senior executive roles, as more executive staff would be needed to form a leadership team for the new district. NSW Health noted that if this leadership team was formed, they would need to reduce senior executive positions in other parts of the organisation, which has not been planned for and could have a 'negative operational impact on service delivery'.[222]

Funding and resourcing for the district

3.11 A range of stakeholders stated that resources in the Hunter New England LHD are inadequate, limited or lacking.[223] This section explores the mixed evidence we received on whether a split would benefit or disadvantage healthcare resources and funds in the district.

Increasing funding and autonomy for the New England area

3.12 Several stakeholders highlighted resourcing and funding challenges in the New England area and rural parts of the district, including at specific locations such as Armidale, Glen Innes, Moree, Narrabri, Wee Waa and Tenterfield.[224] Some said that resources and/or funding are, or at least appear to be, disproportionately concentrated in larger regional and metropolitan centres like Newcastle.[225] Stakeholders called for more resources and funding,[226] including for the New England region specifically.[227]

3.13 While some Australian Salaried Medical Officer's Federation NSW members expressed concern about splitting the district, others were hopeful it would increase regional autonomy over funding and resource allocation.[228] A resident of the LHD was optimistic that a new, separate district would result in additional

[222] Submission 31, NSW Health, p 3.

[223] Submission 5, Miss Navanka Fletcher, p 1; Submission 63, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p 2; Submission 71, Australian Salaried Medical Officer's Federation (ASMOF) NSW, p 9; Submission 77, NSW Nurses and Midwives' Association, pp 6-7; Councillor Russell Webb, Mayor, Tamworth Regional Council, Transcript of evidence, 13 August 2025, p 13; Emma Hardy, Professional Officer, NSW Nurses and Midwives' Association, Transcript of evidence, 20 August 2025, pp 7, 11; Warren Isaac, Member, NSW Nurses and Midwives' Association, Transcript of evidence, 20 August 2025, p 10; Bronwyn Dunston, State Secretary, Country Women's Association of NSW, Transcript of evidence, 20 August 2025, p 15; Susan Sargent, Transcript of evidence, 22 August 2025, p 21.

[224] Submission 5, Miss Navanka Fletcher, p 1; Submission 46, Kathleen Denniss, p 1; Submission 63, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p 2; Submission 77, NSW Nurses and Midwives' Association, p 6; Submission 79, Uralla Shire Council, p 1; Submission 93, Mr John Fogarty, p 1; Warren Isaac, Transcript of evidence, 20 August 2025, p 10; Councillor Susannah Pearse, Mayor, Moree Plains Shire Council, Transcript of evidence, 22 August 2025, p 6; Darrell Tiemens, Transcript of evidence, 22 August 2025, p 12.

[225] Submission 63, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p 2; Submission 71, Australian Salaried Medical Officer's Federation NSW, p 9; Submission 77, NSW Nurses and Midwives' Association, p 7; Leah Daley, General Manager, Gwydir Shire Council, Transcript of evidence, 12 August 2025, p 25; Darrell Tiemens, Transcript of evidence, 22 August 2025, p 11.

[226] Submission 5, Miss Navanka Fletcher, p 1; Submission 71, Australian Salaried Medical Officer's Federation NSW, p 10; Bronwyn Dunston, Transcript of evidence, 20 August 2025, p 18; Sandy Harrison, Country Women's Association, Murrurundi Branch, Transcript of evidence, 20 August 2025, p 18; Dr David Scott, Chair, Tamworth Medical Staff Council, Transcript of evidence, 22 August 2025, p 32.

[227] Submission 5, Miss Navanka Fletcher, p 1; Submission 79, Uralla Shire Council, p 2; Submission 105, School of Rural Medicine, University of New England, p 1; Emma Hardy, Transcript of evidence, 20 August 2025, p 9.

[228] Submission 71, Australian Salaried Medical Officer's Federation NSW, pp 9, 10.

funding.[229]

3.14 Stakeholders said that creating a New England North West district may or will have resourcing and funding benefits,[230] such as:

- enabling better resourcing and infrastructure planning in rural towns[231]
- ensuring that a proportion of funds are allocated to rural healthcare[232]
- allowing the regions to appropriately fund their hospitals.[233]

3.15 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) stated that a transition to local governance in the New England region could support an improved allocation of resources, workforce and infrastructure. While noting the potential risks of the Bill, RANZCOG submitted that splitting the district would provide the opportunity to correct an imbalance in the distribution of resources between metropolitan and rural areas and ensure more equity and transparency in healthcare investment.[234]

3.16 We also heard that a separate district would be more cost effective, as healthcare staff would be based in the New England region. Healthcare workers are currently travelling from the Hunter to staff services in the New England region.[235] It was also suggested that policies and procedures for a New England district would more appropriately address rural and remote needs.[236]

Risks to funding and healthcare for the New England region

3.17 Some stakeholders were concerned that a split would not result in equitable funding and resourcing across the proposed new districts, potentially disadvantaging the New England North West district.[237]

3.18 Dr Louise Wightman, Chair and Senior Project Officer, Maternal Child & Family Health Nurses Australia, expressed concern over fewer services being available in the New England North West district as it is not as densely populated and would be disadvantaged if population-based funding was applied.[238]

---

[229] Submission 2, Mrs Cheryl-Anne Hill, p 1.

[230] Submission 8, Name suppressed, p 1; Submission 45, Mrs Traci Morley, p 1; Submission 63, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p 2; Submission 82, Merced Farming Pty Ltd, p 1; Andrew Bowen, Secretary and Treasurer, Wee Waa Chamber of Commerce, Transcript of evidence, 12 August 2025, p 11.

[231] Submission 82, Merced Farming Pty Ltd, p 1.

[232] Andrew Bowen, Transcript of evidence, 12 August 2025, p 11.

[233] Submission 8, Name suppressed, p 1.

[234] Submission 63, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p 2.

[235] Submission 2, Mrs Cheryl-Anne Hill, p 1.

[236] Submission 8, Name suppressed, p 1.

[237] Submission 71, Australian Salaried Medical Officer's Federation, p 10; Heather Franke, Transcript of evidence, 13 August 2025, p 1; Coda Danu-Asmara, Senior Industrial Officer, Australian Paramedics Association (NSW), Transcript of evidence, 20 August 2025, p 28.

[238] Dr Louise Wightman, Chair and Senior Project Officer, Maternal Child and Family Health Nurses Australia, Transcript of evidence, 20 August 2025, p 13.

3.19 Coda Danu-Asmara, Senior Industrial Officer, Australian Paramedics Association (NSW), told us that if the district was split without additional funding for the New England North West district, it would be left with insufficient hospital services.[239]

3.20 Moree Plains Shire Council supported the proposal to split the district on the condition that investment is made in New England health infrastructure. The Council specifically called for funding for Tamworth Hospital, which would be the largest health service in the proposed New England North West district.[240] The potential impact of the proposal to split the district on local health services and patient outcomes is discussed in chapter one.

Disrupting economies of scale and reducing service integration

3.21 We heard that the district employs economies of scale by operating as one integrated organisation across metropolitan, regional and rural settings and sharing administrative, operational and governance expenses across its network.[241]

3.22 NSW Health explained that this structure enables executive oversight, corporate services, procurement, ICT and policy compliance to be streamlined.[242] They said that this reduces duplication and improves cost-efficiency.[243]

3.23 The Hunter New England LHD warned that splitting the district would fragment existing systems, reduce economies of scale, 'cost more and deliver less', and potentially compromise patient care.[244]

3.24 Some inquiry participants agreed that separating the district could impact efficiencies permitted by its current structure and scale.[245]

3.25 Rural Doctors Association of NSW (RDA NSW) stated that the Hunter New England LHD's economies of scale allow for strategic investment in infrastructure and service innovation. RDA NSW submitted that splitting the district may dilute funding streams across two competing administrations and reduce the district's purchasing power.[246]

3.26 Uralla Shire Council submitted that a split may jeopardise current efficiencies in integrated services, shared digital platforms, specialist networks and training programs at the expense of patients and providers.[247]

---

[239] Coda Danu-Asmara, Transcript of evidence, 20 August 2025, p 28.

[240] Submission 101, Moree Plains Shire Council, p 2.

[241] Answers to supplementary questions, NSW Health, 23 September 2025, p 1.

[242] Answers to supplementary questions, NSW Health, 23 September 2025, p 1.

[243] Answers to supplementary questions, NSW Health, 23 September 2025, p 1.

[244] Submission 30, Hunter New England Local Health District, p 7; Tracey McCosker, Chief Executive, Hunter New England Local Health District, Transcript of evidence, 22 August 2025, p 38.

[245] Submission 18, Mr Rick Banyard, p 1; Submission 57, ACON, p 1; Submission 79, Uralla Shire Council, p 2; Submission 98, Hunter Medical Research Institute, p 1.

[246] Submission 100, Rural Doctors Association of NSW, p 2.

[247] Submission 79, Uralla Shire Council, p 2.

Duplicating costs and administration without addressing systemic issues

3.27 Several stakeholders drew attention to the administrative and funding impact of separating the district, including that it would or may duplicate costs, services and administration.[248] We heard that this reform would occur when the NSW Health system can least afford it,[249] and 'regional communities need more clinical boots on the ground – not more bureaucracy'.[250]

3.28 We were told that the NSW health system is underfunded[251] and 'buckling' under growing pressure.[252] Noting budgetary limitations, some stakeholders expressed alarm or doubt over how separating the district would be funded.[253] RDA NSW were concerned that sufficient resources would not be available for the split to have a positive impact.[254]

3.29 The Australian Salaried Medical Officers Federation NSW stated that their members are strongly opposed to the split if it does not result in increased and more equitable funding across all districts.[255]

3.30 We were also warned that splitting the district would, or may:

- reduce, or place unnecessary strain on, limited health resources[256]
- increase expenditure without improving outcomes[257]
- not resolve systemic issues, including the healthcare staffing crisis[258]
- increase administrative overheads and/or divert funding from frontline care

[248] Submission 56, Susan Sargent, p 4; Submission 67, Australian Medical Association (NSW), p 3; Submission 71, Australian Salaried Medical Officer's Federation NSW, p 9; Submission 79, Uralla Shire Council, pp 1-2; Submission 90, Health Services Union - NSW ACT QLD, p 2; Submission 100, Rural Doctors Association of NSW, p 2; Submission 104, New England Division of General Practice, p 1; Submission 105, School of Rural Medicine, University of New England, p 1; Submission 106, Edward Stubbins, p 1; Heather Franke, Transcript of evidence, 13 August 2025, p 2; Elyse Cain, Policy Lead, NSW Council of Social Service, Transcript of evidence, 20 August 2025, p 2; Fiona Davies, Chief Executive Officer, Australian Medical Association (NSW), Transcript of evidence, 20 August 2025, p 41; Dr Tony Sara, Secretary, Australian Salaried Medical Officers Federation NSW, Transcript of evidence, 20 August 2025, p 27; Dr Tania Day, Transcript of evidence, 20 August 2025, pp 36, 38-39; Dr Michelle Guppy, Head of School, School of Rural Medicine, University of New England, Transcript of evidence, 22 August 2025, pp 22-23.

[249] Submission 56, Susan Sargent, p 4.

[250] Submission 100, Rural Doctors Association of NSW, p 2.

[251] Submission 67, Australian Medical Association (NSW), p 3; Fiona Davies, Transcript of evidence, 20 August 2025, p 42; Dr Tony Sara, Transcript of evidence, 20 August 2025, p 27.

[252] Submission 100, Rural Doctors Association of NSW, p 1.

[253] Submission 71, Australian Salaried Medical Officer's Federation NSW, p 9; Submission 67, Australian Medical Association (NSW), p 3.

[254] Submission 100, Rural Doctors Association of NSW, p 1.

[255] Submission 71, Australian Salaried Medical Officer's Federation, p 9.

[256] Submission 56, Susan Sargent, p 4; Dr Tony Sara, Transcript of evidence, 20 August 2025, p 27; Fiona Davies, Transcript of evidence, 20 August 2025, p 41.

[257] Submission 90, Health Services Union - NSW ACT QLD, p 2

[258] Submission 56, Susan Sargent, p 3; Submission 79, Uralla Shire Council, p 1; Submission 106, Mr Edward Stubbins, p 1.

and the health workforce.[259]

3.31 Several stakeholders recommended addressing and prioritising funding for clinical care and more pressing systemic issues affecting the health system, like workforce development and funding.[260] A number of these stakeholders said that these efforts should be made before or with greater urgency than any structural changes to the district,[261] and instead of focusing on managerial hierarchy.[262]

3.32 Edward Stubbins, who was a board member under the previous New England Area Health Service model, stated that more bureaucracy and separating the district is a suboptimal use of available funds. He noted that improving resources would be the most cost-effective way of strengthening the health service in Hunter New England.[263]

3.33 Uralla Shire Council considered that the issue is not the district's structure but the allocation of resources.[264] The NSW Nurses and Midwives' Association submitted that regardless of a split, funding should be evaluated and fairly distributed across the district to ensure an equitable provision of health services.[265]

3.34 Tracey McCosker, the Chief Executive of the Hunter New England LHD, advised that although there is a view that challenges with regional and rural health service delivery are a result of how resources are allocated and where these decisions are made, the largest issue affecting the district's ability to deliver healthcare is its workforce.[266] Workforce challenges experienced by the district are explored in chapter two.

[259] Submission 71, Australian Salaried Medical Officer's Federation, p 10; Submission 79, Uralla Shire Council, p 1; Submission 100, Rural Doctors Association of NSW, p 2.

[260] Submission 56, Susan Sargent, p 1; Submission 57, ACON, p 1; Submission 77, NSW Nurses and Midwives' Association, pp 4, 8; Submission 79, Uralla Shire Council, p 2; Submission 90, Health Services Union - NSW ACT QLD, p 2; Submission 91, Aboriginal Health and Medical Research Council of NSW, p 3; Submission 105, School of Rural Medicine University of New England, p 1; Elyse Cain, Transcript of evidence, 20 August 2025, p 2; Emma Hardy, Transcript of evidence, 20 August 2025, pp 7, 9; Susan Sargent, Transcript of evidence, 22 August 2025, p 19.

[261] Submission 77, NSW Nurses and Midwives' Association, p 4; Submission 91, Aboriginal Health and Medical Research Council of NSW, p 3.

[262] Emma Hardy, Transcript of evidence, 20 August 2025, p 7.

[263] Submission 106, Mr Edward Stubbins, p 1.

[264] Submission 79, Uralla Shire Council, p 1.

[265] Submission 77, NSW Nurses and Midwives' Association, pp 4, 8.

[266] Tracey McCosker, Transcript of evidence, 22 August 2025, p 38.

Chapter Four – Regional and metropolitan disconnect

Summary

There were mixed views on the Hunter New England LHD's ability to represent, engage and communicate with its regional communities, including its Aboriginal and Torres Strait Islander population. Some stakeholders argued that splitting the district would result in a local administration that can better represent the views of regional, rural and remote communities. However, others said that the split would further isolate the New England part of the district.

Rural and regional communities' healthcare needs

Meeting New England communities' needs

4.1 We heard that rural and regional communities have distinct and complex health needs.[267] Stakeholders explained that regional communities experience barriers to accessing healthcare,[268] including long distances[269] and socio-economic challenges.[270] We were told that rural and regional areas face greater disparity in healthcare as a result of varying accessibility of services.[271]

4.2 We heard that the Hunter New England LHD has towns and cities with ageing populations,[272] and includes pockets of social and/or economic disadvantage, particularly in regional areas.[273]

4.3 The LHD was described as being 'city centric'[274] in its decision making, with limited or no understanding of the distinct needs of rural and regional people.[275]

4.4 We heard that Newcastle, where the LHD is managed, is 'geographically remote' from the northern part of the district[276] – being a seven hour drive from

[267] Submission 63, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p 2.

[268] Submission 32, Country Women's Association, p 2; Submission 95, Save Wee Waa Hospital Committee, pp 3-4.

[269] Submission 86, Cancer Council NSW, p 2; Bradley Gellert, Manager, Policy and Advocacy, Cancer Council NSW, Transcript of evidence, 20 August 2025, p 22.

[270] Daniel Kahl, Business Manager and Director, Merced Farming Pty Ltd, Transcript of evidence, 12 August 2025, p 33; Anne Weekes, President, Wee Waa Hospital Auxiliary, Transcript of evidence, 12 August 2025, p 19.

[271] Submission 57, ACON, p 1.

[272] Submission 24, Jane I'Ons, p 1; Submission 76, Narrabri Shire Council, p 1; Tiffany Galvin, Mayor, Gwydir Shire Council, Transcript of evidence, 12 August 2025, p 28.

[273] Submission 76, Narrabri Shire Council, p 1; Susannah Pearse, Mayor, Moree Plains Shire Council, Transcript of evidence, 22 August 2025, p 5.

[274] Submission 85, Tamworth Regional Council, p 1; Submission 95, Save Wee Waa Hospital Committee, p 5; Russell Webb, Mayor, Tamworth Regional Council, Transcript of evidence, 13 August 2025, p 11; Richard Schwager, NSW Farmers Association Wee Waa Branch, Transcript of evidence, 12 August 2025, p 31.

[275] Submission 65, Sonia Fogarty, p 2; Submission 96, RiverBank Youth Works, p 1; Submission 97, Peter Carrett, pp 4-5.

[276] Submission 65, Sonia Fogarty, p 1.

Tenterfield,[277] and six hours from Moree[278] and Narrabri.[279] Gwydir Shire Council Mayor Tiffany Galvin expressed concern about the district's scale encouraging a 'one size fits most/none' approach.[280] Narrabri Shire Council submitted that the communities located at the extremities of the metropolitan-based district feel that their needs are overlooked.[281]

4.5 We heard that there is a distinct need for accessible healthcare in areas with a large farming community[282] due to the risks involved within the farming industry.[283] However, stakeholders felt that has been disregarded by the LHD.[284] In particular, the reduction in hours of Wee Waa Hospital was criticised by some stakeholders.[285]

4.6 As noted in chapter three, several stakeholders described an imbalance of resource allocation in the district. Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) submitted that there is a common perception among the district's regional communities that although they have complex health needs, they are 'treated as secondary to metropolitan priorities'.[286] Various stakeholders said that the LHD's management deliberately ignores, forgets[287] and neglects[288] regional communities.[289]

4.7 However, we also heard that there are benefits to a bigger LHD, including greater purchasing power,[290] larger research capacity[291] and access to specialists.[292]

Providing culturally appropriate healthcare for Aboriginal people

4.8 There were 71,983 Aboriginal and Torres Strait Islander people in the LHD in 2021, making up around seven per cent of the district's population.[293]

4.9 Some stakeholders brought attention to culturally appropriate healthcare for Aboriginal and Torres Strait Islander people.[294] For example, we heard that

[277] Bronwyn Petrie, Mayor, Tenterfield Shire Council, Transcript of evidence, 22 August 2025, p 8.

[278] Submission 101, Moree Plains Shire Council, p 1.

[279] Submission 76, Narrabri Shire Council, p 2.

[280] Tiffany Galvin, Mayor, Gwydir Shire Council, Transcript of evidence, 12 August 2025, p 24.

[281] Submission 76, Narrabri Shire Council, p 3.

[282] Submission 82, Merced Farming, p 1; Richard Schwager, Transcript of evidence, 12 August 2025, p 31.

[283] Submission 89, Wee Waa Chamber of Commerce, p 1; Submission 93, John Fogarty, p 2.

[284] Submission 93, John Fogarty, p 2; Daniel Kahl, Merced Farming, Transcript of evidence, 12 August, p 33.

[285] Submission 93, John Fogarty, p 2; Richard Schwager, Transcript of evidence, 12 August 2024, p 3.

[286] Submission 63, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p 2.

[287] Submission 47, Amanda Brown, p 1.

[288] Submission 71, Australian Salaried Medical Officer's Federation, p 9.

[289] Submission 11, Name suppressed, p 1; Submission 56, Susan Sargent, pp 4-5.

[290] Submission 18, Rick Banyard, p 1.

[291] Submission 98, Hunter Medical Research Institute, p 1; Professor Frances Kay, Chief Executive Officer and Institute Director, Hunter Medical Research Institute, Transcript of evidence, 22 August 2025, p 22.

[292] Submission 100, Rural Doctors Association of NSW, p 1; Russell Webb, Transcript of evidence, 13 August 2025, p 14.

[293] NSW Government, About Hunter New England Local Health District, viewed 18 September 2025.

[294] Submission 73, Wee Waa Hospital Auxiliary, p 1; Submission 97, Peter Carrett, p 10; Anne Weekes, Transcript of evidence, 12 August 2025, p 17.

receiving healthcare on Country,[295] including giving birth on Country, is important for Aboriginal and Torres Strait Islander patients.[296] The Wee Waa Aboriginal Land Council said that disconnection from Country deters Aboriginal people from going to hospital if they have to travel away from home.[297]

4.10 We heard that changes to the operation of Wee Waa Hospital directly impacted Aboriginal and Torres Strait Islander people in the community.[298] Wee Waa Aboriginal Land Council told us that with limited transport options, travelling out of town to another hospital is a further barrier to seeking healthcare for some Aboriginal and Torres Strait Islander people.[299]

4.11 We also heard that Aboriginal and Torres Strait Islander people are less likely to speak up during telehealth consultations[300] and that this model of care does not always facilitate cultural safety in rural and regional communities.[301]

4.12 Inquiry stakeholders said that birthing on Country is an important model of care for Aboriginal and Torres Strait Islander women.[302] Dr Tania Day from RANZCOG said that John Hunter Hospital supports homebirth models.[303] She noted the recent expansion of the Initial Maternity Assessment and Planning service at John Hunter Hospital. This service provides outreach at Moree for pregnant women to receive early assessment of maternity-related risk and plan the model of care for their pregnancy and birth.[304]

4.13 NSW Health said that it supports a 'well-coordinated care response that respects cultural identity and connection to family'. They stated that this is done by providing maternity services that are aligned with local needs, birthing numbers, and staff availability to ensure care is provided 'as close to home as possible.'[305] However, Emma Hardy from the NSW Nurses and Midwives' Association, told us that there are currently no birthing on Country models in the district.[306]

LHD's engagement with New England communities

4.14 We heard mixed evidence on the LHD's engagement with communities. Some stakeholders mentioned a lack of communication and/or engagement by the LHD

[295] Submission 77, NSW Nurses and Midwives' Association, p 6; Submission 97, Peter Carrett, p 10.

[296] Clifford Toomey, Chair, Wee Waa Aboriginal Land Council, Transcript of evidence, 12 August 2025, p 5.

[297] Submission 40, Wee Waa Aboriginal Land Council, p 1; Clifford Toomey, Transcript of evidence, 12 August 2025, p 8.

[298] Submission 97, Peter Carrett, p 10.

[299] Submission 40, Wee Waa Aboriginal Land Council, p 1; Robyn Keefe, Chief Executive Officer, Wee Waa Aboriginal Land Council, Transcript of evidence, 12 August 2025, p 2.

[300] Submission 40, Wee Waa Aboriginal Land Council, p 1.

[301] Submission 77, NSW Nurses and Midwives' Association, p 6.

[302] Clifford Toomey, Transcript of evidence, 12 August 2025, p 5; Emma Hardy, Professional Officer, NSW Nurses and Midwives' Association, Transcript of evidence, 20 August 2025, p 9; Kate Dight, Mayor, Inverell Shire Council, Transcript of evidence, 22 August 2025, p 5.

[303] Dr Tania Day, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Transcript of evidence, 20 August 2025, p 40.

[304] Dr Tania Day, Transcript of evidence, 20 August 2025, p 35.

[305] Answers to supplementary questions, NSW Health, 23 September 2025, p 2.

[306] Emma Hardy, Transcript of evidence, 20 August 2025, p 9.

with New England communities in Wee Waa and Narrabri.[307] Narrabri Shire Council spoke of a 'disconnect' between the LHD and its community.[308] Similarly, Robyn Keefe from Wee Waa Aboriginal Land Council described communication by the LHD as 'very, very limited'.[309] Some stakeholders from Wee Waa said that the district did not communicate and/or consult with the community before deciding to restrict the operating hours of Wee Waa Hospital.[310]

4.15 In comparison, Inverell Shire Council's Mayor Kate Dight and Moree Plains Shire Council's Mayor Susannah Pearse, both spoke positively about engagement with the LHD.[311]

4.16 Mayor Dight told us about the Inverell Health Forum (the forum). The forum has enabled collaboration between the local community, district executive, Inverell Hospital, University of New England and other key stakeholders.[312] NSW Health described the local health committee in Inverell as providing 'good dialogue' and creating 'a really positive environment in the community to attract workforce and have more people come in and work there'.[313]

4.17 Mayor Pearse told us that Moree Plains Shire Council has a 'great relationship' with the LHD and that the district is 'incredibly available' to them.[314]

4.18 NSW Health stated that it is working to strengthen community engagement, which is a key priority in the Regional Health Strategic Plan 2022-2032.[315] NSW Health is also working to 'foster a shared understanding of health service planning and delivery' through the Shared Understanding Project. The project aims 'to ensure future health services and innovative models of care are informed, understood, trusted and embraced by the community'. As part of their consultation, they held eight face to face sessions in regional areas in August 2024.[316]

Reactivating Local Health Advisory Committees to improve engagement with regional communities

4.19 Local Health Advisory Committees (LHACs) facilitate community engagement between NSW regional towns, LHDs, councils and medical professionals and

[307] Submission 76, Narrabri Shire Council, p 3; Submission 65, Sonia Fogarty, p 3; Darrell Tiemens, Mayor, Narrabri Shire Council, Transcript of evidence, 22 August 2025, p 9; Answers to supplementary questions, NSW Farmers Association, Wee Waa Branch, 2 September 2025, p 1.

[308] Submission 76, Narrabri Shire Council, p 3.

[309] Robyn Keefe, Transcript of evidence, 12 August 2025, p 1.

[310] Kate Kahl, Member, Save Wee Waa Hospital Committee, Transcript of evidence, 12 August 2025, p 18; Robyn Keefe, Transcript of evidence, 12 August 2025, p 1.

[311] Kate Dight, Transcript of evidence, 22 August 2025, pp 1-2; Susannah Pearse, Transcript of evidence, 22 August 2025, p 4.

[312] Kate Dight, Transcript of evidence, 22 August 2025, p 1.

[313] Luke Sloane, Deputy Secretary of Rural and Regional Health, NSW Health, Transcript of evidence, 22 August 2025, pp 42-43.

[314] Susannah Pearse, Transcript of evidence, 22 August 2025, p 4.

[315] Submission 31, NSW Health, p 7.

[316] Submission 31, NSW Health, p 7.

advocate for the needs of local residents.[317] Luke Sloane from NSW Health described LHACs as 'the envoys' of what LHDs are 'trying to communicate out to the community'.[318]

4.20 We heard that the LHAC in Wee Waa[319] is not currently functioning. The Save Wee Waa Hospital Committee submitted that without an LHAC, their community has been left 'with no voice in healthcare planning'.[320] Some stakeholders noted that LHACs declined during the COVID-19 pandemic.[321]

4.21 Inquiry participants told us that LHACs are currently operating to various degrees in Warialda,[322] Bingara,[323] Narrabri,[324] Moree[325] and Inverell.[326] Dr Ian Kamerman, Secretary of the Rural Doctors Association of NSW, spoke of the varied use of LHACs across NSW. He told us that 'Sometimes they're really good and high-functioning' whereas other times they 'lack the people with appropriate skills to actually provide the best advice.'[327]

4.22 Tracey McCosker, Chief Executive of the Hunter New England LHD, told us that 19 LHACs were active with another three in the process of 'reinvigorating'.[328] Hunter New England LHD stated that work to strengthen LHACs will assist in rebuilding 'trust with local communities and ensure transparency in service planning'.[329]

4.23 Save Wee Waa Hospital Committee submitted that they anticipate LHACs to be re-activated by a New England North West district, allowing 'community members a seat at the table and a mechanism for ongoing consultation'.[330]

4.24 RANZCOG argued that a shift to local governance may rebuild trust in local health leadership.[331]

Better communication about healthcare for Aboriginal people

4.25 We heard that Hunter New England LHD initiatives to provide culturally appropriate healthcare to Aboriginal and Torres Strait Islander people could be better promoted.

4.26 NSW Health said that the LHD has 'highly developed Aboriginal Health

[317] NSW Health, *Strengthening Local Health Committees across Hunter New England Local Health District*, June 2024, pp 7, 14.

[318] Luke Sloane, Transcript of evidence, 22 August 2025, p 43.

[319] Kate Kahl, Transcript of evidence, 12 August 2025, p 17.

[320] Submission 95, Save Wee Waa Hospital Committee, p 6.

[321] Submission 74, A Allan, p 1; Tracey McCosker, Chief Executive, Hunter New England Local Health District, Transcript of evidence, 22 August 2025, p 43.

[322] Leah Daley, General Manager, Gwydir Shire Council, Transcript of evidence, 12 August 2025, p 25.

[323] Leah Daley, Transcript of evidence, 12 August 2025, p 25.

[324] Darrell Tiemens, Transcript of evidence, 22 August 2025, p 10.

[325] Susannah Pearse, Moree Plains Shire Council, Transcript of evidence, 22 August 2025, p 4.

[326] Kate Dight, Transcript of evidence, 22 August 2025, p 4.

[327] Dr Ian Kamerman, Secretary, Rural Doctors Association of NSW, Transcript of evidence, 20 August 2025, p 44.

[328] Tracey McCosker, Transcript of evidence, 22 August 2025, p 43.

[329] Submission 30, Hunter New England Local Health District, p 7.

[330] Submission 95, Save Wee Waa Hospital Committee, p 15.

[331] Submission 63, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), p 2.

governance and services', and supports 'a well-coordinated care response that respects cultural identity and connection to family'.[332] As noted in chapter one, the district provides various outreach programs in partnership with Aboriginal Medical Services. The district's Aboriginal health services include chronic disease management, and *Healthy Deadly Feet*, a program addressing high rates of foot related complications that has reduced the length of hospital stays for diabetes-related foot issues in Tamworth.[333]

4.27 However, representatives from Wee Waa Aboriginal Land Council told us they were not aware of these services. Clifford Toomey, Chair of the Land Council, said that 'when these programs get filtered out to us, they pull up at the bigger places in New England, such as Tamworth, such as Armidale, and not a lot of them come out this way'.[334]

4.28 Robyn Keefe, CEO of the Wee Waa Aboriginal Land Council, referred to a Hunter New England bus that provides healthcare for diabetes. She said that there was a lack of timely communication, with the community being given around two weeks' notice about the service before it was delivered.[335]

4.29 We heard that splitting the LHD could improve the ability to meet Aboriginal people's healthcare needs. Robyn Keefe said that a base in Tamworth or Armidale, would allow for the voices of Aboriginal and Torres Strait Islander people to be heard.[336] She also said that regional hospitals 'have more understanding about the outlying areas and what's needed'.[337]

Regional representation on the LHD's board

4.30 We heard that an increase in regional and rural representation in decision making processes would assist in ensuring the views of those in rural and regional areas are represented.[338] However, some stakeholders argued that increasing rural representation on the board would not necessarily result in the adequate representation of regional and rural views.[339]

4.31 Some stakeholders called for greater local decision-making capabilities for regional and rural areas in the district.[340] We received suggestions for alternative ways that this could be achieved, such as establishing regional advisory councils[341] or an administrative 'hub' or board arrangement based in the New

[332] Answers to supplementary questions, NSW Health, 23 September 2025, p 2.

[333] Submission 30, Hunter New England Local Health District, p 10.

[334] Clifford Toomey, Transcript of evidence, 12 August 2025, p 8.

[335] Robyn Keefe, Transcript of evidence, 12 August 2025, pp 4, 7.

[336] Robyn Keefe, Transcript of evidence, 12 August 2025, p 2.

[337] Robyn Keefe, Transcript of evidence, 12 August 2025, p 2.

[338] Submission 100, Rural Doctors Association, p 2.

[339] Answers to supplementary questions, Save Wee Waa Hospital Committee, 26 August 2025, p 1; Answers to supplementary questions, NSW Farmers Association, Wee Waa Branch, 2 September 2025, p 2; Answers to supplementary questions, Wee Waa Chamber of Commerce, 28 August 2025, p 1.

[340] Submission 71, Australian Salaried Medical Officer's Federation, p 9; Dr Michelle Guppy, School of Rural Medicine, University of New England, Transcript of evidence, 22 August 2025, p 28.

[341] Submission 100, Rural Doctors Association of NSW, p 3.

England region.[342]

4.32 The Hunter New England LHD board includes members from Emmaville, Uralla, Repton, Inverell and Newcastle.[343] NSW Health told us that it seeks to ensure that LHD boards are comprised of people 'that represent the community'.[344]

4.33 Tracey McCosker, Chief Executive of the LHD, told us that senior staff live in the New England part of the district, including 'general managers and health service managers in every local area who hold real authority over their budget, recruitment and day-to-day operations'.[345] In addition, she noted that the district's Executive Director of Clinical Operations is based in Tamworth.[346]

4.34 A number of stakeholders supported splitting the LHD as it would allow decisions about health services to consider regional and rural needs.[347] We also heard that it would be a strong signal to repair community confidence[348] and allow for services to be more aligned with rural communities' needs.[349]

4.35 However, we also heard that creating a new district does not guarantee a management that is more responsive[350] and that the current proposal to split the district does not consider the distinct needs of its communities.[351]

4.36 We note that the *Health Services Act 1997* does not require rural representation on LHD boards. Under the Act, LHD boards, among other things, must:

- consist of 6 to 13 people appointed by the Minister
- have 'an appropriate mix of skills and expertise required to oversee and provide guidance to the district'
- include members who 'have knowledge and understanding of the community served by the district.'[352]

[342] Submission 56, Susan Sargent, p 4; Russell Webb, Transcript of evidence, 13 August 2025, p 14.

[343] Tracey McCosker, Transcript of evidence, 22 August 2025, p 38.

[344] Luke Sloane, Transcript of evidence, 22 August 2025, p 39.

[345] Tracey McCosker, Transcript of evidence, 22 August 2025, p 38.

[346] Tracey McCosker, Transcript of evidence, 22 August 2025, p 38.

[347] Submission 8, Name suppressed, p 1; Submission 76, Narrabri Shire Council, p 3Submission 95, Save Wee Waa Hospital Committee, p 7; Submission 96, Riverank Youth Works Ltd, p 1.

[348] Submission 95, Save Wee Waa Hospital Committee, p 13.

[349] Submission 8, Name suppressed, p 1; Submission 63, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p 1; Submission 82, Merced Farming Pty Ltd, p 1.

[350] Submission 90, Health Services Union – NSW ACT QLD, p 2.

[351] Submission 91, Aboriginal Health and Medical Research Council of NSW, p 3.

[352] *Health Services Act 1997*, ss 26(2) and (3).

Appendix One – Terms of reference

That the Committee on Community Services inquires into and reports on the Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025.

Appendix Two – Conduct of inquiry

The Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025 was introduced in the Legislative Assembly on 20 February 2025 and referred to the Committee for inquiry and report.

The Committee resolved to accept the referral on 27 February 2025.

The Committee Chair issued a media release on 5 March 2025 and wrote to targeted stakeholders inviting them to make a submission to the inquiry. Submissions closed on 17 April 2025.

107 submissions were received. A list of submissions is at Appendix Three. Submissions are available on the inquiry webpage.

The Committee travelled to the New England and North West region and held public hearings in Narrabri on 12 August 2025, and Tamworth on 13 August 2025. The Committee held two further public hearings at Parliament House on 20 August 2025 and 22 August 2025. Representatives of community groups, non-government organisations, the agricultural sector, unions, professional associations, local councils, the Hunter New England LHD and NSW Health appeared in person and via videoconference. The Committee also heard from community members and health and medical professionals.

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

Appendix Three – Submissions

No	Author
1	Confidential
2	Mrs Cheryl-Anne Hill
3	Mrs Diana Burtenshaw
4	Confidential
5	Miss Navanka Fletcher
6	Ms Carol Sparks
7	Mr Sid Brummell
8	Name suppressed
9	Mrs Linda Lane
10	Confidential
11	Name suppressed
12	Confidential
13	Confidential
14	Mrs Kerry Varley
15	Mrs (Adriana) Marianne Ledingham
16	Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association
17	Name suppressed
18	Mr Rick Banyard
19	Confidential
20	Name suppressed
21	Ms Wendy Davison
22	Tamworth Medical Staff Council
23	Confidential
24	Mrs Jane I'Ons
25	Kaz Madigan
26	Confidential
27	Tenterfield Shire Council
28	Confidential
28a	Confidential
29	Mr Brian Leslie
30	Hunter New England Local Health District
31	NSW Health

No	Author
32	Country Women's Association of NSW
33	Confidential
34	Ms Karen Orman
35	Mrs Jenny Hatton
36	Confidential
37	Confidential
38	Mrs June Williams
39	Confidential
40	Wee Waa Aboriginal Land Council
41	Confidential
42	Confidential
43	Confidential
44	Confidential
45	Mrs Traci Morley
46	Ms Kathleen Denniss
47	Mrs Amanda Brown
48	Mr Robert Bensley OAM
49	Confidential
50	Name suppressed
51	Name suppressed
51a	Name suppressed
52	Confidential
53	Mrs Kate Knight
54	Name suppressed
55	Dr Eric Baker
56	Ms Susan Sargent
57	ACON
58	NSW Council of Social Service (NCOSS)
59	Mrs Oddette Avery
60	Name suppressed
61	HealthWISE
62	Name suppressed
63	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
64	Mr Ronald Newton
65	Sonia Fogarty

No	Author
66	Mrs Margaret Chamberlain
67	Australian Medical Association (NSW)
68	Name suppressed
69	Mrs Julie-Anne Hill
70	Confidential
71	Australian Salaried Medical Officer's Federation (ASMOF) NSW
72	Confidential
73	Wee Waa Hospital Auxiliary
74	A. Allan
75	Australian Paramedics Association (NSW)
76	Narrabri Shire Council
77	NSW Nurses and Midwives' Association
78	Laurie White
79	Uralla Shire Council
80	Inverell Shire Council
81	Gwydir Shire Council
82	Merced Farming Pty Ltd
83	Ron Thorp
84	Confidential
85	Tamworth Regional Council
86	Cancer Council NSW
87	Name suppressed
88	Confidential
89	Wee Waa Chamber of Commerce
90	Health Services Union - NSW ACT QLD (HSU)
91	Aboriginal Health and Medical Research Council of NSW
92	Name suppressed
93	Mr John Fogarty
94	NSW Farmers Association - Wee Waa Branch
95	Save Wee Waa Hospital Committee
96	RiverBank Youth Works Ltd
97	Mr Peter Carrett
98	Hunter Medical Research Institute
99	Maternal Child & Family Health Nurses Australia
100	Rural Doctors Association of NSW

No	Author
101	Moree Plains Shire Council
102	Australian Food & Fibre
103	Confidential
104	New England Division of General Practice
105	School of Rural Medicine University of New England
106	Mr Edward Stubbins
107	Confidential

Appendix Four – Witnesses

12 August 2025
Narrabri Shire Council Chambers, Narrabri, NSW

Witness	Position and Organisation
Mrs Robyn Keefe	CEO, Wee Waa Aboriginal Land Council
Mr Clifford Toomey	Chair, Wee Waa Aboriginal Land Council
Mr Christian Petersen	Founder/Program Manager, RiverBank Youth Works Ltd
Mr Andrew Bowen	Secretary/Treasurer, Wee Waa Chamber of Commerce
Ms Anne Weekes	President, Wee Waa Hospital Auxiliary
Ms Kate Kahl	Member, Save Wee Waa Hospital Committee
Ms Carmel Schwager	Member, Save Wee Waa Hospital Committee
Cr Tiffany Galvin	Mayor, Gwydir Shire Council
Ms Leah Daley	General Manager, Gwydir Shire Council
Mr Jonathon Phelps	President, NSW Farmers Association - Wee Waa Branch
Mr Daniel Kahl	Business Manager / Director, Merced Farming Pty Ltd
Mr John Fogarty	
Mr Richard Schwager	Treasurer, NSW Farmers Association - Wee Waa Branch

13 August 2025
Tamworth Jockey Club and Function Centre, Taminda, NSW

Witness	Position and Organisation
Ms Heather Franke	Secretary & Delegate, Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association
Dr Michelle Guppy	General Practitioner, Secretary & Treasurer, New England Division of General Practice
Mr Edward Stubbins	
Cr Russell Webb	Mayor, Tamworth Regional Council

20 August 2025
Parliament House, Preston Stanley Room, Sydney, NSW

Witness	Position and Organisation
Mr Ben McAlpine	Director of Policy and Advocacy, NSW Council of Social Service (NCOSS)
Ms Elyse Cain	Policy Lead, NSW Council of Social Service (NCOSS)
Dr Louise Wightman	Chair and Senior Project Officer, Maternal Child & Family Health Nurses Australia
Ms Emma Hardy	Professional Officer, NSW Nurses and Midwives' Association
Mr Warren Isaac	Member, New South Wales Nurses and Midwives' Association
Mrs Bronwyn Dunston	State Secretary, Country Women's Association of NSW
Mrs Sandy Harrison	Murrurundi Branch, Country Women's Association, Murrurundi Branch
Ms Brenna Smith	Manager, Community Cancer Information and Support Services, Cancer Council NSW
Mr Bradley Gellert	Manager, Policy and Advocacy, Cancer Council NSW
Dr Tony Sara	Secretary, Australian Salaried Medical Officer's Federation (ASMOF) NSW
Mr Coda Danu-Asmara	Senior Industrial Officer, Australian Paramedics Association (NSW)
Mr Reece Fredericks	Executive Committee Member, Australian Paramedics Association (NSW)
Dr Tania Day	Chair, Training and Accreditation Committee, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
Ms Fiona Davies	Chief Executive Officer, Australian Medical Association (NSW)
Dr Ian Kamerman	Secretary, Rural Doctors Association of NSW

22 August 2025
Parliament House, Preston Stanley Room, Sydney, NSW

Witness	Position and Organisation
Cr Kate Dight	Mayor, Inverell Shire Council

Cr Susannah Pearse	Mayor, Moree Plains Shire Council
Cr Bronwyn Petrie	Mayor, Tenterfield Shire Council
Cr Greg Sauer	Deputy Mayor, Tenterfield Shire Council
Cr Darrell Tiemens	Mayor, Narrabri Shire Council
Cr Ethan Towns	Councillor, Narrabri Shire Council
Dr Eric Baker	
Ms Susan Sargent	
Professor Frances Kay	CEO and Institute Director, Hunter Medical Research Institute
Dr Michelle Guppy	Head of School, School of Rural Medicine University of New England
Dr David Scott	Chair, Tamworth Medical Staff Council
Ms Tracey McCosker PSM	Chief Executive, Hunter New England Local Health District
Dr Paul Craven	Executive Director for Children & Young People and Families, Hunter New England Local Health District
Ms Elizabeth Grist OAM	Executive Director of Clinical Services and Nursing & Midwifery, Hunter New England Local Health District
Ms Susan Heyman	Executive Director of Operations, Hunter New England Local Health District
Mr Luke Sloane	Deputy Secretary of Rural and Regional Health, NSW Health
Mr Matthew Daly	Deputy Secretary of System Sustainability and Performance, NSW Health
Mr Alfa D'Amato	Deputy Secretary of Financial & Corporate Services and Chief Financial Officer, NSW Health

Appendix Five – Extracts from minutes

Meeting no 12
9:19pm, 27 February 2025
Room 1043/Webex

Members present
In person: Mr Barr (Chair), Ms Butler, Mrs Dalton, and Ms Wilson
Via videoconference: Ms Doyle (Deputy Chair), and Mrs Thompson

Officers present
Caroline Hopley, Dora Oravecz, Sukhraj Goraya, and Yann Pearson

1. ***
2. ***
3. ***

4. Inquiry into Health Services Amendment (Splitting of the Hunter New England Local Health District) Bill

4.1 Terms of reference

The Committee discussed the referral by the House of the Health Services Amendment (Splitting of the Hunter New England Local Health District) Bill.

Resolved on the motion of Mrs Dalton: That the Committee inquires into and reports on Health Services Amendment (Splitting of the Hunter New England Local Health District) Bill.

4.2 Inquiry timeline

The Committee discussed the timing of hearings and sites visits to be held as part of the inquiry.

4.3 Call for submissions

Resolved on the motion of Ms Davis: That the Committee:

- calls for submissions with a closing date of 17 April 2025.
- writes to the stakeholders on the list circulated, and other stakeholders suggested by members, inviting them to make a submission.

4.4 Maps of Hunter New England Local Health District

The Committee discussed the locations of hearings and site visits to be held as part of the inquiry.

5. General business

The Committee agreed to invite representatives of NSW Health to brief the Committee on issues relevant to the inquiry.

***

It was agreed that Committee staff would check member availability on dates in May, June, and August.

6. Next meeting

The meeting adjourned at 9.48am until a time and date to be confirmed.

Meeting no 13

1:28pm, 15 May 2025
Room 814/Webex

Members present

In person: Mr Barr (Chair), Ms Doyle (Deputy Chair), Ms Davis, Mrs Thompson and Ms Wilson
Via videoconference: Mrs Dalton

Apologies

Ms Butler

Officers present

Caroline Hopley, Dora Oravecz, Sukhraj Goraya, Natasha Moir, Yann Pearson, Lloyd Connolly and Janish Hettigama

1. Deliberative meeting

1.1 Confirmation of minutes

Resolved, on the motion of Mrs Thompson: That the minutes of the meeting of 27 February 2025 be confirmed.

1.2 Inquiry into Health Services Amendment (Splitting of the Hunter New England Local Health District) Bill

a. ***

b. Publishing submissions

Resolved, on the motion of Ms Doyle:

- That the Committee accepts and publishes submissions 2 to 3, 5 to 7, 9, 14 to 16, 18, 21 and 22, 24 and 25, 27, 29 to 32, 35, 38, 40, 45 to 48, 53, 56 to 59, 61, 63 to 67, 69, 71, 73, 75 to 83, 85 and 86, 89 to 91, and 93 to 101 in full.
- That the Committee accepts and publishes submissions 20, 51a and 92 with the authors' names suppressed.
- That the Committee accepts and publishes submissions 34, 55 and 74 with the authors' names displayed and identifying and personal details redacted.
- That the Committee accepts and publishes submissions 8, 11, 17, 50 and 51, 54, 60, 62, 68 and 87 with the authors' names suppressed and identifying and personal details redacted.
- That submissions 1, 4, 10, 12 and 13, 19, 23, 26, 28 and 28a, 33, 36 and 37, 39, 41 to 44, 49, 52, 70, 72, 84 and 88 be accepted and remain confidential to the Committee and not be published.

c. Public hearings and site visits

The Committee discussed hearing dates and locations and witnesses to be invited to appear at the hearings.

Resolved, on the motion of Ms Doyle: That the Committee invites the listed witnesses to give evidence at public hearings to be held on 15 to 17 June in the New England area and on 11 and 12 August at Parliament House.
Resolved, on the motion of Ms Doyle: That the Committee seeks approval for funding for members and staff to take part in a three-day site visit from 15 June to 17 June to Narrabri and Tamworth at the estimated cost of $27,000.
The meeting concluded at 1.40pm.

2. Briefing with NSW Health and Hunter New England Local Health District staff
The Committee held a briefing with the following NSW Health and Hunter New England Local Health District staff:

- Luke Sloane, Deputy Secretary, Rural and Regional Health
- Matthew Daly, Deputy Secretary, System Sustainability and Performance
- Phil Minns, Deputy Secretary, People, Culture and Governance
- Steven Carr, Executive Director, System Financial Performance and Deputy Chief Financial Officer
- Tracey McCosker, Chief Executive, Hunter New England Local Health District via videoconference
- Paul Craven, Executive Director Children, Young People and Families, Hunter New England Local Health District via videoconference
- Elizabeth Grist, Executive Director Clinical Services, Nursing and Midwifery, Hunter New England Local Health District via videoconference
- Susan Heyman, Executive Director Operations, Hunter New England Local Health District via videoconference.

3. Deliberative meeting
The meeting adjourned at 2.33pm until 16 June 2025.

Meeting no 14
10:03am, 2 July 2025
Room 1254/Webex

Members present
In person: Mr Barr (Chair)
Via videoconference: Ms Doyle (Deputy Chair), Mrs Thompson, Ms Davis, Ms Wilson and Mrs Dalton

Apologies
Ms Butler

Officers present
Caroline Hopley, Sukhraj Goraya, Natasha Moir, Lloyd Connolly and Janish Hettigama

1. Confirmation of minutes
Resolved, on the motion of Ms Thompson: That the minutes of the meeting of 15 May 2025 be confirmed.

2. ***

3. Inquiry into Health Services Amendment (Splitting of the Hunter New England Local Health District) Bill

3.1 Publishing late submissions

Resolved, on the motion of Ms Doyle:

- That the Committee accepts and publishes submissions 102, 104, 105 and 106 in full.
- That submission 103 be accepted and remain confidential to the Committee and not be published.

3.2 Public hearings and site visits

The Committee discussed rescheduling its site visit to the New England region and Parliament House public hearing dates.

Resolved, on the motion of Ms Davis: That the Committee seeks approval for funding for members and staff to take part in a three-day site visit to Narrabri and Tamworth from 11 August to 13 August at the estimated cost of $30,812.

Resolved on the motion of Ms Wilson: That the Committee holds public hearings at Parliament House on 20 August and 22 August.

3.3 Inviting additional witnesses to public hearings

Resolved, on the motion of Mrs Dalton: That the Committee invites the School of Rural Medicine, University of New England, the New England Division of General Practice and Mr Edward Stubbins to give evidence at public hearings for the inquiry.

4. ***

5. Next meeting

The meeting adjourned at 10:12am until 12 August 2025.

Meeting no 15

9:07am, 12 August 2025
Narrabri Council Chambers

Members present

Mr Barr (Chair), Ms Doyle (Deputy Chair), Ms Butler, Ms Davis, Ms Wilson and Mrs Dalton

Apologies

Mrs Thompson

Officers present

Caroline Hopley, Dora Oravecz, Chris Herbert, Sukhraj Goraya and Lloyd Connolly

1. Pre-hearing deliberative meeting

1.1 Confirmation of minutes

Resolved, on the motion of Ms Davis: That the minutes of the meeting of 2 July 2025 be confirmed.

1.2 *

1.3 Submissions

Resolved, on the motion of Ms Butler: That the Committee accepts and publishes an amended version of submission 57 in full.

Resolved, on the motion of Ms Doyle: That submission 107 be accepted and remain confidential to the Committee and not be published.

1.4 Media orders

Resolved, on the motion of Ms Wilson: That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearings on 12 and 13 August 2025 by committee staff and media organisations, 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.

1.5 Supplementary questions

Resolved, on the motion of Mrs Dalton: That the Committee adopts the following process in relation to supplementary questions for the public hearings on 12 and 13 August 2025:

- Members to email proposed supplementary questions for witnesses to committee staff within 2 business days of the uncorrected transcript being circulated to members.
- Committee staff to circulate all proposed supplementary questions to the Committee, with members to lodge any objections to the questions within 1 business day of the questions being sent to members.

1.6 Answers to questions taken on notice and supplementary questions

Resolved, on the motion of Ms Butler: That witnesses from public hearings on 12 and 13 August 2025 be requested to return answers to questions taken on notice and supplementary questions within 1 week of the date on which the questions are forwarded.

The meeting concluded at 9.11am.

2. Public hearing – Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025

Mr Clifford Toomey gave a Welcome to Country.

The Chair opened the public hearing at 9.23am and made a short opening statement.

Mrs Robyn Keefe, Chief Executive Officer, Wee Waa Aboriginal Land Council, was sworn and examined.

Mr Clifford Toomey, Chair, Wee Waa Aboriginal Land Council, was sworn and examined.

The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.

Mr Christian Petersen, Founder/Program Manager, RiverBank Youth Works Ltd, was sworn and examined.

Mr Andrew Bowen, Secretary/Treasurer, Wee Waa Chamber of Commerce, was sworn and examined.

The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.

Ms Anne Weekes, President, Wee Waa Hospital Auxiliary members, was sworn and examined.

Ms Kate Kahl, Member, Save Wee Waa Hospital Committee, was sworn and examined.

Ms Carmel Schwager, Member, Save Wee Waa Hospital Committee, was sworn and examined.

The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.
Cr Tiffany Galvin, Mayor, Gwydir Shire Council, was affirmed and examined.
Ms Leah Daley, General Manager, Gwydir Shire Council, was affirmed and examined.
The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.
Mr Richard Schwager, Treasurer, NSW Farmers Association, Wee Waa Branch, was sworn and examined.
Mr Jonathon Phelps, President, NSW Farmers Association, Wee Waa Branch, was sworn and examined.
Mr Daniel Kahl, Director / Business Manager, Merced Farming Pty Ltd, was sworn and examined.
Mr John Fogarty was sworn and examined.
The Committee questioned the witnesses.
Mr Fogarty tendered a map of the Hunter New England Local Health District.
Mr Phelps tendered the opening statement and attachments that he prepared for the hearing.
Evidence concluded; the witnesses withdrew.
The public hearing concluded at 2.31pm.

3. ***

4. Post-hearing deliberative meeting

The Committee commenced a deliberative meeting at 3.47pm.

4.1 Publishing transcript of evidence

Resolved, on the motion of Ms Wilson: That the corrected transcript of public evidence given today be authorised for publication and uploaded on the Committee's webpage.

4.2 Accepting and publishing tendered documents

Resolved, on the motion of Ms Davis: That the Committee considers the documents tendered during today's hearing at the hearing to be held in Sydney on 20 August.

5. General business

The Chair noted that Professor Michelle Guppy, who is appearing at the Tamworth public hearing for the New England Division of General Practice, will also appear at the Sydney hearing on 22 August representing the School of Rural Medicine, University of New England.

6. Next meeting

The meeting adjourned at 3:50pm until 13 August at the Tamworth Jockey Club and Function Centre, Taminda.

Meeting no 16
9:15am, 13 August 2025
Tamworth Jockey Club and Function Centre

Members present
Mr Barr (Chair), Ms Doyle (Deputy Chair), Ms Butler, Ms Davis, Ms Wilson and Mrs Dalton

Apologies
Mrs Thompson

Officers present
Caroline Hopley, Dora Oravecz, Chris Herbert, Sukhraj Goraya and Lloyd Connolly

1. Public hearing – Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025

The Chair opened the public hearing at 9.15am and made a short opening statement.
Ms Heather Franke, Secretary & Delegate, Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association, was sworn and examined.
Dr Michelle Guppy, General Practitioner, Secretary & Treasurer, New England Division of General Practice, was sworn and examined.
Mr Edward Stubbins, was affirmed and examined.
The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.
Clr Russell Webb, Mayor, was sworn and examined.
The Committee questioned the witness. Evidence concluded; the witness withdrew.
The public hearing concluded at 11.01am.

2. Deliberative meeting

The Committee commenced a deliberative meeting at 11.08am.
Resolved on the motion of Ms Doyle: That the corrected transcript of public evidence given today be authorised for publication and uploaded on the Committee's webpage.

3. Next meeting

The meeting adjourned at 11.09am until 20 August in the Preston Stanley Room at Parliament House.

Meeting no 17
9:03am, 20 August 2025
Preston Stanley Room and videoconference

Members present
In person: Mr Barr (Chair), Ms Butler, Ms Davis, and Mrs Thompson
Via videoconference: Ms Doyle (Deputy Chair), and Mrs Dalton

Apologies
Ms Wilson

Officers present
Caroline Hopley, Dora Oravecz, Natasha Moir, Lloyd Connolly and Janish Hettigama

1. Deliberative meeting

1.1 *

1.2 Accepting and publishing documents tendered in Narrabri

Resolved, on the motion of Ms Davis: That the Committee accepts the following documents tendered during the public hearing held in Narrabri on 12 August:

- Map of the Hunter New England Local Health District, tendered by Mr John Fogarty.
- Opening statement and attachments, tendered by Mr Jonathon Phelps.

1.3 Media orders

Resolved, on the motion of Ms Doyle: That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearings on 20 and 22 August 2025 by committee staff and media organisations, 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.

1.4 Supplementary questions on notice

Resolved, on the motion of Mrs Dalton: That the Committee adopts the following process in relation to supplementary questions for the public hearings on 20 and 22 August 2025:

- Members to email proposed supplementary questions for witnesses to committee staff within 2 business days of the uncorrected transcript being circulated to members.
- Committee staff to circulate all proposed supplementary questions to the Committee, with members to lodge any objections to the questions within 1 business day of the questions being sent to members.

1.5 Answers to questions taken on notice and supplementary questions

Resolved, on the motion of Mrs Thompson: That witnesses appearing on 20 and 22 August 2025 be requested to return answers to questions taken on notice and supplementary questions within 1 week of the date on which the questions are forwarded.

1.6 General business

The Committee discussed the conduct of the hearing.
The meeting concluded at 9.11am.

2. Public hearing – Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025

The Chair opened the public hearing at 9.13am and made a short opening statement.
Mr Ben McAlpine, Director of Policy and Advocacy, NSW Council of Social Service, was affirmed and examined.
Ms Elyse Cain, Policy Lead, NSW Council of Social Service, was affirmed and examined.
Mr McAlpine tendered a document titled 'Geographical patterns of all cancer survival indicators across NSW'.
The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.
Dr Louise Wightman, Chair and Senior Project Officer, Maternal Child & Family Health Nurses Australia, was affirmed and examined.
Ms Emma Hardy, Professional Officer, NSW Nurses and Midwives' Association, was affirmed and examined.
Mr Warren Isaac, Member, NSW Nurses and Midwives' Association, was affirmed and examined by videoconference.
The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.
Mrs Bronwyn Dunston, State Secretary, Country Women's Association of NSW, was affirmed and examined by videoconference.
Mrs Sandy Harrison, Country Women's Association, Murrurundi Branch, was affirmed and examined by videoconference.

The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.
Ms Brenna Smith, Manager, Community Cancer Information and Support Services, Cancer Council NSW, was affirmed and examined.
Mr Bradley Gellert, Manager, Policy and Advocacy, Cancer Council NSW, was affirmed and examined.
The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.
Dr Tony Sara, Secretary, Australian Salaried Medical Officer's Federation NSW, was sworn and examined by videoconference.
Mr Coda Danu-Asmara, Senior Industrial Officer, Australian Paramedics Association (NSW), was affirmed and examined.
Mr Reece Fredericks, Executive Committee Member, Australian Paramedics Association, was affirmed and examined by videoconference.
The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.
Dr Tania Day, Chair, Training and Accreditation Committee, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, was affirmed and examined.
The Committee questioned the witness. Evidence concluded; the witness withdrew.
Ms Fiona Davies, Chief Executive Officer, Australian Medical Association (NSW), was affirmed and examined.
Dr Ian Kamerman Secretary, Rural Doctors Association of NSW, was affirmed and examined.
The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.
The public hearing concluded at 4.01pm.

3. Deliberative meeting

The Committee commenced a deliberative meeting at 4.02pm.

3.1 Publishing transcript of evidence

Resolved, on the motion of Mrs Thompson: That the corrected transcript of public evidence given today be authorised for publication and uploaded on the Committee's webpage.

3.2 Accepting and publishing tendered documents

Resolved, on the motion of Ms Davis: That the Committee accepts a document titled 'Geographical patterns of all cancer survival indicators across NSW', tendered by Mr McAlpine during today's public hearing.

4. Next meeting

The meeting adjourned at 4.04pm until 9am on 22 August in the Preston Stanley Room.

Meeting no 18

9:02am, 22 August 2025
Preston Stanley room and videoconference

Members present

Mr Barr (Chair), Ms Doyle (Deputy Chair) (by videoconference), Ms Butler, Ms Davis

Apologies

Mrs Dalton, Mrs Thompson, Ms Wilson

Officers present

Caroline Hopley, Dora Oravecz, Lloyd Connolly, Janish Hettigama

1 Deliberative meeting

1.1 Confirmation of minutes

Resolved, on the motion of Mrs Davis: That the minutes of the meetings of 12 August and 13 August be confirmed.

1.2 Correspondence

The Committee considered correspondence received 15 August 2025 from Ms Carmel Schwager, providing clarifications to evidence she gave on 12 August.
Resolved, on the motion of Ms Doyle: That correspondence from Ms Carmel Schwager clarifying evidence she gave on 12 August be published with personal contact details redacted, and that a footnote and link to the published letter be inserted at the relevant section of the transcript.

1.3 *

The meeting concluded at 9.04am.

2. Public hearing – Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025

The Chair opened the public hearing at 9.17am and made a short opening statement.
Cr Kate Dight, Mayor, Inverell Shire Council, was sworn and examined.
Cr Susannah Pearse, Mayor, Moree Plains Shire Council, was affirmed and examined by videoconference.
The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.
Cr Bronwyn Petrie, Mayor, Tenterfield Shire Council, was sworn and examined by videoconference.
Cr Greg Sauer, Deputy Mayor, Tenterfield Shire Council, was affirmed and examined by videoconference.
Cr Darrell Tiemens, Mayor, Narrabri Shire Council, was sworn and examined by videoconference.
Cr Ethan Towns, Councillor, Narrabri Shire Council, was sworn and examined by videoconference.
The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.
Dr Eric Baker was affirmed and examined.
The Committee questioned the witness. Evidence concluded; the witness withdrew.
Ms Susan Sargent was affirmed and examined by videoconference.
The Committee questioned the witness. Evidence concluded; the witness withdrew.
Professor Frances Kay, CEO and Institute Director, Hunter Medical Research Institute, was affirmed and examined.
Dr Michelle Guppy, Head of School, School of Rural Medicine University of New England, was affirmed and examined by videoconference.
The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.
Dr David Scott, Chair, Tamworth Medical Staff Council, was sworn and examined by videoconference.

The Committee questioned the witness. Evidence concluded; the witness withdrew.
Ms Tracey McCosker, Chief Executive, Hunter New England Local Health District, was affirmed and examined by videoconference.
Dr Paul Craven, Executive Director for Children & Young People and Families, Hunter New England Local Health District, was affirmed and examined.
Ms Elizabeth Grist, Executive Director of Clinical Services and Nursing & Midwifery, Hunter New England Local Health District, was sworn and examined by videoconference.
Ms Susan Heyman, Executive Director of Operations, Hunter New England Local Health District, was affirmed and examined by videoconference.
Mr Luke Sloane, Deputy Secretary of Rural and Regional Health, NSW Health, was affirmed and examined.
Mr Matthew Daly, Deputy Secretary of System Sustainability and Performance, NSW Health, was sworn and examined.
Mr Alfa D'Amato, Deputy Secretary of Financial & Corporate Services and Chief Financial Officer, NSW Health, was sworn and examined.
The Committee questioned the witnesses. Evidence concluded; the witnesses withdrew.
The public hearing concluded at 4.19pm.

3. Deliberative meeting

The Committee commenced a deliberative meeting at 4.28pm.

Publishing transcript of evidence

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.

4. Next meeting

The meeting adjourned at 4.28pm until a date and time to be determined.

Unconfirmed minutes of meeting no 19

2.34pm, 27 October 2025
Room 814 and videoconference

Members present

Mr Barr (Chair), Ms Doyle (Deputy Chair) (by videoconference), Ms Butler (by videoconference), Mrs Dalton, Ms Davis (by videoconference), Mrs Thompson (by videoconference), Ms Wilson (by videoconference)

Officers present

Caroline Hopley, Dora Oravecz, Natasha Moir, Lloyd Connolly, Janish Hettigama

1. Recording meeting

Resolved, on the motion of Ms Doyle: 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. Confirmation of minutes

Resolved, on the motion of Ms Doyle, seconded by Mrs Thompson: That the minutes of the meetings of 20 and 22 August 2025 be confirmed.

3. Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025

3.1. Correspondence

The Committee noted the following correspondence received:

- Edward Stubbins, providing information regarding the inquiry, received 29 August.
- Elizabeth Grist, clarifying evidence given on 22 August, received 29 August.
- Professor Frances Kay, clarifying evidence given on 22 August, received 1 September.

Resolved, on the motion of Mrs Dalton, seconded by Ms Butler: That the correspondence from Elizabeth Grist and Professor Frances Kay clarifying evidence they gave on 22 August be published, and a footnote and link to the published letters be inserted at the relevant sections of the transcript.

3.2. ***

3.3. Publishing additional information, answers to questions on notice and answers to supplementary questions

Resolved, on the motion of Mrs Dalton, seconded by Ms Doyle:

1. That answers to questions on notice received from the NSW Council of Social Services, NSW Nurses and Midwives' Association, Cancer Council NSW and Susan Sargent be published on the Committee's webpage.
2. That answers to supplementary questions received from the NSW Farmers Association, Wee Waa Branch; RiverBank Youth Works Ltd; Save Wee Waa Hospital Committee; Wee Waa Aboriginal Land Council; Wee Waa Chamber of Commerce; Wee Waa Hospital Auxiliary; Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association; New England Division of General Practice and NSW Health be published on the Committee's webpage.
3. That additional information received from the Hunter New England LHD be published on the Committee's webpage, with the tables on pages 2 to 3 of the document redacted.
4. That answers to supplementary questions received from Edward Stubbins be published on the Committee's webpage with page 2 of the document redacted.

3.4. Consideration of Chair's draft report

The Committee agreed to consider the report chapter by chapter.

Resolved on the motion of Ms Davis, seconded by Mrs Thompson:

- That chapter 1 be renumbered as chapter 3
- That chapter 2 be renumbered as chapter 1
- That chapter 3 be renumbered as chapter 2
- That paragraphs 1.1 to 1.10, the heading 'The Health Services Amendment (Splitting of the Hunter New England Health District) Bill', and recommendation 1 be moved to the start of renumbered chapter 1.

Resolved, on the motion of Ms Davis, seconded by Mrs Thomspon: That chapter 1 as amended stands as part of the report.

Resolved, on the motion of Ms Davis, seconded by Ms Doyle: That the word 'maternity' be inserted in paragraph 2.14, before 'specialised and emergency care'.

Resolved, on the motion of Ms Doyle, seconded by Ms Butler: That chapter 2 as amended stands as part of the report.
Resolved, on the motion of Ms Doyle, seconded by Mrs Thompson: That chapter 3 as amended stands as part of the report.
Resolved on the motion of Ms Wilson, seconded by Ms Davis: That paragraph 4.30 be omitted.

4.30 The impact of the split on healthcare and services for Aboriginal people is discussed in chapter two.

Resolved on the motion of Ms Doyle, seconded by Mrs Dalton: That chapter 4 as amended stands as part of the report.
Resolved, on the motion of Mrs Dalton, seconded by Ms Butler:

1. That the draft report as amended be the report of the Committee, signed by the Chair and presented to the House.
2. That the Chair and secretariat be permitted to correct stylistic, typographical and grammatical errors.
3. That, once tabled, the report be published on the Committee's webpage.

4. ***
5. ***
6. Next meeting

The meeting adjourned at 3.24pm until 5 February 2026.