Submission No 90

HEALTH SERVICES AMENDMENT (SPLITTING OF THE HUNTER NEW ENGLAND HEALTH DISTRICT) BILL 2025

Organisation: Health Services Union - NSW ACT QLD (HSU)

Date Received: 1 May 2025

Legislative Assembly
Committee on Community Services
Parliament of New South Wales
6 Macquarie St, Sydney NSW 2000

Dear Legislative Committee Members,

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

The Health Services Union (HSU) writes to the Legislative Assembly Committee on Community Services in response to the proposed dissolution of the Hunter New England Local Health District (HNELHD), and the establishment of separate entities: the Hunter Local Health District and the New England North West Local Health District.

Before any such proposal advances, it's important to understand the history and rationale behind the HNELHD's formation. In 2004, amendments to the *Health Services Act 1997* saw 17 area health services consolidated into eight, following a recommendation from the Independent Pricing and Regulatory Tribunal. The Hunter New England Area Health Service (now HNELHD) was established in January 2005 through the amalgamation of the Hunter and New England Area Health Services. The state health service restructure aimed to reduce duplication in management and administration, with projected savings of $100 million annually redirected to improve clinical services and staffing.

In his second reading speech, Mr Roy Butler MP cited chronic under-resourcing of rural health services within the HNELHD and a lack of collaboration with rural networks as key reasons behind the bill. Concerns were raised about increasing centralisation of services and a perceived disconnection between HNELHD's Newcastle-based administration and New England's rural communities.

The HSU acknowledges the pressing need for rural communities to have responsive, accessible healthcare, particularly given the ongoing challenges of attracting and retaining health professionals, vast geographical distances, and the unique health profiles of rural populations. However, these challenges are not unique to New England but are shared across rural and remote regions of New South Wales.

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The central issue raised by the member for Barwon appears to be with the management of HNELHD and whether it is adequately addressing the needs of the rural communities in the New England region. While transformative action is certainly required to address the rural and remote health crisis, splitting the HNELHD risks not addressing the underlying issues. Such a move could recreate inefficiencies, duplicate administrative structures, and increase overall expenditure without necessarily improving outcomes. The challenge lies not in boundaries but in leadership, workforce support, and meaningful rural health planning. Funds that would be consumed by administrative restructuring would be far better directed into workforce expansion, infrastructure and rural service innovation. Establishing a new local health district does not guarantee more responsive management, particularly if it is created without adequate resourcing or clear accountability.

Addressing the root cause of rural workforce shortages requires tailored strategies:

- **Workforce Incentives**: Expanded incentive schemes to account for the social and geographic isolation from regional families. Measures such as increased wages, additional leave entitlements for travel to visit family, and subsidised internet and mobile services to stay connected.
- **Investing in Local Training Pipelines**: Evidence shows that health professionals who train in rural areas are more likely to remain there. New England would benefit from extending programs such as:
    - the Rural Allied Health Educator model: facilitates rural placements for students and improves the likelihood they will work in rural settings
    - School-Based Apprenticeship and Traineeship program: successful at guiding students toward healthcare careers in their communities
    - Far West Metro-Rural GradStart Exchange Program: utilised in the Far West to provide rural new graduates with valuable training experiences in larger hospitals to take back to rural communities.
- **Affordable Housing**: Workforce attraction is tied lack of affordable housing in rural communities. Building on programs like the $5.1 million health worker housing investment in Far West NSW, and a targeted "help to build" scheme for health workers, aimed at boosting both housing supply and workforce retention in the New England region.

Tailored incentives for senior health professionals would structure around the desire for career satisfaction, access to teaching opportunities, research engagement, and an expanded scope of practice. HNELHD is uniquely positioned to provide this by leveraging partnerships with John Hunter Hospital, the Hunter Medical Research Institute, and the universities of Newcastle and New England, to support and retain senior staff in the New England areas.

Rather than dividing the HNELHD, a more sustainable model would involve senior clinicians, health professionals, consumers, and community representatives in rural areas to play a more active role in shaping service delivery. Their input should be embedded in the governance of the HNELHD, particularly in setting strategic priorities for rural health services, addressing the rural need for a more flexible, community-focused model of care.

Sincerely,

Gerard Hayes AM

Secretary – Health Service Union, NSW/ACT/QLD
National President – Health Services Union

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