REPORT ON PROCEEDINGS BEFORE

LEGISLATIVE ASSEMBLY SELECT COMMITTEE ON REMOTE, RURAL AND REGIONAL HEALTH

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO WORKFORCE ISSUES, WORKPLACE CULTURE AND FUNDING CONSIDERATIONS FOR REMOTE, RURAL AND REGIONAL HEALTH

At Macquarie Room, Parliament House, Sydney on Friday 24 November 2023

The Committee met at 13:00.

PRESENT

Mr Joe McGirr (Chair)

Ms Liza Butler
Mrs Tanya Thompson

PRESENT VIA VIDEOCONFERENCE

Mr Clayton Barr
Ms Trish Doyle
Mrs Leslie Williams

*Please note:

[inaudible] is used when audio words cannot be deciphered
[audio malfunction] is ued when words are lost due to a technical malfunction
[disorder] is used when members or witnesses speak over one another

The CHAIR: Welcome to today's public hearing of the Legislative Assembly Select Committee on Remote, Rural and Regional Health's inquiry. Today's hearing is part of our inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health. We will be hearing from a range of witnesses from across the healthcare sector. The hearing is being broadcast to the public via Parliament's website, and we have a combination of witnesses appearing in person and via videoconference. The second day of hearings will commence at nine o'clock on Monday 27 November.

Before we commence, I acknowledge the Gadigal people, who are the traditional custodians of the land we meet on here at New South Wales Parliament. I also pay my respects to Elders past and present, and extend that respect to other Aboriginal and Torres Strait Islander people who are present today or watching proceedings on the New South Wales Parliament's website. I thank everyone who is appearing before the Committee today. I declare the hearing open.

Mr RICHARD COLBRAN, CEO, NSW Rural Doctors Network, sworn and examined

Dr TOM DOUCH, Deputy Chair, NSW Rural Doctors Network, sworn and examined

Dr MICHAEL BONNING, President, Australian Medical Association (NSW), affirmed and examined

Ms FIONA DAVIES, CEO, Australian Medical Association (NSW), affirmed and examined

Ms MARGARET DEERAIN, Director, Policy and Strategy Development, National Rural Health Alliance, before the Committee via videoconference, sworn and examined

Ms CLARE FITZMAURICE, Policy and Data Analytics Officer, National Rural Health Alliance, before the Committee via videoconference, sworn and examined

Dr ROD MARTIN, College Councillor NSW, Australian College of Rural and Remote Medicine, before the Committee via videoconference, sworn and examined

The CHAIR: Can each witness please confirm that you have been issued the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

RICHARD COLBRAN: Yes.

TOM DOUCH: Yes.

MICHAEL BONNING: Yes.

FIONA DAVIES: Yes.

MARGARET DEERAIN: Yes.

CLARE FITZMAURICE: Yes.

ROD MARTIN: Yes.

The CHAIR: Would any of the witnesses like to make a brief opening statement? We'll go in turn. We might start with the National Rural Health Alliance.

MARGARET DEERAIN: Thank you for this opportunity to present at the public hearing. The National Rural Health Alliance is the peak body for rural health in Australia. We now have 50 national members and develop policy, run programs and, above all, advocate for the health and wellbeing of the seven million people—that is 30 per cent of the population—living in rural Australia. Importantly, our membership covers the multidisciplinary health workforce working in rural Australia. In 2023 the alliance commissioned Nous Group to undertake a major research piece on whether rural Australia is receiving its fair share or equitable share of the health spending dollar. The report we released is titled *Evidence base for additional investment in rural health in Australia*. The Nous analysis quantifies the national rural health deficit at $6.55 billion annually. This equates to $848 of health funding spent less on each rural person every year compared to their metropolitan counterparts. This is in the context of a population of more than seven million people in rural Australia.

Nous found a triple disadvantage for rural Australians: their social determinants of health, a higher cost of access and delivery, lack of scale, distance and poor service availability. Access to high-quality, affordable primary healthcare services prevents avoidable hospital admissions and reduces hospital stays. Primary health

care is in dire straits in many rural locations and, indeed, has failed much of the population, where communities are receiving little or no access to care due to a shortage of doctors, nurses and other health professionals, an inequity of funding, inadequacy of funding mechanisms and a lack of support. This comes when we know rates of chronic diseases are increasing generally, and rural Australians experience high rates of many of these conditions. They need the care provided by multidisciplinary health teams.

The alliance believes there is scope for the state and Australian governments to further support greater investment in locally led, place-based healthcare models that can support multidisciplinary teams and meet specific population health needs. Primary healthcare practices need sustainable funding, including block funding options which mean that they can continue to serve rural communities and not be at risk when a General Practitioner (GP) or other essential healthcare worker inevitably retires or leaves an area. Thank you for the opportunity to input into your deliberations.

The CHAIR: Thank you very much, Ms Deerain. I now might go to the Rural Doctors Network (RDN) for their opening statement.

TOM DOUCH: Thank you very much for the opportunity to make this presentation. We value the opportunity as the Rural Doctors Network. My name is Tom Douch. I've got a background in anaesthetics and general practice in Young and as a previous chair of the Murrumbidgee Local Health District. I'm here to support our CEO, who will make the bulk of our presentation, but to indicate that the opinions being expressed have got the full support of our board. I would also like to extend the RDN's acknowledgement to the traditional owners of the lands on which we meet and pay our respect to Elders past and present as we make this presentation.

RICHARD COLBRAN: It's a privilege to be here to represent not just the Rural Doctors Network staff and board but also the communities that the network supports across rural New South Wales. We've prepared a few comments which we hope help as an opening statement. The Rural Doctors Network turns 35 this year. It's a not-for-profit charity. It emerged out of the 1987 rural doctors' dispute in New South Wales. One of the things that might be poignant at the moment is to reflect back on how far we've come since 1987 because many of the originals from that time have shared to me they've never seen a situation in terms of workforce and access to care in rural New South Wales as bad—ever. At the moment we're asking ourselves the question, "Do we really understand the issues and are we doing enough?"

Rural Doctors Network would like to acknowledge that there is progress being made against the 44 recommendations of the rural health inquiry. We'd also like to acknowledge and thank the New South Wales Government, the Ministry of Health and the Local Health Districts (LHDs) for their efforts in progressing some of that work. But we also would like to ask that that progress, and completion of work, is also documented and communicated to communities and the stakeholders within the sector. In terms of health workforce, what we'd like to talk a little bit about is the fact that health workforce is one component to creating access to quality health care in remote and rural communities. It's not the whole of the story, but it is a very important component of it.

One of the things that we've come to identify is the risk of working in isolation. Already we've seen in some elements of the recommendations and the strategies that have been taken to implement those recommendations, if things work in isolation—yes, they're completed and they tick a box. However, it's the integration and synchronisation across the system, not just in the state health system but also in the state Government processes such as education, juvenile justice and also in the Federal Government sphere, including National Disability Insurance Scheme (NDIS) and aged care. If we're not integrating and synchronising work in terms of workforce support and attraction, recruitment and retention, often things are left incomplete or can create greater issues.

Another aspect in relation to workforce is that so much attention goes to supporting the individual. However, currently we're seeing a situation where if employers aren't providing a safe and productive and viable workplace, our workforce has nowhere to go. One of the things that we'd like to also bring to the attention of this Committee today is that we think greater attention should be put to supporting, but also to the accountability of organisations and funding programs that impact the rural health workforce and ultimately creating access to health care for rural communities.

At this point in time in our nation's history and the state's history, the conversation regarding Indigenous health is very, very important. We'd also like to acknowledge that there is reference in the inquiry recommendations to Aboriginal community controlled health organisations. RDN and its broader network strongly support the support for a vibrant and sustained Aboriginal community controlled health system and the Aboriginal medical services. Within that, greater consideration and greater career pathways for Aboriginal Australians should be considered as part of future and ongoing work.

There are things that are working in New South Wales. There are things that are working nationally and things that are working internationally. The evidence is very clear when things do work and why they work, and the methods and the governance that goes to that. One of the critical problems that we face across our sector is the fact that attention is often forgotten in relation to the need for strong governance and also for the notion of supporting things that already work. We tend to keep calling out for innovation, but we don't celebrate the things we should be trying to invest in, and continue, that are already working. Quite often, areas that require governance and administration and bringing together great collaboration across the sector are not seen as something to be funded, because it's soft work. I'd be prepared and willing and interested to share with you more examples of things that are working, where great governance and strong collaboration are being supported through administration funds but are leading to better outcomes.

One example of that, if I may—because I think it's worthy here—is to reflect on the New South Wales Rural Resident Medical Officer Cadetship program that's so well known across New South Wales. The cadetship program was started in the shadows of the rural doctors' dispute. It's been running for 34 years and is now globally renowned as having an over 50 per cent strike rate in retaining medical professionals in rural practice. The New South Wales Government and the New South Wales health system is widely acclaimed for that work. We have great things happening in this state, and that's something that we should consider moving forward.

With all of the attention going to bringing a new workforce into New South Wales, we think it's also very important at this point to reflect on the importance of retention and strategies that go about protecting the health and wellbeing of those that have already committed to a lifelong career in rural health in New South Wales. There is work being done in this space, but we're very concerned that if that's not raised up as a higher priority, we'll be losing the people that have held the system together for so long.

Finally, the notion of being positive—in the last three to four years, with all the things that we've been dealing with, the notion of the underpinning positivity of rural Australia and rural New South Wales appears to take a battering. Today we'd very much like to encourage everybody to be thinking about continuing to speak about the positivity of rural, and the opportunities in rural. If rural Australia and rural New South Wales are important to the nation thriving, more needs to be done to support the social outcomes for all of rural Australia. Thank you very much again for the privilege to be here today. There are many, many people that are paying attention to this Committee and the Committee's work and the Government's efforts to support rural health, and we'd like to acknowledge their efforts as well.

MICHAEL BONNING: The Australian Medical Association (AMA) NSW would like to thank the Committee for the opportunity to provide the submission and the chance to appear before you today. We acknowledge the traditional owners of the land upon which we are meeting and pay our respects to Elders past, present and future. I'm a practising GP, formerly of the Royal Australian Navy and now of Greater Sydney. The AMA acknowledges that there are distinct challenges for rural, remote and regional healthcare workers, as well as the flow-on effects to health outcomes, patient experience, wait times and the quality of care for people who live in the regions. We recognise the importance of this for residents in rural, regional and remote areas and that the best possible services—and the full suite of those specialist services—should be available within acceptable reach of their homes.

The 17 months since we last convened with regard to the recommendations of Portfolio Committee No. 2 see a recognition by the AMA NSW that there have been some improvements. We note the efforts to improve support available through the ministry. The establishment of the Deputy Secretary for Regional Health and the establishment of the Minister's advisory group on regional health are key stand-outs in that. But so many of the recommendations which have not been moved on are yet to result in any significant change. While we note that there is commentary made about progress, that isn't often backed up by where we think it is at the moment. Improvements, especially in workplace culture, funding and workforce supply, would play that significant role that Mr Colbran spoke about earlier in reducing the disadvantages in accessibility and health outcomes experienced by those who live in rural and regional areas, along with better support for the health workforce servicing and working in those areas. It's the view of the AMA NSW that government initiatives designed to reinvent and expand initiatives to attract and retain doctors to rural, regional and remote areas remain lacking.

Challenges faced by health workers in rural, regional and remote settings centre around the attraction of the medical workforce and their retention; contracts, especially those for GP Visiting Medical Officers (VMOs), but also for VMOs in general; ensuring flexible and patient-centred focus towards medical roles; staff accreditation and training; workplace culture; transport; and a lack of innovation. Attracting and retaining health professionals to live and work in these areas is a catalyst issue for regional health services. The inquiry's previous focus upon a narrative that rural, regional and remote health is poorly resourced and associated with poor outcomes was not a fair reflection of those working in rural, regional and remote New South Wales, and may, as Mr Colbran said, be associated with a further discouragement of doctors moving into these communities

for those reasons. It's a critical threat for New South Wales Parliament to ensure a continued focus on the medical workforce and the attraction and retention of doctors in regional areas.

In surveys conducted over time by the AMA NSW, doctors working in rural, regional and remote areas reported being on call and called in more frequently than their metropolitan colleagues, and that makes sense. In those circumstances there are far fewer layers of more junior clinicians between you and the patients, and your teams, and often means that doctors are working in roles where they are shouldering a significant burden. I bring your attention from our submission to the situation in Tamworth where, through actions to work within the VMO Determination for the anaesthetists there, the AMA NSW was able to look at more flexible arrangements and bring about a better future, we think, for that department, resulting in a one-in-12 on-call arrangement and, certainly, also prolonging the longevity of many of those clinicians who are in that department, most of whom are over the age of 50 already.

We recognise that there is the need to look at different ways to employ and engage medical staff to ensure that they are, in fact, able to deliver on what they seek to do, that they do not suffer moral injury when they are doing so, and they have sustainability of their career. We recommend a full review of the workforce be undertaken, with LHDs required to provide advice on the demographics of the current workforce. We know that lots of this has been done within the general practice arena and within communities to understand 'key person risks'. But feedback from doctors working in hospitals regarding their intention to work, preferred on-call models and gaps in the roster will be greatly beneficial to understanding this picture and where critical risks exist.

We note that there has been recent media coverage as well conflating VMOs and locums. Both of these roles are important parts of the service delivery model in rural, regional and remote areas, but it's damaging and inappropriate to confuse the roles. I would imagine that members of the Committee can understand it's a VMO who is a long-term serving member of a community and provides services into that community over often decades, as compared to a locum who may well provide services to the community for a short period of time, which is a very different service model. We have heard from our members working in these areas their deep concern in relation towards increasing qualification requirements. Members are reporting that doctors in these areas, who have skills and experience to safely work, are now unable to fill some of these roles that are being advertised because they are unable to meet the niche nominal qualifications for such positions. That takes away from a strong generalist community workforce that is, otherwise, now unable to access and undertake the roles that they should be able to.

Acquiring those specialist qualifications is often restricted due to geographic isolation, and so we recognise that often pushes doctors to move back to metropolitan areas to gain skills, and then they may not return to regional areas. We are simply highlighting the importance that there are limited services, and specialist expertise, in rural, regional and remote areas, and in that we need to recognise that, continuing to retain that workforce and not squeeze them out because of different requirements is critical. We note also that it is in our view that the rural, regional and remote workforce should be offered greater training and education opportunities, so that we can keep those skills close to where the patients are, to where our community lives – outside of metropolitan areas.

It has been raised by our members as well the issue of transfer of patients between smaller hospitals and their designated referral hospital. If you are in a small town and you are managing a patient where their care is beyond potentially your skill level at this point in time, but you are told by a designated referral hospital that they can't take the patient either, that is of critical worry to the individual doctor on site and recognises the limitations that they have, and they have recognised those limitations and are seeking referral, but then they are left in the worst possible circumstance – with a designated referral hospital who will not take their patient. That is frequently an issue if we recognise that that deterioration and that pushback from major centres also has a moral injury on doctors, who feel like they've tried to do their best, but actually someone continues to deteriorate before their very eyes.

It is our hope to work with this inquiry and in an ongoing sense to ensure that regional health practitioners are supported by the healthcare system in which they serve, some of those are examples thereof. There are distinct challenges facing remote, rural and regional healthcare workers, and it's imperative we address these preventing the flow-on effects to health outcomes, patient experiences, and wait times. This is not from a doctor but this is a quote from a survey that was done: "Talent scarcity in our regional healthcare system is not just a hurdle. It's a barrier to progress." This is from a CFO: "As a CFO, I'm deeply concerned about the impact this has on our ability to provide healthcare services at the requisite level and on our financial sustainability." I'm happy to take your questions, thank you.

ROD MARTIN: Thanks for the opportunity to present to the Parliament on behalf of the college. For your information, the college has fellows and registrars who are kind of providing the highest levels of care across rural and remote New South Wales. We currently have 462 fellows in the state, 75 per cent of whom are in Monash

areas three to seven; and pleasingly we have 216 registrars, 61 per cent of whom are training in slightly more remote areas in that four to seven category. These doctors are all required to have higher degrees of rural-specific competency, including in emergency and advanced hospital care requirements, primary care as well as public health services. Briefly we will address four of the more specific things that we thought were more urgent requirements. I will try and remember to make references to the key recommendations as there were quite a few from the original document.

The first is that for the New South Wales rural generalist program to be successful, we believe that there needs to be a substantial change in how the program is positioned in New South Wales. We think that it needs to be able to exercise more independence, and it's often seen as a subset of the Health Education and Training Institute [HETI], that it restricts some of the flexibility that seems to be required. Instead, we think that a now mature New South Wales Rural Generalist Training Program should be enabled to interact with greater flexibilities with those that it currently interfaces with, and also those into the future. Obviously, it still needs to be able to interact with HETI rather than be governed by HETI to the extent that it is and that the programs, more appropriately, be responsible to a responsible Minister, rather than some of the other functions within ministry.

Recommendations nine, 15 and 33 all relate to employment, employment models, and appropriate remuneration. When we talk to future rural generalists (RGs) in New South Wales and across the country we are often reminded of generational differences. Our upcoming RGs still seek challenge and diversity in practice as rural doctors always have, but these future generations are looking for these things with a definite emphasis on balance and recognition. They will not sacrifice time, nor income, nor conditions as part of their choice to work in rural New South Wales. If we're to move away from the expensive, sometimes unpredictable and at times unsafe dependence on unfamiliar doctors to keep New South Wales towns and cities safely doctored, there needs to be an urgent and comprehensive body of work to look at employment models and appropriate modelling for the conditions under which these new RGs, both trainees and some qualified doctors, are employed. This could also mean a move away from the current employment models of previous generations, and a move towards some of the employment models that future RGs will be looking towards.

In order for the SEM, the single employer model, to be a success there needs to be a clearly defined sole arbiter of the process across the state. It would be inappropriate for each of the LHDs to have their own SEM rules—as I said, the single employer model rules—each of which will have subtle variation in its execution. It'll just provide more uncertainty for junior doctors and they'll vote with their feet. We believe that the current version of the New South Wales rural generalist program, or something that it could evolve into, would be an appropriate sole arbiter for this purpose, and we also believe that empowering it under a responsible Minister is likely the best step to achieve this.

The second outcome from the Portfolio Committee (PC) 2 report is simplifying accreditation processes and training across the state for RGs, with a great number of Local Health Districts (LHDs) across the state all requesting similar information, all the time, each time an RG seeks to work in a different location. LHDs also have quite different employment conditions and training requirements. All of this results in a high level of repetition, which often sees RGs getting fed up with the process and having another reason to leave and go to a different state, or not to move between LHDs, to be able to get the training that they require. Ideally, what we would like to see is a single point of clearing for all RGs, both RGs in training as well as fellowed RGs, to smooth this process. There also needs to be a statewide review of the VMO model in New South Wales.

The CHAIR: Dr Martin, is that point number three now, the VMO model?

ROD MARTIN: I'm coming to the end of point two. We've only got two short ones. There needs to be statewide review of the VMO model in New South Wales. There are certainly questions about the viability and a strong possibility that the current model will not be appealing to the future work styles of rural doctors. Other jurisdictions see recruitment and retention successes for their staff specialist-level appointments, and rural generalists are predominantly providing this level of service in other states, complete with the preservation of conditions and leave arrangements, and an income that is commensurate with the level of qualification and experience of our fellows.

Our third response is to Recommendation 27. It relates to maternity obstetrics services. We recognise that this is a gnarly issue across the country, with ever decreasing numbers of RG obstetricians in the system or coming into training. Since the initial hearings, the situation seems to have become worse, with some locations closing and many being barely viable. There was a teleconference last night of a number of RG obstetricians across the country. Unfortunately—scarily, for me, as a rural obstetrician in New South Wales—we have some of the more threatened services in the country. There are even large level four services that need to go on bypass between one and three days at a time, with many patients having to travel an extra 100 to 200 kilometres, or, even worse, necessitating quite expensive retrievals so they can safely deliver in a distant centre. Our great fear is that if we

have a couple of larger services that need to be on bypass sequentially with long retrieval times, sooner or later we're going to potentially see an avoidable death of a mother or baby.

Whilst more meetings are not necessarily the answer, the gravity of this situation warrants a substantial stakeholder forum to identify and improve services where they struggle, but also to look at other solutions that can be delivered safely. A new RG obstetric workforce may warrant radical solutions, such as offering more training places in these areas at the expense of already well-occupied ones and incentivised pathways to rural obstetrics. Rural towns and cities should, at a minimum level, have a service of a physical doctor in their communities for not only urgent, but emergency, requirements. Increasingly, rural facilities are running without an onsite doctor for 12 to 24 hours.

The CHAIR: Dr Martin, is this point number four?

ROD MARTIN: This is point number four. Increasingly, rural facilities are running without an onsite doctor for periods of up to 12 to 24 hours, instead needing to rely on a videoconference doctor, often sitting in a distant office. This puts everyone involved with the care of patients, especially those critically unwell or as a result of trauma, at substantial personal and professional risk. It also puts patients at avoidable risk. Australian College of Rural and Remote Medicine (ACRRM) rural generalists fellow with a set of skills that enable safe clinical capacity for urgent and emergent care. The college believes that the workforce can return to these hospitals with continuity if we shift to a more rural generalist model of providing care into even some of our larger rural and regional hospitals. Additionally, Fellows of ACRRM (FACRRMs) can also fellow with an advanced specialised training skill in emergency medicine. Again, in other jurisdictions, some of these advanced standing emergency medicine doctors are running departments. There's not a specific recommendation in the report, but there had been a note made of a number of times where the report made reference to virtual care as one of the solutions, and t's always been the college's standing that virtual care should only really enhance actual care, not replace it. Again, thank you for the opportunity to present.

The CHAIR: Thanks, Dr Martin. I'm conscious that we've got limited time, so we'll try to hit some of the main points. My question is going to be directed to all of the folk to answer briefly in turn, if you can. We've heard evidence—and certainly I've become aware—that perhaps the situation with primary care, and general practice in particular, is worse than it's ever been. Why is that? Second to that, what can NSW Health do about that, given it's a Commonwealth issue? Thirdly, there are communities with GPs in the community who are not in hospitals. What can NSW Health do to reverse that? Perhaps I can start with Dr Bonning from the AMA. Why is primary care in such a state at the moment and what can NSW Health do, in particular with regard to hospitals?

MICHAEL BONNING: Even with a significant increase in the number of medical graduates coming out of Australian universities over the last 20 years, we've seen a continuing decrease in the number of Australian medical graduates who enter general practice training, whether that be through the Royal Australian College of GPs or the Australian College of Rural and Remote Medicine. That number has dropped to somewhere around the low teens in terms of percentage. One of the things is that the industrial arrangements and others that exist within the hospital system and that of the primary care system haven't necessarily stayed aligned. What we've seen in Victoria is an opportunity whereby the Victorian Government has topped up—by up to $30,000, I believe—the arrangements for GP trainees or people entering general practice training. Another one—with Tom sitting next to me—is also to look at the role of the single employer model in creating better pathways for industrial arrangements to be maintained between junior doctor time and progression into doctor-in-training time in general practice and to move on from there. In addition to that, those models then will often create environments where doctors stay both involved in private general practice as well as also providing services to hospitals.

The CHAIR: Dr Douch, do you want to make a comment?

FIONA DAVIES: Sorry, can I just make—I will acknowledge NSW Health's efforts, as Mr Colbran said, about establishing a working group that is specifically focused on trying to improve arrangements for the payment of VMOs. That has been an active group. I sit on the working group, as do the rural doctors. It's constrained by the fact that it's required to make recommendations, which fit within a current budget framework. I think that is a challenge, but they are looking at options such as loaded-up day rates and how we bring the GP VMO determination to something which makes it more attractive to work in the hospital and, in general practice, because we are certainly seeing increasing feedback that the difficulties in working in the hospital environment mean people simply stay in their general practice. We want to acknowledge the work that's undertaken, but there's an opportunity for significantly more work to make it more attractive to be a GP VMO.

The CHAIR: Can I just follow up on that? You talked about the difficulties of working in the hospital. Could you just elaborate on those, and is culture a factor in that?

FIONA DAVIES: The feedback we're receiving is yes. But it's also that the VMO determination was—it's often based on fee for service, and the demands of fee for service can change, as in you can't really stay in your general practice and cover the hospital, but there's not quite enough work to cover the hospital. But, yes, we are hearing in some instances that there are cultural issues or the way people are treated within the hospital that I think do need to be addressed, where you can simply choose to remain in your general practice. Probably there are others on the panel who could comment more effectively, but there does appear to be issues about working within the hospital system.

The CHAIR: Being mindful of the time and that my colleagues want to ask questions, does anyone else want to make a comment?

TOM DOUCH: Chair, I think we could build on the theme just very quickly. The philosophy in the past has been that it has been a privilege for a VMO—to apply for VMO "privileges" is a word we've used. It's just been assumed that a person moving into a rural town to work as a GP would provide that care at the hospital. We've got to change that philosophy around a little bit. NSW Health has to make a concerted effort at attracting people. It very much is tied up in that cultural theme that's been expressed. Most of the members I spoke to over the last few days at our conference talked about the difficulty they have with their relationships, and it stands out when you find a doctor who has a good relationship with their local facility.

It's a sad thing to say, whether it's a theme for the whole system or not, but I think we've got to change the philosophy where NSW Health does not assume that it gets a VMO. It's got to apply to attract that VMO through the efficiencies of its system and the way it interacts. Credentialling would be an example. We recredential a doctor after so many years; they have got to reapply. If the doctor is performing well, if there are no adverse reports, if the morbidity and mortality, and the quality of care processes within an LHD are saying that doctor is working well and there's nothing negative coming out of the national regulatory authorities, then why do we go through that process?

The CHAIR: Thank you, and I'm going to probably follow up with some supplementary questions around that issue.

Mrs TANYA THOMPSON: Keeping to that theme, I'm interested to talk about the locum model. We have heard firsthand how it is currently operating with locums, in particular in some regional hospitals, and how having the turnover of locums within the hospitals affects the workplace culture. If you are trying to retain the longstanding staff that you have, if you can't establish good and constant relationships, if you have a turnover of different locums, how is that affecting the culture within your workplaces? Is the Rural Health Workforce Incentive Scheme enough? Are we doing enough in that space, and what further do you suggest we could be doing to improve retention for workforce in that area?

ROD MARTIN: The two impacts that we see from locums are the clinical impact—I'm in Armidale with 25,000 people and what used to be quite reasonably well-served specialist services. We now get such variation in what our locums can and can't do that no one is certain about who they're going to get come in through the door. That builds uncertainty across all levels of clinical service, whether it's nursing or other doctors. We will often get locums who turn up who simply do not have the skill set that they need for [inaudible] rural facilities and we end up having to call other people in to try and patch up for that. All at the same time, those locums are being paid two to three times as much as the person who might get called in for it.

The sting in the tail for having locums that are very well paid is that plenty of people don't want to get into a training program now because they can be a locum for five to 10 years and pay off their mortgage—but not necessarily provide services to the same level as the regular doctor would. Everywhere there's a feeling like the locum funding is pulled out of a different pool of money, so it never impacts on a hospital bottom line. It explains why we can't attract more regular doctors, because they are going to get paid a lot better for coming and doing the same job as a locum—or sometimes a lesser job as a locum.

RICHARD COLBRAN: From the rural doctors perspective, this isn't just a doctor issue. The locum issue and incentive payments come up, and often it relates back to the doctor situation. My understanding is, now that there are some locum payments that are increasing, it's not gone above $4,000 a day. Yet five or six years ago it was around $1,800 a day. In this conversation, though, it's important to recognise that it's not actually about the person being the doctor; it's actually about the system. This isn't new. It's been growing and developing on us. It worries me personally, in terms of our conversations and trying to look at how the system is working. We have examples right now, such as the locum situation, that if we don't fix these situations now, what's going to happen in five or six years' time? So what I'd like to encourage is thinking about the system and not just about the doctor who is trying to get secure funding.

It often does come back to the notion of is it about money. I don't think that's actually the case. Most of the rural practitioners—be they nurses or allied health workers—that I speak to, they appreciate an incentive and appreciate being paid well. But it's actually not their motivation. Their motivation is being able to thrive, to be safe culturally and to be able to put into practice the years of training that they've gone about. So building again on the theme earlier around the workplace environment, the culture, the way that they're appreciated and valued, I think is at the heart of what we're talking about. The money is important, yes. But, at the same time, being able to demonstrate and fulfil your career and your personal aspirations is actually more important for most of the people we're talking about.

Mrs LESLIE WILLIAMS: First of all, I want to applaud those who particularly made comments about what is actually working well in our regional communities when it comes to health, because we know that there are initiatives that are getting great outcomes. We should make sure that we scale them up, wherever we can. That brings me to my question, particularly in relation to programs around workforce and initiatives. Dr Bonning talked about some in Tamworth that were working well. My question is to the Rural Doctors Network. Do you have any other examples of where there are some innovative workforce initiatives programs that are getting good outcomes and that potentially we could scale up in other areas?

RICHARD COLBRAN: There are examples that we have and we have prepared. They are just involving the Rural Doctors Network, but I will be able to provide a couple here, as I offered earlier. One I would particularly like to speak about—because of the notion of integration and synchronising between all the different systems—is a piece of work that was commenced before COVID started that had the involvement of state, federal and private organisations participating in western New South Wales. Back at that time, there was a program set up called the western New South Wales 2030 health workforce project. This would have been around 2016/2017. An important notion of that was thinking about a decade or more of planning.

Over 50 organisations and service deliverers and employers in western New South Wales came together to build an integrated approach for supporting a health workforce plan for the region, and that included the local health districts as well. It saw a number of initiatives—about 30—start in terms of attract, recruit and retain. Everything from coordinated advertising campaigns, welcome packs and concierge, not just to health clinicians but to families, and even one of the most difficult circumstances that we deal with in our state, is the bundling up of point FTE roles in remote and rural communities, and organisations coming together and being prepared to put the money into a single pot. That program appeared to be very successful. COVID did have an impact. I think it was actually then also taken into the Murrumbidgee region. It was almost a precursor to the single employer model as well. So that would be one example. I'm happy to provide others if you like.

Mrs LESLIE WILLIAMS: I think it would be great to have a look at some of those other examples, because I'm one who believes that if there are things that are working well, then we should do what we can to see if they will scale up and replicate in other communities. It is not that I'm suggesting every community is the same; we know that that is certainly not the case in regional and rural areas. But maybe with some tweaks we can get them to work there as well.

The CHAIR: We might ask for some additional information you might have on that model and any evaluation of its current success. We might make that a supplementary question.

RICHARD COLBRAN: Yes.

Ms LIZA BUTLER: Thank you, everyone, for your time today. It's greatly appreciated. We've just recently done a tour up north—so a bit of a preamble—and what we heard from the doctors up there about attracting junior doctors was, as I think we heard from all of you today, the lack of supports that they have when they are there. One of them today was about the designated referral hospital not taking—relying totally on telehealth. We heard that they feel really unsupported and that they are very scared of liability and making the wrong decisions, so that forces them back to the metro. You talked about the rural medical cadet program, and you've got a 50 per cent success rate. What are you doing differently to retain those doctors, and how do you continue to support them? Is there a best practice model that we could look at to keep those doctors?

RICHARD COLBRAN: If you wouldn't mind, I will answer the second part, which is the cadetships, but I think probably the AMA is better placed to speak about the junior doctor situation, if that's okay, first.

MICHAEL BONNING: Sure. To recruit and keep a doctor takes a community. So that comes back to the comments made just before, where you actually get the different parts of that community to work together—the welcome, the engagement of partners, the education of children, the finding of services and all of that. Where we see that work best, that is what builds something that might otherwise be just available within a metropolitan area. We rely upon a community to extend its arms out and embrace a junior clinician or doctor-in-training who

is coming to that community, whereas in metropolitan areas, many of those things are just expected of the doctor themselves.

What we know is that where there are strong communities—and I will note that Lismore has actually retained the majority of its doctor-in-training staff recently. Even though they have gone through incredible hardship, they have really strong community up there and in some ways that has bonded them together. That, I think, is always a very good example. While we recognise that clinical practice across health care can be a hardship at times—it can be a very taxing and difficult environment—when you do that with support, you grow. When you do that without support, you burn out. That has ostensibly been the experience of junior doctors who have often very diverging experiences of regional practice.

The CHAIR: I'm going to take the Chair's prerogative here. I'm actually going to go to Ms Deerain from the NRHA because I'm just conscious that the Rural Health Alliance hasn't had an opportunity to comment, and we've got five minutes.

Ms TRISH DOYLE: My question was going to be to Margaret. Moving away from solely doctors for a moment. Thank you all for being amongst us this afternoon. The Rural Health Alliance, Margaret, puts forward in your submission the Primary Care Rural Integrated Multidisciplinary Health Services as a place-based model for health care. A couple of things: What role could this particular model play in developing and strengthening the workforce, and have there been any trials or has there been any progress in implementing this?

MARGARET DEERAIN: Thank you for the question. Yes, it's a model we've been advocating for, for some time, and it is a model designed for thin or failed markets. It's on the principle that we want a multidisciplinary team, where we can have it. We know that the fee-for-service model through the Medicare Benefits Schedule (MBS) just does not sustain a number of primary health practices. They can't just survive and recruit allied health and nursing staff to work with them on that funding. Our model, which we call Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS), is based on—it would need an injection of funds, the block funding, to set up a business and allow a community to establish a practice. The idea is that it is community led and community owned. They work out what they need in their community and then set up a practice that can employ GPs, nurses, allied health, Aboriginal health practitioners—whatever is needed.

The idea of the model is that primary health care funding in a lot of rural locations just cannot sustain itself under the current funding models. It needs—what we would say—block funding and a real desire to do multidisciplinary health care and have it led by the community to meet their population health needs. We would love to see it up in more trials. We know certain practices that are using a similar model. In fact, often when practices have been bought out, if you like, by community organisations, they are trying to work to that. But they do rely on seeking any funding they can get. Funding can come from the NDIS or aged care. It doesn't have to be just Health to secure funding. But, in our view, it takes a level of government to inject block funding to keep some of these practices going.

The CHAIR: Are there examples currently of that PRIM-HS model, or is it more practices that are a bit like it? That's the first. It sounds as though this is something that requires Commonwealth and state getting together, basically. Is that right? Is that happening?

MARGARET DEERAIN: That is right. We don't think it's happening enough. Well, there are certainly examples of local government coming in and doing a similar model. Possibly in Victoria, where it is a little bit of a different kind of community health-based funding model, there are similar models. I don't think we could say there is anyone doing the pure PRIM-HS model, but certainly there are examples with local government and even the Royal Flying Doctor Service has bought out practices to inject that block funding and buy out a practice and then be able to employ health professionals as employees. So, yes, there are certainly examples. We'd like to see more examples and more pure examples, but it would take that—

The CHAIR: It would be good if you could provide us with some information on those examples. Can I just say, I think PRIM-HS is the new name for rural community controlled organisations. I think there was reference to that in the previous Committee's recommendations. We just need to pick that piece up. I'm conscious that it's now two o'clock, so that brings our time to a close. We do have more witnesses now appearing. I thank everybody, once again, for preparing your submissions and for making time to give evidence under oath. The Committee very much appreciates also the work that all of you and the health professionals do in our rural communities, which are a great place to live and work. Thank you very much.

(The witnesses withdrew.)

Dr TREVOR CHAN, Faculty Chair, Australasian College for Emergency Medicine, sworn and examined

Dr SHAMUS SHEPHERD, Australasian College for Emergency Medicine, sworn and examined

Dr VICKI MATTIAZZO, Royal Australian College of General Practitioners, Rural, before the Committee via videoconference, affirmed and examined

Dr KARIN JODLOWSKI-TAN, Royal Australian College of General Practitioners, Rural, before the Committee via videoconference, sworn and examined

Ms KAREN CARTER, Pharmaceutical Society of Australia, before the Committee via videoconference, affirmed and examined

Mr LUKE KELLY, Pharmaceutical Society of Australia, affirmed and examined

Associate Professor PETER THOMAS, Medical Workforce Policy and Advocacy Sub Committee Chair, Royal Australasian College of Medical Administrators, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome witnesses from the Australasian College for Emergency Medicine, the Royal Australian College of General Practitioners Rural, the Pharmaceutical Society of Australia and the Royal Australasian College of Medical Administrators appearing in the room and online. Would you each confirm that you have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

TREVOR CHAN: Yes.

SHAMUS SHEPHERD: Yes.

LUKE KELLY: Yes.

VICKI MATTIAZZO: Yes.

KARIN JODLOWSKI-TAN: Yes.

KAREN CARTER: Yes.

PETER THOMAS: Yes.

The CHAIR: I note that Professor Thomas is a colleague of mine in the Royal Australasian College of Medical Administrators. We both serve on the policy advisory committee of that organisation in a voluntary capacity. I thank the witnesses for appearing today. Would any of the witnesses like to make a brief opening statement before the commencement of questions? I'll start with Dr Chan.

TREVOR CHAN: We have prepared a few words but, in the interests of the large numbers, we will keep that brief, if that's alright with the Chair. We represent the Australasian College for Emergency Medicine (ACEM) —the peak emergency body in Australasia—a not-for-profit organisation tasked with training specialist and emergency physicians. We draw upon the firsthand experience of our New South Wales emergency specialists. Of the almost 900 fellows in New South Wales, over one-third are based in regional, rural and remote areas. The numbers are similar for our ACEM trainees. Also complementing the emergency medical workforce are career medical officers—ACEM certificate and diploma graduates—who work alongside general practitioners, rural generalists and other specialists.

While these numbers may appear on the surface to be satisfactory, factors such as reduced fractions, limited permanent opportunities, and balancing life priorities and work priorities means they do not adequately reflect the challenges facing the profession of emergency health care across regional, rural and remote New South Wales. These challenges lead to burnout. The emergency department can be a stressful environment, and the lack of staff, more patients, and access block combine to adversely impact the workforce culture. When workplace culture suffers, more people leave the emergency department workforce, further demoralising the remaining workforce and impacting on the ability to recruit and retain medical staff.

The CHAIR: Thank you very much, Dr Chan. We will move to the Royal Australian College of General Practitioners. Would you like to make a statement?

VICKI MATTIAZZO: Yes, I'll respond on behalf of us. My name is Dr Vicki Mattiazzo. My colleague Dr Karin Jodlowski-Tan and I are here today on behalf of the Royal Australian College of General Practitioners, the RACGP. We are both part of the rural faculty and practising rural general practitioners (GPs). I want to thank the Select Committee on Remote, Rural and Regional Health for the opportunity to give evidence today. The

RACGP is Australia's largest professional general practice organisation, representing over 24,000 rural members. We represent four out of five rural GPs. The recent Health of the Nation report revealed that each year 90 per cent of Australians visit a GP, and that's equivalent to about 22 million people. As the most accessed sector of the healthcare system, it is imperative that we support the general practice workforce in order to provide consumers in New South Wales, particularly those in rural communities, with sustainable care teams and promote health equity.

Healthy general practice primary care takes pressure off hospitals. The RACGP supports sustainable and flexible employment models with pay equity between urban and rural, including single employer models where appropriate, and needs to be involved in the development of these models; a statewide system of accreditation for VMOs; multidisciplinary team care; better cooperation between Commonwealth and state funding arrangements and resource sharing to match community needs; improved access to education and support to meet community needs; telehealth to supplement but not replace face-to-face consultations; expansions of systems that work well, such as Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS), Drug and Alcohol Specialist Advisory Service (DASAS) and GP support lines; and, finally and importantly, a freeze on payroll tax in line with most other states so that general practice remains viable. We are grateful for the opportunity to present these issues to the panel.

The CHAIR: Thank you, Dr Mattiazzo. We might move to the Pharmaceutical Society of Australia.

LUKE KELLY: Thank you for the opportunity to speak today. My name is Luke Kelly. I'm here representing the Pharmaceutical Society of Australia, or the PSA, as the New South Wales branch president. I've been 40 years in this career as a community pharmacist, business owner, and now a pharmacy business broker. I'm pleased that Karen Carter has been able to join today from Gunnedah. Karen is a member of the PSA New South Wales branch committee, fellow of the PSA and pharmacy owner in Gunnedah and Narrabri pharmacies. The PSA is a peak national professional pharmacy organisation, representing 36,000 pharmacists around Australia working in all sectors and across all locations. There are 10,668 pharmacists in New South Wales. The PSA is a profession standards setting body and the custodian of standards, guidelines and the code of ethics, which are fundamental to supporting quality and integrity in professional practice.

Pharmacists are known for their expertise in medicines, but we also deliver preventative care, triaging, and public health interventions. There is a strong network and infrastructure of community pharmacies throughout New South Wales, and we are generally the most accessible primary healthcare provider. The PSA is committed to strengthening the health workforce, including through fully utilising pharmacist expertise and investing in the delivery of contemporary, innovative, and flexible models of collaborative person-centred care. This may include telehealth service delivery and outreach models of care.

The use of medicines is the most common healthcare intervention, and pharmacists must be able to contribute to medication safety and quality use of medicine initiatives. Pharmacists can help prevent harm from the use of medicines and avoid unnecessary hospitalisations, and help people to get the most out of their prescribed therapy. We must look to reform any regulatory barriers that currently hinder professional practice. Pharmacists are committed to person-centred, team-based care, and investment in digital functionality and interoperability will be vital going forward. Pharmacists can help improve access to vaccinations and other preventive health services, and support people improve their health, medicine and digital literacy. Through pharmacists, PSA is also keen to contribute to improved arrangements for palliative care services for people in remote, rural and regional Australia. PSA appreciates the opportunity to give evidence today, and we welcome any questions from the Committee.

PETER THOMAS: I think the Royal Australasian College of Medical Administrators (RACMA) submission is complete and stands for itself. I'm here in my capacity as chair of the Medical Workforce Policy and Advocacy Sub Committee for RACMA. I think our key recommendations are on the medical workforce—in particular, the GP workforce, GP proceduralists, consideration of the generalist-specialist workforce, and also a strong framework for service registrars and career medical officers in the regional workforce. Also, we would just like to comment about, although a valuable adjunct, telehealth and virtual health are not regarded by RACMA as replacements for locally based services, and the importance of connection to community for medical and clinical services in the regional and rural setting. I'm happy to move straight to any questions from this point.

The CHAIR: Thank you very much, Professor Thomas. I might start the questioning, and then my colleagues will have questions in turn. I'd like to start my questioning with the College of General Practitioners. We have received evidence that the entry rate into general practice of current medical graduates is at an all-time low—perhaps as low as 15 per cent. Also, I certainly have become aware of very low numbers entering rural general practice training in rural locations this year, and I'm aware of changes to rural general practice training. Frankly, in submissions, in our travels and in evidence, the Committee has heard that rural general practices—which should be the bedrock, in some ways, of primary care in rural communities and hospitalised practice—are

in such a difficult state. I'm just interested in your views about the training program and what, in reality, are the prospects for improved—rural generalists and rural general practitioners working in rural areas.

VICKI MATTIAZZO: I'll start off, and then I'll hand over to my colleague Karin, who is more involved in the training. This is a multi-layered issue, starting right from the selection of medical students and who is electing to become doctors. I think we do need to take a look at pathways for rural kids to become rural practitioners. Whether they become medical practitioners or allied health nursing, I think it's reflected across the board. I think some of the universities are starting to look at some of those pathways to make it more equitable, but I do think that that is an issue. I always feel very disheartened when I have work experience students in our clinic who would love to work in the health sphere but there are so many barriers in them proceeding to those careers, because we know the evidence is definitely towards people who have lived rurally are more likely to work rurally. I'll hand over to Dr Jodlowski-Tan to perhaps talk more about the training aspects that have been implemented since then.

KARIN JODLOWSKI-TAN: Thank you, Vicki. My other role in the college is actually as the national clinical head of rural pathways, and I have been working across all jurisdictions with our training teams, so this is very close to what I do. As Vicki said, there is a multi-layered approach to this. We talk about training pipelines, which I would rather refer to as pathways, but it also starts with the bigger picture of creating clear career pathways for rural GPs and rural generalists (RGs). Our approach has been working along all the continuum of the training pathway, leading from medical students, where we're working with the universities, trying to integrate what we do rather than people duplicating or having gaps in supporting medical students' interests.

What we have identified are several major points of leakage to that pipeline into general practice. The biggest leakage is probably between when they finish medical school to when they actually enter vocational training. During that junior doctor space, that's when they often lose sight of what general practice does because they're in the hospital system. They see other non-GP specialists, and then they forget about general practice. One of the things we're doing is trying to increase their exposure with the universities and the hospitals, increase their exposure to general practice, having rotations into general practice. Particularly with the new Australian Medical Council (AMC) internship requirements, that hopefully will help support that. The John Flynn Prevocational Doctor Program will support some of that work as well. We're working with the RG coordination units in New South Wales and working with the Health Education and Training Institute (HETI) as well to try and enhance the effectiveness of those programs.

Once you get through that junior doctor stage, we also need to help them see what the career prospects are if they're going to a rural location, because a lot of them have a fear of not being able to get back into the career they want or not get back into the bigger hospital systems if they need certain aspects of their training there. We need to dispel that fear, and we also need to enhance the value of rural generalists and rural GPs across the state. We saw that happen in the Queensland model, where they worked very closely on increasing the value—they had a pillar, about the value of rural generalism. With that came credentialling and increased pay rate for rural generalists. They were very successful in raising the status of a rural generalist.

These are things that can be done to enhance the numbers and quality of those people going rural. There are other areas too where there's a dwindling GP workforce, which makes it very hard for people to get consistent exposure to rural general practice where they're needed because there may not be trainers in places that really need GPs, so they're not getting exposed to those workforce needs areas. Vicki was going to talk about something that's related to this, about what we can do to improve vertical integration. I am not sure if you want to add to that at this point, Vicki.

VICKI MATTIAZZO: I think we were talking about innovative approaches whereby we're looking at supervision not just in the older-style models but where we have medical students being supervised by registrars and being able to expand that program for more peer support. Would that be right, Karin?

KARIN JODLOWSKI-TAN: Yes, that's one aspect. The other place we have actually been innovative across the last two years is we've been piloting and then refining a model of remote supervision. For example, in western New South Wales, where we're desperately short of workforce and supervisors on site, we have a model where we can have supervisors who are remotely located, supported by on-site supervision teams. We've been working with different local health districts in implementing those, as well as our training team. In fact, our two pilot sites were in Norfolk Island and Walgett, and in both places the registrars have stayed on after fellowship. So that, to us, is an indicator of how it can be very successful.

The CHAIR: I just wonder if you could tell me how many trainees started in the last entry point into rural general practice training in New South Wales?

KARIN JODLOWSKI TAN: I would have to take that on notice to look up the exact figures. We do know that we have increased intake from next year into the south-east and the north-east, but in rural areas, particularly in western New South Wales, the numbers are still really low. Can I take that on notice?

The CHAIR: Yes. I guess what I'm trying to get at here is that there have been recent changes to general practice training in terms of it going back to the colleges. Certainly I have heard there has been dissatisfaction with previous training in recent years, but what I'm flagging to you is a concern that there are actually very few people now training at all in rural general practice, compared with what's happened in recent years even.

I'd be very interested in the numbers now and in the future, because, from the Committee's point of view, rural general practice is very important, clearly, and you've stated that yourselves. But if there's no one training in it then the prospects are, frankly, grim. I'd like to know what the numbers are, what the colleges' plans are in that area and what is happening to the rural general practice training program, which I think you now have carriage of, along with Australian College of Rural and Remote Medicine (ACRRM)—two separate programs, but you're the major body. So take that on notice, please, but that would be a very important piece of information.

Mrs TANYA THOMPSON: I have a question for the Pharmaceutical Society of Australia. With the current shortage of GPs that we see, we now see that shift of people who are making pharmacists their first port of call—rightly so—for medical assistance for general issues. What challenges are being faced by pharmacies or pharmacists in this space, and how do you feel you could be better supported to overcome these challenges so that this could continue on, especially with the extended scope of practice that we're seeing now?

LUKE KELLY: I'll pass over to Karen shortly, who is going to have a lot more experience on the ground than I do. These are the sort of roles that we have traditionally taken on where people will come to us first because we're available, even in the cities, and GPs are hard to get into, and triaging people is always something we have done. If we can handle it at our level we certainly do handle it and, with the expanded scope of practice, that ability is going to definitely grow and that hopefully will take pressure off GPs generally, but particularly in rural and remote areas. For actual examples I think I'll hand over to Karen, because she's been working in this for quite a proportion of her life. Go for it, Karen.

KAREN CARTER: We have implemented the Urinary Tract Infection (UTI) trial and the oral contraceptive trial in both of our businesses. We have seen some uptake of clients coming in for those services, but we have had to refer people on as well because of the criteria, so we do work with the local general practice to be able to try and get people in a bit quicker when there's a referral. But I think it does give patients an option, particularly for women, for those conditions, so that's been good.

What can help to assist us? Obviously, workforce issues. Our current pharmacists are getting a higher rate of pay compared to two years ago. There are pay issues but also people on the ground. Just an example of that—our funding—we have funding for an intern, and then we used to get funding for another year after that, but because I'm in MM4, that second year has been cut. We still do keep our pharmacists on, but the funding for that second year has been taken away. That would be helpful, to have some funding to keep our interns on. As Karin said before, if you can get people to be practising in rural areas, they often stay in those rural areas, so it's encouraging them to stay then.

Mrs LESLIE WILLIAMS: I have a question to Dr Mattiazzo from the college of general practitioners. In your submission you mentioned that you were looking to have a Memorandum of Understanding (MOU) with NSW Health so you can work better to support our rural GP and rural generalist training. Can you tell me, is that progressing, and where is that up to? Obviously, it's always a benefit when you've got those relationships and you're able to work collaboratively. Can you give us an update on that?

VICKI MATTIAZZO: I'll have to take it on notice to find exactly where we are at, but we are always encouraging collaboration between the state and general practice. I think sometimes we often feel that we get left out of conversations, especially for planning. For example, disaster planning in bushfires and in COVID—general practice was often left out of a lot of conversations. I think it's really important that we continue to have good relationships to use our resources to their best use. But I'll have to take on notice exactly where that document is at.

KARIN JODLOWSKI TAN: I can add to that, if I may? We started that discussion last year when we met first but, because of the college-led training and the changeover, it was suggested that we postpone. We are actually having a meeting with them on 6 December to take up that conversation again on establishing clear ways of working together.

Mrs LESLIE WILLIAMS: This question is also to the college of general practitioners. In your submission, you also welcomed the single employer model—the SEM—to attract more people into the rural generalist pathway. We have heard from the Rural Doctors Network, who also talked favourably about the model.

What do you see as some of the challenges of expanding the implementation of the SEM into rural areas, noting that there have already been some of those initial steps taken in western New South Wales?

VICKI MATTIAZZO: Could I answer first, Karin, and then you can follow on? We are encouraged by some trials already beginning in western New South Wales, and I think also in the southern region, which is where I am from mainly. It's good to see this progressing. It leads onto the first question about pathways to stop that leakage of people not moving back into the primary care system from the hospital system because there are concerns about loss of conditions and leave et cetera, and also encouraging people to commit for longer times in rural areas. We see benefits and we're supportive of the process.

I suppose one thing that we're cautious of is that we need to also bring the general practice group, including the practice owners, into the discussions and development of those models, so that they are not further disadvantaged and financial pressures are put upon those practices, who are fairly marginal, mostly—so that we're not putting extra pressure on those practices. I think that's a really important part of the development of the models.

Ms LIZA BUTLER: My question is also to Dr Mattiazzo. You talked about pathways for rural kids, but you spoke about barriers. What do you see are those barriers that we could be addressing to encourage rural kids, because, as you say, they're more likely to live and study there, and they'll stay there?

VICKI MATTIAZZO: I think things are changing in terms of medical schools. I'll talk specifically about medical schools because I also realise that this is a broader issue with allied health and nursing as well. In terms of selection processes, they are looking at alternative processes that are not so reliant on the University Clinical Aptitude Test (UCAT) scores because we know that urban schools are much more likely to provide coaching et cetera, to allow that sort of process to advantage those candidates. Obviously there's financial support because there are lots of financial barriers in terms of kids moving to the city. They have to move out of home and getting into college accommodation is incredibly expensive. There are also educational barriers as well. Most universities will give some allowance to rural students. I know that in Queensland they are looking at a number of different models—the University of Queensland, for example—where they have a tiered approach, depending on a student's rurality, to help overcome and flatten out some of those disadvantages. We need to be more creative and not so reliant on perhaps some of the more traditional admission processes.

The CHAIR: Dr Mattiazzo, are you aware that the Commonwealth Government has required medical school programs in New South Wales to have 30 per cent of their intake being students from rural regions for probably the last 15 years?

VICKI MATTIAZZO: I didn't know there was specific quotas, but I was aware that universities do have quotas. It also depends on how they count a rural student, perhaps, and whether they have had all of their education in a rural area or whether they have spent part of their life in a rural area. I'll have to take that on notice. I am not exactly sure how they're counting their numbers.

The CHAIR: I'm familiar with the criteria with that. What interaction has the college had with universities generally in that space?

VICKI MATTIAZZO: Karin, would you like to address that one?

KARIN JODLOWSKI-TAN: Yes. We've been having regular meetings with them over the past two years in leading up to college-led training in establishing those relationships, understanding how their education system and their program works and bringing them together in a national forum to try and ensure resources are shared. We are hoping to work towards a shared curriculum so there's consistency in how general practice training is delivered through the university space. We're also working quite closely with a number of the rural clinical schools and university departments of rural health in creating those training pathways and vertical integrations, and seeing how we can support each other in ensuring there's a strong percentage of those students going into general practice careers. We've been working quite closely with them.

The CHAIR: I'm going to flag a supplementary question on how that's progressing because that sounds quite recent.

Ms TRISH DOYLE: Thank you all for making time to be amongst us this afternoon and sharing your expertise and knowledge. Please be as frank as you want to in asking for what you believe is needed. My question is to Dr Chan. In your view, do you think the investment into urgent care centres with their nurse practitioners—and that includes our paramedics for remote, regional, rural health in New South Wales—will alleviate some of the pressure in emergency departments?

TREVOR CHAN: Thank you for the question. Apologies to the Committee; I forgot to introduce Dr Shamus Shepherd, who's next to me here as an emergency physician from Orange. I might get Shamus to talk a little about the rural setting. Urgent care clinics from the Commonwealth and the urgent care services that the

state is providing all go some way to looking at the overcrowding side of emergency departments, but that's only really a smaller part of the problem of the congestion in the departments overall. The bigger one is looking at the access block, which is the flowthrough to the rest of the hospital. There will be a role to play. How big that role is, is yet to be determined. We're guided a little bit by the New Zealand experience around their use of urgent care centres and urgent care services, and they are well taken up. Again, it's really finding the place for patients to be able to go to when perhaps their primary care physician isn't available, rather than going to the emergency departments themselves. So some part but probably not big in the end.

SHAMUS SHEPHERD: I might take you up on your offer to be frank. My answer would be no. The demand that we are seeing in the rural and regional areas is not from the low-acuity GP patients; it's all high acuity. There's more patients and they're sicker. The hospitals are heaving and they're full. It's not GP patients that are in beds; it's sick patients. The GP-style patients will wait in the waiting room and they do wait. That's because of lots of reasons but largely it's access to primary care. Urgent care centres, in our mind, won't fix the access block, which is the critical challenge that's facing all the regional departments at the moment, along with workforce shortages.

Ms TRISH DOYLE: I do appreciate you being frank. I have to declare an interest here because my son's a paramedic. He often talks about the many areas benefitting and would benefit more—and work alongside our doctors—whether it's in a hospital space or something we call an urgent care centre, if we saw an increase in paramedics. Essentially doctors on wheels. I appreciate your comments.

Mr CLAYTON BARR: Sorry, I'm just launching into a biscuit at this end so I'll probably be in ED this afternoon with cardiac arrest. Dr Chan and Dr Shepherd, in your submission you refer to the work in, work out model—which sounds great by way of description—being done by Outback Futures. When I google Outback Futures, I can only find them in Queensland. Is there an Outback Futures model operating in New South Wales?

TREVOR CHAN: Not that I'm aware of at this point but we do draw upon all the experiences of our other states and New Zealand to see what we can move forward. One of the models that we have moving forward is the blended supervision model. Again, the trials that are moving forward in that space are also interstate.

Mr CLAYTON BARR: So I'm not hopeless with Google; there was every chance that I was. That then leads me to another couple of parts of your submission. You talk about locums, which we've discussed in some other places. Our Committee has heard about locums in other places so I'd like you to expand on the locums part of your submission and also the role of the Australian College for Emergency Medicine (ACEM) and things like that. Could you talk about how that's working at the moment, problems and possible solutions?

TREVOR CHAN: I might ask Shamus to start with that one first, if that's okay.

SHAMUS SHEPHERD: I might hark back to the experience of Orange because it ties into this a little bit. I think the work-in work-out model was an example of a way of getting people effectively across the mountains. That's how I think about it. It's hard to get doctors across the Blue Mountains. Once you get them there, they stay. The reason I stayed is because I'm friends with the pharmacists and friends with the GPs. Our kids go to the same school and we're in the same pub trivia team. People have a good time once they're out there and they stay. It's getting them out there that's the hard thing.

The Orange experience pre-my time in 2014-15 was—a cabal is the wrong word—a group of locums that rotated out and started working in Orange Hospital. It built up a clinical service that the emergency department could deliver, and the quality and standards and the experience of working there. They all then signed up and stayed there and live out there now. I have always thought that was a really interesting kind of model, and Orange has been a really high functioning regional emergency department.

Locums are pervasive throughout regional and rural New South Wales now. They certainly say they're not the enemy, and they're not the enemy—they're filling a market need. They're in such demand that I think you have heard the exorbitant prices that they can charge, and again that's not their fault, that's a market factor. But it's really damaging the rural workforce, in that they work next to rural doctors of equal or senior experience, getting paid sometimes three times the rate, so they're often getting paid more than I am.

I think you referenced Fellows of the Australasian College for Emergency Medicine (FACEMs). FACEMs are emergency specialists and they're integral to the safety and clinical service delivery of emergency departments. There's not enough of them in rural and regional New South Wales and they do a really difficult and very disparate job to their metropolitan colleagues. Their conditions are much more onerous in terms of they're on call more often, and when we're on call we come in, because our junior staff are much more junior. When I'm on call, I almost invariably end up in the emergency department overnight. Whereas when I was at Liverpool for eight years—which is the biggest trauma centre in New South Wales and was for a while in Australia—I was on call

once a month and I was never called in, in eight years, because there are so many other resources within the department. I think that's a difficulty in attracting FACEMs out to the regions.

Mr CLAYTON BARR: Just for clarity, the reason I was linking those two things together is with regards to Outback Future, it's sort of semi-permanent. They are the same people going out and doing the work and they build the relationships and the networks. That's what I like about what was described there as the model. Locums, one of the people who spoke earlier described it—my words not theirs—is a bit of a jackpot around the skill set you get in your locum. Not all locums are the same in terms of skills, which must make it difficult to manage.

SHAMUS SHEPHERD: I would use lucky dip rather than jackpot. I think that is probably a better description, just in terms of—the money they get is so much now. More and more junior doctors are attracted to that style of work. We now employ much more junior doctors at much higher rates than we have ever seen in recent history.

Mr CLAYTON BARR: Finally, you make reference to telehealth. We are hearing that telehealth should be there to augment or supplement, but I think we're hearing from other sources that it's becoming the semi-permanent option for lots of cases.

SHAMUS SHEPHERD: I work in telehealth as well. I'll do a day a fortnight or a day a month in the western New South Wales version of telehealth, which is called vCare. I have always viewed it, certainly yes, as a supplement to clinical practice. I actually look at it as an attraction to recruitment to the regions as well. It's pretty scary being a GP out in Goodooga; there's not much around you. But if you know you can pick up a phone when you get a really sick patient and talk to me, or probably better, talk to Trevor, a good emergency physician, that's a big thing. Professional and social isolation is a real problem for doctors and all medical practitioners out there.

I think the more you build the scaffolding of support around them, both at junior and senior level, the better our chances of getting people out there, because the lifestyle's really good and I think they enjoy it out there. That's why they move out there, but the professional challenges can be significant. I view telehealth as one of the kind of solutions to that. It's not a panacea; it doesn't replace it. Sadly, when we can't get doctors out there, it does, so I talk to a lot of regional sites that are nurse-only sites, a lot of the multi-purpose services. I speak to a lot of the nurses out there. Again, for them, it's not the voice of God, but they certainly feel—sometimes it must feel like it's divine intervention when they have got a friendly voice on the end of the phone to support them.

Mr CLAYTON BARR: I think it was more the latter. When you have a doctor there who is being supported by telehealth, I think people are comfortable with that, but when there's no doctor and telehealth is the only thing, I think that's the concern. It puts a lot of pressure on the nurses, right?

SHAMUS SHEPHERD: Agreed, 100 per cent. But if there wasn't telehealth there—that's what I mean, it's not supposed to replace the doctor and that's the wrong model. But if there is no doctor there, they are not abandoned. You can't shut the service.

The CHAIR: I would like to follow-up on the locum questions, if the Committee will indulge me. To Professor Thomas, Dr Chan and Dr Shepherd, you've spoken about the high rates for locums. We have heard, and Mr Barr has reflected, the issue of skill level of locums seems to be mid-career medical practitioners without specific speciality practice, and we have heard also about how it undermines residents; the doctors who are working in places. We do know that locums are important and not just in emergency departments. Frequently health districts use them to keep small sites open. I'm interested in a couple of things. First of all, Professor Thomas from the Royal Australasian College of Medical Administrators and yourselves, what would be your approach to tackling this, because it is clearly a critical issue?

Secondly, I must say we have had some commentary around people scheduled for locums who pull out at the last moment, leaving shifts uncovered, because a higher rate of pay is suddenly asked for than what was negotiated, and on that basis they don't fill the shift. I don't know if you've heard or been involved in a situation like that. If you haven't, please don't say that you have. But sufficient people have commented on that to me for me to be extremely concerned about that as a risk to ongoing shifts and provision of care. There's a specific question there about locums pulling out at the last moment, demanding higher pay, and then a more general question about how you would approach tackling the locum question. Perhaps, Professor Thomas, you could start off because you've not had much to say and I will come back to Dr Shepherd and Dr Chan.

PETER THOMAS: I suppose we have to approach the problem of locums in two different ways. In the first, going back to the points that have been made, sometimes we are seeing quite junior doctors who are taking locum positions. We have to consider a credentialing framework and a set of competencies. That can be difficult, and having worked in regional and rural New South Wales, the last minute, the urgency of getting a locum, the locum workforce can be a problem for medical administrators looking across a whole service. But I think

ultimately we have to think about a credentialing framework under scope of practice. Also, we need to think, particularly in the longer term, training competencies and expectations that we want from our locums who might be working for three, six months or even now up to 12 months in a health service.

The second point is that we have locums that are junior medical doctors, but we have to also understand the importance of locums for short term, particularly for isolated practitioners. I think it's an important resource for them, and there are some examples where that works very well. If you think about the Sydney kids network, they are recruiting them, paediatric staff specialists, usually first-year start specialists, who will actually create a locum pool to support regional services. That's very common across New South Wales from Sydney kids network on behalf of a number of different agencies and a tiered structure of agencies. If we consider the locum workforce, we have to think about 'are they safe and capable and have a credentialing framework?' We also need to think about how to direct those longer-term locums into training programs and how to try and attract and retain them when they do enter regional, rural health services.

Then we also need to think about colleges supporting, perhaps recruitment or local health districts or networks recruiting more senior members of staff to help with locum replacement for us practitioners. On the second part, when it comes to last-minute changes to locum availability because of market forces, certainly in western New South Wales, there was an attempt to create a hierarchy—a tiered structure of agencies, with feedback to the agencies of locums that will pull out at the last minute—to therefore have preferential agencies that the local health district as a group with many hospitals requiring intermittent locum cover would use.

There are probably some levers that we can pull in terms of locum agencies, despite market forces. But also, ideally, in the same way hospitals create a casual pool, if we can consider a statewide casual pool to start to balance that internal competition—because what we're really saying here is we're cannibalising each other's workforce, in many ways, to the highest bidder. Despite the award arrangements about what can and can't be offered, we know that market forces determine the price of a locum. On a Friday afternoon, when you need somebody for Sunday night, those prices escalate. We have to have some way to try and regulate that internal market and perhaps create a statewide casual pool with reasonable rates, where we can have a credentialing framework and where we can try and help redirect some of that workforce back into specific health services. It will be a different approach—something we haven't tried before—but might actually give more sustainable resourcing, acknowledging that the locum workforce does have some importance and a role to play, particularly in regional and rural health care.

TREVOR CHAN: Just to add to those comments, the workforce issue is about long-term workforce supply. That's really where you need to get to in the end to balance that out. One of the measures that may help in the interim is networking arrangements between the larger metropolitans and the regions. That's certainly something the college is looking into and encouraging in that space. In regards to locums and pulling out, locums can get sick too, so we won't necessarily know why, in short-term changes. I think it's really more about recurrent behaviour and if it's an issue there in that space that would say, perhaps, that person is not best suited to work in those environments. And the last part is that the market forces are Australia-wide, so bordering Queensland, bordering South Australia and bordering Victoria, and the ACT in the middle, also need continuity of rates and conditions because they are also in that market.

SHAMUS SHEPHERD: I'd agree with all of those comments, particularly Professor Thomas's. The only other thing I'd add is that a potential solution to short-term locum usage is over-recruitment at the beginning of the year. We see an increased use of locums towards the end of the year as people go on leave, get sick or get better jobs and leave. Over-recruiting at the start of the year leaves that excess pool of doctors that can then fill that. It is a cost incursion at the start of the year that you potentially save with locum use at the end of the year. We've suggested that in a few different forums, but it's never really been taken up, although other jurisdictions might practice it, I think.

The CHAIR: Can I just follow up with you, Dr Chan, on the networking suggestion? I presume this is an arrangement where there is almost a dual appointment between a regional centre and a metropolitan centre. In other words, it's not an appointment to a metropolitan centre which then, at its whim, relocates people out, but there's an appointment with a commitment to work in a rural centre along with the metropolitan centre.

TREVOR CHAN: Yes, I think it's definitely worth looking at all of the different options that might suit in regards to joint appointments or fractions that might relate to work in the rural and regional space. It's probably a better scenario to look at it in the entirety of the metro workforce rather than just necessarily new recruits. That way, the workload, the distribution and the networking can be more evenly distributed. I think that will also look at greater options for people, as well as reducing the issue of relying on a small pool of new people to engage in those networks. I think here, the college's view is to leave it a little bit broad and look at whatever options might work best based on the workforce.

The CHAIR: Just to be clear there, because that's quite an interesting point, you're saying you actually should be focusing on those appointments being from middle- or senior-level staff, because they are the people with the expertise to cope, and just opening it up to junior staff has its own issues.

TREVOR CHAN: Actually, from the college perspective, it is looking at specific rural terms—not ones that are just outer Greater Sydney, but really rural and regional—again, supported by the local FACEMs there or supported in another fashion through some telehealth options as well. I think the college would look at it across the entirety, because that would be a way that can build the regional and rural workforce moving into the future. If you start them early enough and you support them, as Shamus has said, once they get out there and see what it's like, there's a greater potential to want to stay and make it part of their ongoing life-work balance.

The CHAIR: I forgot to say that I'm actually a retired fellow of the Australasian College for Emergency Medicine. I should've declared that. Finally, I want to come back to the pharmacists and ask if you've got any comments to make. I feel like you've had less of an opportunity in the evidence so far. I wonder if there are any comments you'd like to make to finish up.

LUKE KELLY: What we're talking about are long-term goals to recover the workforce. I fully appreciate the effort that's going into that; that's brilliant. In some respects, it has got to be reflected in the pharmacist workforce as well. I offer the fact that pharmacists are really keen to be a part of the solution here. I feel that we are a part of the solution. One of the blocks, though, in the current day is the over-reliance on old technologies. The communication between healthcare workers generally should be better. Telehealth is just one part of the solution. I can refer to Karen here but, for example, for pharmacists, recently the ability to do a telehealth home medicine review was taken away, which is bizarre. Karen might tell her experience with travel there.

KAREN CARTER: I have done medication reviews at Walgett, Lightning Ridge and Brewarrina, and I travelled to those areas. I was trying to go every three months, but with telehealth I could go every six months and then cut one of my visits. But now that's not actually available, so I have to physically go for those reviews. I'm willing to do that service to those areas, but it costs me more to do that. I think the staff are very appreciative when we do turn up, but we can assist with some sort of telehealth as well.

The CHAIR: Thank you very much to all of you who have appeared. I very much appreciate it. We'll bring the session to a close there. Thank you for appearing before the Committee. We may also send you some further questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions? During the hearing we flagged that there would be a couple of areas where we would seek additional information. Everyone is nodding. Once again, I thank you for taking the time to make the submissions that you have, for the work that you are doing and for appearing today and providing evidence. Thank you.

(The witnesses withdrew.)

(Short adjournment)

Mr PAUL MILLER, NSW Ombudsman, affirmed and examined

Ms MONICA WOLF, Chief Deputy Ombudsman, NSW Ombudsman, affirmed and examined

The CHAIR: Good afternoon and welcome. Thank you very much for appearing today as witnesses to this hearing. Can you each please confirm that you have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

PAUL MILLER: Yes, we have.

MONICA WOLF: Yes.

The CHAIR: Thank you. Would either of you like to make a brief opening statement before the commencement of questions?

PAUL MILLER: I have a very brief opening statement, if I may, but I'll begin by acknowledging that we are on Gadigal land. I pay my respects to Elders past and present as well as the children of today, who are the Elders of the future. As you know, we've provided a written submission to the Committee, so I can keep this opening statement quite brief—just to provide some background and context in relation to the NSW Ombudsman's interest in the recommendations of the upper house committee and to provide some information about what we've been doing since their report was handed down.

It's recommendation 41 of the Portfolio Committee No. 2 report that most clearly relates to the role and functions of the NSW Ombudsman. That recommendation was for the establishment of an independent health administration ombudsman. The NSW Ombudsman had not been invited to give evidence to that Committee, although we did make a brief submission on 18 March 2021 to the Committee concerning the application of the now repealed Public Interest Disclosures Act 1994 in relation to health services. After we became aware of the Committee's recommendation, we wrote to the Government, as well as to our own parliamentary oversight committee. That letter was sent on 31 May 2022 by then acting Ombudsman Monica Wolf. I can tender a copy of that to the Committee, if you would like.

The letter drew attention to the fact that the NSW Ombudsman already had all of the key features and functions of the health administration ombudsman as proposed by Portfolio Committee No. 2. Attachment A to our submission to this Committee sets out a table with all of those functions and features. In our letter to the Government, however, we also pointed out that the New South Wales public health system is the largest healthcare system in Australia, with the largest workforce of all New South Wales government departments, and that the resources of the NSW Ombudsman have been highly constrained.

Given that context we acknowledge that, although we may have all of the functions of a health administration ombudsman, it is likely there are matters that could warrant further scrutiny that have not always done so. Further, it is likely that our role has not always been widely promoted to or accessed by public officials working across the health system. The fact that the parliamentary committee itself made this recommendation without referring to the functions of the NSW Ombudsman is perhaps suggestive that awareness and visibility of the role and functions of my office in the health sector could clearly be improved.

With that in mind, on 9 December 2022 I wrote this time to my parliamentary committee, as well as to the Chair of Portfolio Committee No. 2. Again, I'm happy to tender a copy of that letter. That letter attached a paper which outlined the actions my office was taking and further actions we proposed to take following the Committee's inquiry. I'll very briefly outline some of the issues that I raised in that letter. First, as I said, in the recent two years there have been general and specific funding enhancements to the Ombudsman, which will assist but not fully resolve resource constraints.

Second, in the health context in particular, there can be grey areas between what is conduct, clearly, of an administrative nature, and what is non-administrative conduct. The Ombudsman can only deal with complaints about administrative conduct and may potentially investigate if that conduct is unlawful or unreasonable. Conduct that is not administrative, including conduct that purely concerns decisions and actions of a clinical nature, would fall outside the Ombudsman's remit. Third, it seems possible that maladministration complaints, and possibly public interest disclosures within the health system, may not always be appropriately identified as such if they arise in the context of a workforce grievance or clinical incident report. Fourth, the protections for whistleblowers in the health system are not consistent, depending on the concern that is being reported. By that, I mean that the Public Interest Disclosure (PID) Act covers only specified categories of serious wrongdoing. Other reports, such as a report about a serious clinical error or a serious risk to public health, may not be protected by that Act.

Fifth, the Ombudsman has recently been conferred some new functions that may intersect with the health system. These include the new PID Act 2022, which commenced in October this year. It also includes new powers

to review and report on complaint handling systems of public authorities and to refer complaints we receive about a public authority back to that authority for investigation. This is the most important part: We can then monitor the progress of an investigation and require the authority to report back to us on its outcome. Sixth, and finally, I noted that the Ombudsman could, with appropriate funding, establish a focused health administration unit within our office. It is that sixth issue that I want to briefly turn to now as I can confirm that in the 2023-24 appropriations a funding allocation has been made to allow us to establish such a unit.

Let me start by explaining what that unit is not. It is not a comprehensive sector ombudsman within our office that will handle all complaints, investigations and other matters that may relate to the New South Wales health sector. The funding provided allows for the establishment of four new ongoing positions, one of which is a dedicated deputy ombudsman. On 3 November we advertised the newly established position of Deputy Ombudsman, Health Administration. That role is a statutory officer under the Ombudsman Act and, for employment purposes, is classified as an SES Band 1. The deputy ombudsman will be a key leadership role within our office and is focused on the application of the Ombudsman's existing functions and application of existing resources within the New South Wales public health system.

It is to be a highly visible role. It is to promote awareness and understanding of the work of the Ombudsman in the health sector; to increase the Ombudsman's accessibility and visibility to public health workers and health customers; to identify and support an effective response to systemic administration issues identified within the sector; and to work collaboratively across all of the Ombudsman office's existing functional areas to ensure coordinated and impactful exercise of those functions where they impact on the health sector. That includes complaint handling, investigations, public interest disclosure oversight, Aboriginal programs and, of particular relevance in this context, our work reviewing the deaths of children.

Advertising for the position has just closed and recruitment is underway. It is hoped that the new deputy ombudsman can be onboarded around February 2024. The deputy ombudsman will then initially focus on recruiting team members and developing the unit's operating model and work plan. Monica Wolf, Chief Deputy Ombudsman, leads the division responsible for complaint handling, investigation and systems oversight, and will work with the new deputy ombudsman to establish that new unit. Monica and I are happy to expand on anything that I have just touched on or in our submission.

The CHAIR: Thank you, Mr Miller. I will lead off with some questions. I'm sure the Committee have some questions. I'm mindful that we have half an hour. The current Government has committed to implementing all of the recommendations of the previous inquiry. The previous Government had not committed to implementing this particular recommendation. Are you able to comment on whether the proposed unit within your organisation is intended to fulfil the implementation of that recommendation?

PAUL MILLER: I can't speak on behalf of the Government, but to explain the situation, what we have explained to government is that all of the functions and features, including the features around independence et cetera, that the Committee had proposed of a health administration are functions and features that already exist with the NSW Ombudsman's office. That's the legal and structural position. The issue is: has the NSW Ombudsman been able to fulfil to a practical extent what Portfolio Committee No. 2 would have expected of a new health administration ombudsman? That is where the health admission unit comes into play. There are no new statutory functions proposed to be conferred on the NSW Ombudsman. The role is primarily about coordinating the existing functions and particularly increasing visibility and accessibility of those functions.

The CHAIR: You noted that the previous committee, in making the recommendation, didn't consult with you, and I think you reflected that perhaps that in fact illustrated a little bit of the issue about visibility. You've also made a comment about the new Public Interest Disclosures Act, and I want to come back to that because you talked about recommendations to legislation to include clinical serious incidents in that. I'll just come back to that. But it seems to me that part of the issue is not just visibility and understanding of your office but there seems to be—let me put it this way. The way you've described your function, you don't handle industrial relations matters as pertaining to an individual and you don't deal with clinical incidents.

So if I was in the health sector, I can imagine that there would be several instances where either a clinical serious incident or an industrial relations matter I believe reflected administrative concerns. But because there is that sort of almost out there statement, "We don't deal with industrial relations; we don't deal with clinical serious," it seems to me that has clouded the fact. Because my interpretation would be that insofar as there are administrative issues with industrial relations—in other words, a pattern of bullying and harassment within a unit or, alternatively, administrative decisions that have resulted in poor clinical outcomes—then that would not be inappropriate for you. I wonder if you could just comment on that and—this is where I'm coming from—whether clarifying that will be an important function going forward.

PAUL MILLER: I agree, and if it sounded like I was putting an out there statement about the exclusion of those matters from our jurisdiction in black and white terms, I didn't intend to. My point really was that the issue of what is administrative conduct raises a grey area in relation to clinical conduct. If I can give you an example, a clinical error by a professional clinician is not of itself administrative conduct. The way that an agency handled a report about that error would be administrative conduct. Within the health system there are sophisticated mechanisms for reporting clinical incidents, and the point that I was making earlier was that sometimes once things get on a particular path, they're viewed as being only about that issue, which is that it's a clinical issue rather than an administrative issue. I think I agree with the premise of your question, which is that I suspect that there are numerous issues within the health system that do involve, at least to some degree, administrative conduct and concerns about wrong administrative conduct that are not being identified as maladministration because they're seen as, "This is about the exercise of clinical judgement." So I agree with you.

The CHAIR: If I can just follow up then, the health system has a process of root cause analysis of clinical incidents, the idea of which is to actually have a sort of no-blame situation. I certainly don't want to interfere with that process and I suspect that you don't either, but I do make the observation that administrative decisions are not somehow free from clinical consequences and that there may be a role—let me put it that way—for the Ombudsman. Certainly we probably need to make that clearer. I know Mr Barr has his hand up for a question but with his permission I'm just going to follow up one more. I think you've referred to the need to include serious clinical incidents in the PID legislation. Can you comment on that?

PAUL MILLER: Yes, I can. When the new PID bill was being introduced into Parliament, my office tabled a report about that piece of legislation and one of the things we pointed out was that there were questions about whether the categories of serious wrongdoing that are covered by that piece of legislation warrant further consideration. And by that I meant that the categories are exhaustive, so you have to fall into one of the particular categories listed. Generally speaking, they are corrupt conduct, serious maladministration, serious and substantial waste of public resources, and a number of privacy and information contraventions et cetera. What we pointed out was that certainly in most other Australian jurisdictions there is additional coverage for things like serious risks to public health and safety, serious clinical issues. As you've just pointed out, it may be that an issue that does raise serious concerns about public health or safety may happen to also raise concerns about maladministration and so might fall within the PID Act that way but it's not an express category of wrongdoing in the PID Act. In our report we suggest that consideration be given to the protections available for people who report those things that are not clearly corrupt conduct, maladministration et cetera.

Mr CLAYTON BARR: Clearly people want to be able to complain to someone who is independent that can swoop in and check whether or not people were properly dealt with in the medical system. In terms of your submission, I'm just trying to get my head around—you can make recommendations but there doesn't seem to be any enforcement. What happens if you make a recommendation and the hospital just goes, "Yeah, yeah, yeah, that's fine", and puts it in the bottom drawer or they write back to you and go, "We've done general improvements to system 101 and that's not going to happen again." How do you actually force change?

PAUL MILLER: It's a good question and it goes to the distinction, I think, between a regulator and an ombudsman. The Ombudsman has no powers to compel agencies to accept or implement any recommendations that we make. I think that's one of the important features of an ombudsman. It's not something that I would be agitating should change. I think it's inherent in our role as, in a sense, the external complaint handler of last resort. In terms of formal recommendations, though, if we make formal recommendations, for example, following an investigation, and the agency declines to implement those recommendations or accepts the recommendations but then does not move to implement those recommendations with what we would consider satisfactory speed, then our final and actually only sanction is to make a report to Parliament. It's called a section 27 Ombudsman Act report, and it's then for the Minister to make a statement in Parliament. The Minister is required to provide an explanation as to why that recommendation has not been implemented. But, as you say, we are not a regulator of the system. We are an ombudsman.

Mr CLAYTON BARR: Just on that, are you saying that you do have the power to investigate? So if you make a recommendation that the hospital assesses the wheels on the beds once a month, do you have some sort of ability to enter the workplace and to check to see whether that's being done?

PAUL MILLER : It depends. What I was talking about were recommendations that follow a formal investigation by the NSW Ombudsman. During complaints handling, it may be that we make suggestions, and we would call them "suggestions" only because our Act uses the term "recommendation" in a particularly formal sense, but, for all intents and purposes, they are recommendations to the agency to take appropriate action. In that case, unless there was an investigation, there would be no subsequent report to the Minister or to Parliament.

The CHAIR: Did you make a comment earlier—just for my own clarification—that you do have some powers under the new Act to follow up recommendations?

PAUL MILLER : Under legislation that was passed last year, which amended the Ombudsman Act, one way that we can now deal with a complaint about a public authority is to refer it back to the public authority with an instruction that they investigate and report back to us on the outcome of that investigation. Then it's a matter for us to indicate whether we are satisfied with their investigation and that outcome. That's a power that we've had in the community services sector for a long time but it's not a power that we've had in the public authority sector previously. It's a power that Independent Commission Against Corruption (ICAC) has always had and uses quite frequently in respect of reports of corrupt conduct where it's the type of corrupt conduct that would be better investigated by the agency itself rather than the ICAC.

The CHAIR: Thank you for clarifying that. To come back to Mr Barr's point, once you've made a suggestion—or, indeed, a recommendation—your capacity to check whether that's been acted on is fairly limited?

PAUL MILLER : In a legal sense, that's correct. We don't have legal power to compel that, no.

The CHAIR: And in some circumstances you can do a section 27 report to Parliament and the Minister would be required to respond.

PAUL MILLER : Correct.

Ms TRISH DOYLE: If we were to be brutally honest here and ask whether NSW Health is adequately managing complaints by their employees, what would you say?

PAUL MILLER : I would say that I'm not in a position to make a definitive observation in that regard. It goes to that issue about the extent to which the complaints that we receive necessarily give us a clear or representative picture of the sector. Generally speaking, our visibility of what is happening in the health sector at the moment is based on the complaints that we receive, but, obviously, that's a small fraction of the complaints that Health itself deals with and relates to a very small fraction of what is happening in the health system generally. So I'm loathe to make a definitive judgement, I suppose, about the entire sector and the way it handles complaints.

Ms TRISH DOYLE: You are way too diplomatic. I suppose the next request is I wonder how many people actually let you know that they've already made the complaint to NSW Health when they make contact with you? They're probably more likely to let us know, as local members, because my answer to my own question would be no, based on the fact that people are looking for another forum to investigate their complaints because NSW Health doesn't have the capacity or the system is broken. It would be interesting to know whether you have a question that you put to people when they reach out to you with a health issue—whether they have actually been through a process. How many people have actually been through a process with either the Health Care Complaints Commission (HCCC) or within Health itself?

PAUL MILLER : It's a fair observation. The thing I should point out, I suppose, is that, generally speaking, as an ombudsman, we are typically and appropriately the final, last-resort avenue for complaints. So in most cases, people will complain to us after they have exhausted all internal avenues. Indeed, while we don't always require this—depending on the nature of the complaint and also the circumstances of the complainant as to whether this is appropriate—in many cases, if a complainant comes to us and they haven't gone through the internal complaint-handling process within the relevant agency, we will say to them that it is appropriate that they give the agency the opportunity to respond to their complaint, before they come back to us. So they will go through that process and we say, "Come back to us if you are still dissatisfied." That's assuming that it is an administrative issue that's within our jurisdiction. We do get complaints, particularly in relation to matters which are clearly about clinical care and clinical outcomes, where people have exhausted both the internal avenues and the HCCC avenue, so we may receive complaints about both Health and the HCCC in that circumstance.

Mrs TANYA THOMPSON: I was just branching off from that, and I'm glad you finished on that point. Do you feel that the Ombudsman should have an arm where you deal with the clinical aspect of these complaints? Considering what is happening within our health system and the enormous amount of complaints that are coming through HCCC and NSW Health, should there be another arm attached to the NSW Ombudsman to deal with the other sector of it?

PAUL MILLER : It's not obvious to me that that would be an improvement to the current oversight system. If there were concerns about the handling of complaints about genuinely clinical matters, where you require the kind of clinical expertise which frankly we don't have, then the appropriate response I think is to fix, if they are broken, the existing systems. If there are questions about the capacity or resourcing of the Health Care Complaints Commission then I'm not going to be advocating that we should be given a function if part of the issue is that they are not adequately resourced to perform the function that they already have.

The CHAIR: One final point, because we are at the end of our time—has there been a review of the Memorandum of Understanding (MOU) between yourselves and the HCCC?

PAUL MILLER : There has. We have MOUs with most of the related complaint-handling bodies in New South Wales, whether that's the Anti-Discrimination Board or the Law Enforcement Conduct Commission (LECC). We have, I think in July this year, refreshed the MOU with the HCCC. I'm sure I've got a copy in my folder, if you'd like it.

The CHAIR: Could you take this on notice, identifying where you were able to clarify improvements to the process and discussion between the two organisations?

PAUL MILLER : Yes.

The CHAIR: On that note, I thank you for appearing before the Committee today. That's been very helpful. Particularly given the recommendation that came out of the previous inquiry, I think that's helped us understand that much better. We may send you further questions in writing. I've already indicated one where I'd like some follow-up. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

PAUL MILLER : I would be happy to do that, certainly. I referred to two documents in my opening that I would be happy to tender. Would you like me to do that?

The CHAIR: Yes. That would be very helpful. Thank you.

(The witnesses withdrew.)

Mr DAVID McCANN, Mayor, Coolamon Shire Council, sworn and examined

Mr TONY DONOGHUE, General Manager, Coolamon Shire Council, affirmed and examined

Councillor DARRIEA TURLEY, AM, President, Local Government NSW, before the Committee via videoconference, affirmed and examined

Councillor WENDY WILKS, Convenor, Inverell Health Forum, affirmed and examined

Councillor JOANNE WILLIAMS, Inverell Health Forum, sworn and examined

Dr CHERYL McINTYRE, Inverell Health Forum, sworn and examined

Mr ANDREW McINTYRE, Inverell Health Forum, sworn and examined

The CHAIR: I welcome our witnesses from Coolamon Shire Council, Local Government NSW and the Inverell Health Forum, who are appearing in the room and online today. I note that a number of you have travelled some distance and the Committee are appreciative of that. Can each of you please confirm that you've been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses? Everyone has that?

DAVID McCANN: Yes.

The CHAIR: There is an opportunity for each of the groups here to make short opening statements. I ask you keep in mind that we have your extensive submissions, and we appreciate that work. So a brief opening statement would be appreciated, with an emphasis on brief, because the Committee wants to explore aspects of your presentations. Perhaps we could start with the Inverell Health Forum.

WENDY WILKS: I am introducing the Inverell Health Forum, which was formed to find ways that the local council, where I'm a councillor, could help ease our health crisis. Data shows that COVID was a blip but the tsunami is coming for us. We believe the way forward is with Commonwealth, state and local governments working together, and business and entrepreneurs assisting where it is workable. The stats for doctors in rural, regional and remote areas has an average of 2.3 doctors per thousand people where metro has 4.4. Inverell has 0.7 of a doctor per thousand citizens, and 50 per cent of the GPs that we do have are over 55. We have 18,000 people.

We need a resident superintendent or a rural general surgeon so we can be considered for the single employer model in our hospital. We depend on registrars training with our medical centres but the allocating has changed since the Commonwealth removed the need for experience in the country. In real terms, for us, I understand that 60 went south and only four places north of Tamworth. We would be happy to see the registrars gaining regional experience in 12-week rotations, just like the Mudgee-Hornsby example. Dr Joe, you spoke in your inaugural speech in 2016 of an anti-rural mindset, and I believe that to still be a barrier. You mentioned the three points: towns would wither—ours has grown by 30 per cent since then; services and training are best done in the city, and you said that was wrong; and the distance from where decisions are made is too far, with no consultation. I would like to pass now to my forum medical obstetrician, but that is my opening statement.

CHERYL McINTYRE: Thank you for the opportunity to speak. I welcome the chance to try and refocus on the reason that we as health professionals are out there doing the jobs that we do, and that is the people that we care for. We want to try to improve access to care for rural people as close to home as possible, as inpatients and outpatients. Even for simple things like an obstetric ultrasound, to get a free service, people have to travel 260 kilometres to Armidale if they want to access that. Otherwise there are private, paid services in town. We are trying to push to increase the availability of things that people need as close to home as they possible can—also for inpatient care, because often people are sent away for things that could be offered safely in our town. They are sent away either due to a lack of staffing so they can't open that bed, or other administrators rule over the medical decisions that are made and people are sent away for those reasons. It increases the stress levels to people being cared for and does pull families apart as they have to go away to access care, whether that be birthing services, palliative care services or other health services.

We do feel that the decisions for what happens in our town and what is able to be done locally is made by people from far away who often have never visited our town, let alone actually lived or worked there. We do feel that we should be able to make more of our decisions, with more local input from the health professionals, doctors and nurses. Our health services are allowed to do less than we used to. Years ago we used to be able to do birthing services from 35 weeks onwards. Suddenly our role delineation was changed without an actual change in the skill levels of the people offering the service, so all the people from 37 weeks and below now have to be sent away. Again, we weren't a part of that decision-making. It means that a larger number of the ladies that we care for

during their antenatal stage have to be sent away. We need to have more say on what is safe to do in our town so that we can offer that service to more people. It will be much cheaper for them to access care closer to home and simpler and more suitable for the people involved—especially when they've got other kids to look after at home as well.

We also are finding it very difficult in that often our hospital isn't fully staffed. For example, if they can't find a scout nurse, we go on bypass so all of our maternity patients then have to be sent to bigger centres. We need to know that the smaller hospital administrations are going to work hard at trying to fill those gaps, rather than finding BCP, or business continuity plans, as a simple way of saying, "We don't have enough. We'll go on bypass." There are so many people that are getting sent away because we don't have a scout nurse. We need to train more people up to fulfil these roles so that we can care for people properly close to home.

The CHAIR: Dr McIntyre, there might be an opportunity to continue a little bit later. I'm going to switch to Coolamon and then to Local Government for their opening statements and then we will commence the questioning, if you don't mind.

CHERYL McINTYRE: Absolutely.

DAVID McCANN: In the interests of brevity, I don't have much to say. I'll defer to Mr Donoghue, who will read a short statement. Suffice it to say that our submission goes to what we believe is the significant role local government can and does play in the provision of health services in rural and regional New South Wales. We are a provider of aged care within the Coolamon shire. Whilst we acknowledge that aged care is primarily a Federal responsibility, without local government being involved in the provision of those services, those residents would very quickly find themselves in the New South Wales health system and tying that system up quite significantly. So I will stand by the submission we made. I would like to quickly point out there are two typographical errors, which are not significant, but Allawah Lodge, which is the aged-care centre at Coolamon, is a 33-bed facility, not 34. And the Coolamon-Ganmain Health Service Plan that was produced by Murrumbidgee Local Health District is dated November 2022, not 1922. I will now hand to Mr Donoghue.

TONY DONOGHUE: Just to set the scene for the services we provide in our community, we are a shire population of 4,300 and a town population of 2,300. We have been very proactive in providing the type of health facilities that our community needs. We have a very significant health service precinct. The last couple of years financial support and projected costs do not reflect the overall work that has gone into providing the services that are available in the shire, from the first provision of land when they were going to close the hospital in the nineties to undertaking a $1.5 million upgrade in 2020 to the council owned and managed residential aged-care facility—meaning that council has the type of infrastructure that helps attract health professionals. We are having trouble housing them at the moment, but we go all right attracting them.

This does not mean that we do not continue to struggle to adequately and appropriately service the healthcare needs of our community. We still have to step in when markets fail. As an example of what we provide, council owns and operates a 33-bed residential aged-care service on an annual $2.5 million budget with a capital value of $25 million. We operate Allawah Community Care, which has home care packages—75 packages. We run the Commonwealth Home Support Programme (CHSP) provision and we do the community transport. We provide the doctor and dentist surgery in Coolamon at a subsidised rent. We own that at a capital value of $800,000. We provide the doctors surgery in Ganmain, which we own, and we provide a subsidised rent. We own the land that the Coolamon Multipurpose Service is on, and the community health services, and that is at nil rent.

We provided $100,000 in value of land and an additional $100,000 in cash towards the ambulance station so that it was able to be placed in Coolamon. We provided rooms at the community centre for the allied health professionals free of rent. We've built a house for the doctor. We have subsequently built a house for 10 employees from the Philippines to reopen beds in our Allawah Lodge precinct. We own and manage 24 self-care units in Coolamon at a capital value of $7.5 million. We own and manage 20 single beds, over-55 low-income units in Ardlethan, Coolamon and Ganmain. These are all provided as support to the health system and the fact that we believe there is a need for our community to age in place.

DARRIEA TURLEY: Thank you, Chair and Committee members, for providing the opportunity for me to appear at today's hearing. I appear today as President of Local Government NSW, the peak body representing all 128 councils across the state. I'm also a councillor at the Broken Hill City Council. I mention that to explain my remote attendance at today's hearing, but also because of my own personal experience of living in a rural and remote community and of four decades of working in rural and remote health, from Lightning Ridge to Balranald and everything in between, and at one stage from Oberon to Broken Hill and everything in between. With that, as the level of government closest to the community, councils play a key role in helping to maintain and improve the health and wellbeing of our residents. This is especially true in rural, regional and remote communities.

Local Government NSW contributed to the original healthcare inquiry. We wholeheartedly welcomed all 44 recommendations they made. We are pleased that both the former and current state governments have begun the process of implementing those recommendations through a range of initiatives. While the provision of health care is a state and federal government responsibility, the reality is that, in the absence of adequate provision, it is the councils that often take on additional responsibilities to support these communities. This issue of cost shifting is often a significant and growing concern to councils across the state. Our submission includes detailed survey findings, demonstrating the significant impact of this cost shift in the provision of critical healthcare services and facilities to regional, rural and remote communities.

Our analysis identified nearly $2 million of direct costs borne by 21 of New South Wales' smallest councils or joint organisations. I am pleased that Coolamon council is here today. The submission provided by Coolamon council also provided excellent detailed examples of cost shifting, including funding of training of healthcare staff, construction of accommodation for health practitioners, purchasing of land for new medical facilities and even supporting spousal employment. This is unfortunate but not uncommon for councils across the state. The provision and maintenance of these services and facilities comes at significant cost to council. As well as the very real impact on annual budgets, councils also bear the burden of lost opportunities and have fewer funds to spend on other important services such as sporting grounds, halls, gyms and swimming pools.

In short, the local government sector needs to be appropriately recognised and resourced for the vital role it plays in supporting the provision of critical health services to the communities, in the attraction and retention of medical practitioners in rural, regional and remote New South Wales. It is clear that an intergovernmental approach is needed. Local government welcomes the announcements just this week by the Federal health Minister, Mark Butler, that the Federal Government is establishing a Working Better for Medicare Review to look at the critical lack of access to doctors in regional and rural Australia. In particular, we note three main policies will be under the review, including the Monash modified model, an outdated policy that Local Government NSW has long called for amendments to.

Similarly, the local government sector welcomes the opportunity to work closely with the newly created Regional Health Division within the New South Wales Department of Health, as they oversee the implementation of the full list of recommendations of the original health inquiry, and provide regular progress updates to the Minister. Councils also want to work collaboratively with their local health districts and their local health advisory committees to deliver and improve health outcomes for their communities. It is only an intergovernmental approach, where all three spheres of government are working together, that the health outcomes for our communities will be improved. Local Government NSW looks forward to working with both the parliamentary Committee and with the Government at a state and Federal level to ensure those health outcomes are delivered. Thank you for your time today.

The CHAIR: My question is first to the Inverell Health Forum. Have you noticed any improvements since the review and the work being done? It is early days, of course, but are there any observations on the work? Secondly, I'd like a little bit more detail on the decision about closing the obstetrics service. So the first question is, do you have any observations on NSW Health, communities, the supply of doctors—any reflections?

CHERYL McINTYRE: I haven't seen any improvements just at this stage. In fact, I think since COVID we've only seen a decline, really, in the provision of care and the number of practitioners available. I've been in Inverell for 25 years now. When I first got there, there were nine doctors doing obstetrics, and now there are two of us, and we've only been the same two for the last decade, at least. We do get doctors coming to town. Retention is an issue, and retention of them within the hospital system. A lot of them are staying in town, but don't want to work with the hospital any longer. So that relationship has always been a little bit difficult, and we want to try to help improve that as well, and improve training in the country so that we can build up a young workforce to continue the work into the future.

The CHAIR: So there are two obstetricians there?

CHERYL McINTYRE: GP obstetricians.

The CHAIR: But I think you said the obstetric unit doesn't function now, or did I misinterpret that?

CHERYL McINTYRE: Glen Innes closed. That's another town 45 minutes from us. Their obstetric service closed completely because they didn't have enough midwives and so that then increased pressure on us because we are now seeing quite a lot of the patients from there as well. Our service is often on bypass. Even when we've got obstetricians, often there might not be, for example, a scrub nurse so you can't take someone for a caesarean urgently and then our unit is closed to birthing. Even though we are there as obstetricians, we still have to come in and look after the people, but we have to be transferring them out for their labour because we

can't offer them a caesarean, because we don't have enough theatre staff to do a caesarean if it is required. That's happening more and more often in the last couple of years.

The CHAIR: Here we have a situation where there's a unit that's just about to fall over, with due respect.

CHERYL McINTYRE: Yes.

The CHAIR: Two GP obstetricians is not sufficient to sustain a unit.

CHERYL McINTYRE: We have been for the last decade or so. Pretty much, if you are in town, you are on call. We are on call all year, the two of us—both of us together.

The CHAIR: Thank you for your contribution to that, but I am not sure that's a sustainable model going forward.

CHERYL McINTYRE: I think it isn't, because a lot of the young ones don't want to do that. We need to get some more people in so there is more to share the load.

The CHAIR: What steps are being taken now to ensure that your unit has a future? At the moment, it seems to me that it's working but it wouldn't take much for it to not work. There needs to be a plan going forward, not just medical but I would suggest nursing. What steps are being taken to ensure that?

CHERYL McINTYRE: We have talked to the Area Health about it but they said it's our responsibility to find more practitioners to replace ourselves with. We are a training facility, so we train up GPs. We are trying to train more people to take on these roles. Some of them are interested in obstetrics, some of them, not so. They can't do all of their obstetric training with us because they need to go to bigger centres to actually do some of that training. We have trained up some GP obstetricians in the time that I have been there, but they have gone to bigger centres to continue working. They haven't stayed in our smaller unit.

The CHAIR: What about recruiting support staff?

CHERYL McINTYRE: Again, we are pretty keen for the hospital to train up some people to do scrub nursing and scouting so that we have a proper workforce so we can offer caesareans to people, but we can't advertise for those positions because they are within the Area Health. I don't believe that they are actually currently advertising for those or training anyone in those roles.

The CHAIR: I just want to make the comment that now is the time that action needs to be taken, not when the service disappears.

CHERYL McINTYRE: Absolutely, because then we can hand over the skills and actually overlap with the newcomers so that we can support them rather than have them come in with no senior staff.

Ms LIZA BUTLER: My question for you is around the obstetrics as well. First of all, when there's an emergency caesarean, where do they have to go to?

CHERYL McINTYRE: Normally, when we are fully open, we do the caesareans ourselves. We do that onsite. If we are closed—as in, we don't have enough theatre staff—we have to try and identify people that are going to go into labour as it happens so that we can get them there before they need the caesarean that we can't give them. We are being woken up and having to come in and assess people, more through the night when they are not fully labouring, because we need to try and then get them somewhere that they have access to that caesarean, if they do need it.

Ms LIZA BUTLER: So where do they go? How far?

CHERYL McINTYRE: The nearest town that they can access that is Armidale. That is 130 kilometres away by road.

Ms LIZA BUTLER: And they would be in an ambulance?

CHERYL McINTYRE: Yes, by road.

The CHAIR: But Armidale doesn't always have services—

Mrs TANYA THOMPSON: Armidale's not—

CHERYL McINTYRE: Armidale doesn't always have services either. Sometimes we are stuck in a pickle because we need to get somebody out and Armidale is unable to take them for whatever reason—whether their beds are full or whether they don't have an obstetrician. Sometimes they also don't have obstetric cover and sometimes they don't have anaesthetic cover, the same as us. Then they've got to go to Tamworth, which is 2½ hours. So you need to be assessing that person and making sure it's safe for them to go by road for 2½ hours

to get to that. Or we have to try and look after them ourselves if they are too far along in their labour, knowing there's no back-up because there is no plan B and we can't do a caesarean if they need it. It's getting more and more stressful.

Ms LIZA BUTLER: I have a follow-up question. Is your Area Health service out there proactively trying to recruit to these positions?

CHERYL McINTYRE: I don't know that the positions are even advertised. I have not heard that they are, so I don't know that.

Ms TRISH DOYLE: Hello to everyone on a Friday afternoon, as we head rapidly towards beer o'clock. I appreciate you being amongst us and sharing in a very frank manner some of the real difficulties that are often not heard in Sydney about the struggles of regional and rural communities. Probably more than anyone today, you have spoken really frankly and truthfully about this. To the Inverell crew, thank you for outlining some of those critical issues. My son is a paramedic and I think he did part of his student placement out your way. He was one of those paramedics in an ambulance who helped a woman give birth on the road in the back of the ambulance, so I have heard that firsthand. Darriea, I have been out your way many a time. The hundreds of kilometres that people have to travel is really problematic. Are there any systemic workplace culture issues, do you think? We know that geography is an issue, but are there systemic workplace culture issues for any of you in your regional healthcare services that you can identify that might be impacting on staff experience at work and retention of staff or staff burnout, besides the obvious things? Have they been articulated time and again or not?

DARRIEA TURLEY: I'm happy to make some comments around this. As someone who worked in the Area Health, I did do a bit of a stint in general practice and working with a GP, and then went back into the health system to work. One of the things that I always have tried to drive is, why is it that we don't see health as that best practice of work? There is a phrase they use: "If you can't attract people, why is it that you can't attract people?" Quite often, through that challenge of nurse trainees coming out doing their grad programs, we see that it is how we actually nurture them that they would consider working in a regional area. Considering how many come out to the area, how many do actually stay in a rural and regional area?

We have spent a lot of money on GP and doctor training to come and have this experience, but nobody seems to feel that it's a workplace they want to come back to. It's an area that I push with the Minister to say, "It should be a place of first choice of work. It's such a great experience working in health. It's an opportunity to serve and work in rural and remote health. You'll never have the experience anywhere else." But, somehow, that culture that is there doesn't keep the retention going. I think that there are challenges there. I think an honest and frank survey is always hidden. I worked as a senior manager so I know there are surveys there that your committee can get that are hidden. But I certainly worry that we are not really looking at it as a company would look at it by saying, "To attract people, we need not only to hand over good money but we need to have a culture that people want to feel safe to work in."

Mrs LESLIE WILLIAMS: Thank you particularly to those people who have travelled a considerable way to be at the hearing today. My first question is to the two gentlemen from Coolamon Shire Council. You talked about an incredibly impressive list of resources and infrastructure that you've provided as a council to support the local health system, from aged-care facilities to land for the ambulance and so on. So what is missing in Coolamon? It sounds like you've got it pretty well sorted, but I'm guessing probably not.

DAVID McCANN: I would say, from a strategic point of view—and probably different to everyone else—we have a very, very strong working relationship with our local health district. They are very open and easy to communicate with, from our point of view, but I am aware that that level of communication doesn't exist right across the state. That may well be an issue that needs addressing, but, from our point of view, we have a very good working relationship. That has allowed us to begin conversations with Murrumbidgee Local Health District at a level where we are actually working on problems, rather than trying to establish ground rules as to who can do what and who should be doing what. I would suggest that that's probably one of our strengths. Tony may have other thoughts.

TONY DONOGHUE: There has been a strong commitment from the community, and the council has backed that commitment to ensure that health is an important service that we continue to have, because we believe that is paramount to our community's cohesion. Prior to our investment, we saw people leave the towns just to get health care, and that was not appropriate to our community. So the investment was made, and our council backed it.

DAVID McCANN: Perhaps just to finish that off—one of the major factors in relation to the health service plan that the Murrumbidgee local health service developed is what they refer to as their hub-and-spoke model. For us, it's a very exciting proposition because it's putting a level of health service facilities in local

communities that can be sustained and manned by the larger centre, which in our case is Wagga Wagga, and there are a number of fantastic initiatives coming out of Wagga Wagga in relation to rural health that we are fully supportive of and wish to be involved with.

But, again, going back to that relationship with the local health service, the hub-and-spoke model that they are proposing is attractive to us, because in the case of Inverell we have heard of a trip of 135 kilometres. Similarly, in our area, those sort of road trips are still required from places like West Wyalong to Wagga and so forth. But by investing in service facilities, for example, at Coolamon, that's a halfway stop, so to speak, to get to the major centre of Wagga. So we are excited about that. We think that they are on the right track.

Mrs LESLIE WILLIAMS: Well done, you. Can I just add one further question, Chair, with your indulgence. My question this time is to Councillor Turley, as the president of Local Government NSW. One of the things that was mentioned from the Coolamon example, and one of the issues which I think is replicated across the region, is key worker accommodation. Are you aware of any local government areas where they have been able to maybe implement some different kinds of initiatives to try to solve that issue of key worker accommodation?

DARRIEA TURLEY: I will take that on notice and get back to you. I would encourage at any stage if the Committee would like to speak to any of our councils to see how health is improving in their communities to please do that, but I will take that on notice. I know that it is one of the bigger challenges because if you don't have safe, reasonable accommodation, you can't retain workers. But I will take that question on notice.

Mrs LESLIE WILLIAMS: That would be great. Thank you. It's always good to reflect on something, like Coolamon—except for the key worker accommodation—that's working well. I think if we can have an understanding of what some different strategies are and initiatives, that would be helpful for the Committee.

DARRIEA TURLEY: I was just going to add, with your indulgence, that one of the challenges for all these small councils is that it's money they need to invest. It's a priority to them because if they don't have a doctor, their communities won't stay. If they don't have health services, their communities cannot grow. But while they're investing that, they're making some really tough decisions where they're cutting back on their standards or not having enough workers or reducing the impacted services. But their priority is always their community and access to health, although I will take that question on notice.

Mr CLAYTON BARR: Can I say to everyone that's online and appearing in person today, thank you so much for your submissions. Even though I live in Cessnock, which is on the outskirts of, I guess, the Newcastle-Maitland area, and we have our challenges here in health, but to realise what you guys do, in your local councils, and just by getting up out of your seat and making it happen yourselves—the value of your submissions to a person like me is just incredible. Thank you so much for that. Of course, Mr Mayor, for Coolamon to wait 101 years for your health plan to be implemented is something.

I want to go to a submission from Inverell. I know it's not a part of the terms of reference for this particular inquiry, but you talk about establishing local independent health committees, and I think Recommendation 42 spoke about getting health committees back up and running was going to be a bit of a priority. With your indulgence, Chair, knowing this is outside the terms of reference, is there any sign that that's happening? Anyone of you can answer that question. Are we getting local health committees up and running in our local areas? Because that's supposed to be one of the priorities here.

The CHAIR: It's not entirely outside the terms because I think community is an important part of recruitment, as we have heard from Coolamon. So I think it's quite appropriate. I think Councillor Wilks would like a shot at this, to start with.

WENDY WILKS: There is some progress on the health committees, Mr Barr, and it is coming—it's heartening because I think that's the communication that we need. That's what really should make a difference: the communication between the town and those who make the decisions in other departments. That's really important for us. I think the committees need to be established, and they are beginning to be. Once they start again—I think with COVID they died down and weren't effective; I really agree with that. There is progress, so that's a good thing.

Mr CLAYTON BARR: Coolamon, have you got a view on that?

The CHAIR: Councillor Williams just put up her hand, and then we might go to Coolamon.

Mr CLAYTON BARR: My apologies.

JOANNE WILLIAMS: Thank you. I would just like to add that Inverell Hospital serves a community of approximately 18,000 people, and our community really needs some commitment that we can have a doctor

24 hours a day, every day. We would like to see funds diverted from transportation of patients to the treatment of patients. It puts a lot of stress—physical and emotional stress—on patients having to be transported away from their homes, away from their families. It also adds financial stress for their families. That's something that we would like to see, that diversion of funds from transportation to treatment in Inverell.

The CHAIR: Thank you. Mr Donoghue?

TONY DONOGHUE: My answer around the Local Health Advisory Committee (LHAC)—as I'm assuming that's what you are referring to—is that the LHACs were previously running street raffles and buying beds that supported the hospital. They're now changing their focus—in our area, anyway. We meet with the chair and Jill Ludford, the CEO of Murrumbidgee Local Health District (MLHD), probably twice a year. LHAC are the conduit between the community and the health services. I have seen, in my opinion, an improvement through that process from the old model of running street raffles for a bedpan.

Mr CLAYTON BARR: The intention is for the committee to be a conduit of information, not to be running raffles or fundraisers—I think that's a whole separate question—so that's good to hear. Just checking in, Inverell would be in the Hunter New England Local Health District. Is that right?

CHERYL McINTYRE: Yes.

Mr CLAYTON BARR: My understanding is that Hunter New England health has just employed someone specifically to take on this task and role.

CHERYL McINTYRE: Correct.

Mr CLAYTON BARR: I hope you see progress. Do any of you have health facilities where there are accommodations for your health workers on hospital grounds or on site, and is that an option that is being funded to assist with workforce?

CHERYL McINTYRE: There are three pods that have been put on the hospital grounds, and I believe they're for agency nursing staff. The doctors are usually put up in the local caravan park when they have locum doctors come in, whether they're anaesthetists or Emergency Department (ED) locums.

Mr CLAYTON BARR: Do you have spare grass and ground at your hospital that could accommodate more accommodation?

CHERYL McINTYRE: There does seem to be grass.

WENDY WILKS: Yes.

The CHAIR: So the doctors are normally in the caravan park?

WENDY WILKS: Yes. There is a program that we have been part of—and Councillor Williams has been running that—where we are getting students out and we have actually arranged to billet them privately. The council also has a policy where any doctor we get, we will help with a car or accommodation so that we can actually support that. The biggest thing for us is finding it, and the question is what can be done in the hospital, and that usually stumps the doctor who actually wants to practise his or her trade. When they come to the hospital, they would like to actually be a doctor.

Mr CLAYTON BARR: That is brilliant. To finalise my commentary, we've heard earlier today it takes a community to recruit and retain a doctor, and you guys are onto that. Bravo for everything that you are doing.

WENDY WILKS: Thank you. We are trying.

The CHAIR: I would like to follow up with a couple of questions with the indulgence of the Committee. I'd like to go to Coolamon. You said you have recruited 10 overseas staff for aged-care facilities?

TONY DONOGHUE: Care service employees.

The CHAIR: Have you also been involved in recruiting GPs? How many GPs do you have and how have you assisted in that?

TONY DONOGHUE: We have supported the GPs. We have built them a house. That doctor has eventually decided to stay and has bought the house from us. We have provided immigration support to another doctor to come to Coolamon. We have just got 10 care service employees. We built them a house within three months. That was $700,000. I think we spent $150,000 on getting them here. We spent agency fees. We've spent $350,000 this year at our aged-care facility waiting for these people to arrive. They arrived this Monday. They have started work, so there is a weight off my shoulders this week, which has been very good. I had a meeting with Samira the other day, and she informs me she has another two doctors coming—

The CHAIR: That's the doctor?

TONY DONOGHUE: That's our doctor who is the Visiting Medical Officer (VMO). She is seeking council support to find accommodation for them when one of them turns up later this year, and another one early next year.

The CHAIR: I don't want to verbal you, but I take from that description that clearly the situation with regard to having that general practice functioning in the town is critical. It is obviously critical for the hospital and for the aged-care facility. It seems to me that council keep a pretty close eye on it in terms of the staff there and in terms of making sure it is staffed. Is that right? What is your relationship like? It sounds like you have actually grown some workforce there.

DAVID McCANN: We are heavily invested in our health services as a local council, to the point of the aged-care workers that we have just received and welcomed on board from the Philippines. A number of them are trained as nurses in the Philippines and one of our initial stumbling blocks with that process—and sorry, I should point out that Gilgandra has also brought on board 15, I believe, under the same program, so there are 25 aged-care workers in southern New South Wales now. A number of them have trained as nurses in the Philippines, and one of our first stumbling blocks was the fact that in the Philippines they are trained under the United States system of nursing, which is not recognised in Australia.

As a council we have decided to upskill those employees that do hold those qualifications, and we have engaged a local provider in Wagga who will train them up to registered nurse level. It is our hope and our intention, really, that once they have fulfilled their contractual arrangements with us and they wish to stay in Australia, they may well be filtering into the New South Wales health system as trained nurses. That is just an example I guess of another way that we are engaged in trying to help the workforce.

The CHAIR: That is an extraordinary story. Your submission was very powerful. That's why I wanted you to be here. It's almost like a success story. It illustrates the importance of community in the sustainability of health service, I suppose. I guess what I was trying to get out with the medical staff—I suspect that if a couple of doctors left or a doctor was thinking of leaving, you would immediately become involved in addressing that, working out what was happening and trying to either plan for replacement or the future of it. Would that be correct?

TONY DONOGHUE: The answer to that is yes; however, we have limited abilities on keeping people that want to go and attracting people. But we do help where we can, and we provide the services that we can to ensure that is as easy as possible.

The CHAIR: With the indulgence of the Committee, I'm just going to go back to Inverell. Dr McIntyre, how many GPs are there in Inverell—a community of 18,000—and how many work at the hospital?

CHERYL McINTYRE: There are about 13 GPs in town. The number that are currently working at the hospital would be about five or six, so that's an issue, because the ones out—

The CHAIR: Why do you think that is?

CHERYL McINTYRE: Working at the hospital as well, it divides your roles in a complex sort of way. On the one hand, I'm a business owner. I'm a co-owner of a general practice, so we're trying to work in our general practice and see patients there and keep that operational. When you are called away from that, you are still having to pay your business costs, but then you are working for the hospital. Sometimes you have to cancel a day's worth of patients if you have suddenly been called to the hospital for an emergency situation that takes hours to sort out.

Whilst that is also a wonderful thing to be doing because often it is to do with birthing services, and we're happy to do that, it's more complex I guess than if you're doing just one role and that is your sole focus. Not everybody wants to do that because it takes them away from their practice and, also, it is often under-recognised, the work that is done within the hospital. We don't always get input as doctors into the way things are run, or making it work in a more smooth way that would work with both of those things that we are trying to achieve. I think it'd be—

The CHAIR: Does the hospital have times when it is without medical cover?

CHERYL McINTYRE: Yes. Frequently.

The CHAIR: Frequently?

CHERYL McINTYRE: Yes.

ANDREW McINTYRE: I'd just like to add, there are probably about 6,000 people in Inverell without a doctor. If you go to the hospital, you can't service those people, and those people are faced with an hour-and-a-half

drive to the nearest town, which doesn't have doctors, so they are faced with a three-hour drive to Tamworth, or a four-hour drive to Coffs Harbour.

Mrs TANYA THOMPSON: And that's just for basic medical care?

ANDREW McINTYRE: That's for a GP. Or they can phone InstaScript to get a quick fix.

CHERYL McINTYRE: Some GPs recently retired, and so suddenly we had a reduced workforce in July this year. That was a practice that saw about 3,000 patients, so they now don't have a GP full time. They do have a little bit of cover—I think once a fortnight there's a day or two a week. But there are a lot of people without a GP at the moment. The other practices just can't suddenly take on that massive volume because we're struggling to see everybody in a timely fashion ourselves.

The CHAIR: Presumably, that wasn't sudden.

CHERYL McINTYRE: No, we knew that was coming. As individual practices we're trying to do a lot of things to try to head that off, because it was coming. One of the things we've been doing—our practice is a training practice so we train medical students from first year and second, third, fourth, and fifth years. We've been doing that for many years now. We also train GP registrars and we train GP obstetricians as well. We've been a training practice for a long time. We're just at the end of our second year of Longitudinal Integrated Clerkship (LIC) training, which is in collaboration with the University of New England, where we have medical students in their last year of training do six months in a general practice, shared with the hospital and with the local Aboriginal medical services (AMS). The students get to learn what's it like in an apprentice-type way and get some of the skills that they'll need for next year, when they are interns and they don't have that same level of supervision. So we've been doing that. We've had four sets of six-month fifth-year students come through that. Some of them are really looking to come back to our area again.

We've realised that we're not catching some of these people early enough in their training for them to be exposed to general practice in a rural setting to then realise it is an opportunity at all. Often, we get them really late in their training, when they've already set roots somewhere else. They come to us for six months but their plan is always to go back to where they came from. If we're catching people earlier, when they're in first year, second year, third year and lower, then they're more likely to realise, "Wow, this is an opportunity. I could do this into the future." Some of the students that have come have just said, "I had no idea this is what you guys were doing out here, as a general practice in a rural area." A lot of them are quite enthused about the work we do and I think we're trying to work, as a practice, at getting them in earlier to get them that exposure to rural medicine earlier.

The CHAIR: I think that point about exposing junior medical staff to general practice earlier, and I would add probably during their hospital training, is pretty important. I was actually driving a slightly separate point and that is, that obviously it was a situation where a practice was about to—it would have been forecast, I would imagine, one or two years ahead?

CHERYL McINTYRE: Yes.

The CHAIR: Clearly it would have had implications for both health care in the town and the hospital rosters.

CHERYL McINTYRE: Yes.

The CHAIR: My guess is that everyone said, "That's going to happen", but essentially no one took any proactive action around addressing that as an issue. Did the Primary Health Network (PHN)?

WENDY WILKS: The PHN have been fabulous.

CHERYL McINTYRE: Yes.

WENDY WILKS: They've given us a $30,000 grant and we've put up the same. Business wants to put up more than that, so the money's not the problem. It's finding the people that are happy to come to the area and be happy with what they are allowed to do in the hospital. I would really like to see our hospital classification where we are allowed to be what—Armidale has a population of 25,000. We have 18,000 and when you add Glen Innes and the other people we're taking for maternity we are up to 30,000. We have 30,000 and a doctor is not there 24/7 in our hospital.

The single employer model sounds fantastic but then we have to have a superintendent, I understand, before we can even start that process. We're further north and we're not in the—I've heard of this now, this Modified Monash Model. Moree, which is to the west of us, is more remote so it gets more, with 9,000 population, than we can because we are not remote, but what we can do—we are beaten every way we go. I don't want to be beaten

and I don't like being beaten, so I'm trying to communicate. I need the knowledge of the people who know and I want to communicate so that we get good relationships with everyone involved so that we can change it. I really love what I've heard from Coolamon. Our council is very keen to help but they just don't know where, and so are people in the community. I love to hear what I've heard today. That'll be a big help. I appreciate that.

The CHAIR: You've described a situation, if I can reflect it back to you, where you've really got a very active community, council and local medical workforce.

WENDY WILKS: Yes.

The CHAIR: It sounds to me the missing ingredient is a commitment to the services in the health facilities? A commitment, to be frank, to maintain and upgrade them.

WENDY WILKS: Yes.

The CHAIR: I'm not sure how we make that happen. What you're saying is that you'll do the hard yards recruiting. You need NSW Health to be more receptive and more supportive and, particularly, think through the issue of service provision?

WENDY WILKS: Yes.

The CHAIR: I understand it's a chicken-and-egg argument.

WENDY WILKS: Yes, it is.

The CHAIR: If you don't have the doctors, you can't provide the services; but then if you can't provide the services, you don't have the doctors. But you have to start somewhere in that process.

WENDY WILKS: Yes.

The CHAIR: Okay, that's very helpful.

DAVID McCANN: If I may, the important point there is that we know we are in it for the long term. We know, as a community and a council, that we're going to be there irrespective of what changes come about. There'll be some part for us to play. We know that private companies that provide aged care, for example, won't come to small communities. There's no money in it for them to do it, so it's always going to be a council responsibility to look after its community. I think what you just said about providing the facilities that allow that to happen would be such a huge bonus for us. We will continue to do what we do and spend the money that we do, but to have Health providing the facilities and acknowledging what's happening would also be very much appreciated.

DARRIEA TURLEY: These councils, and councils across New South Wales and our rural areas, are absolutely amazing. Their dedication is unquestionable but the challenge for them is what else could those council funds be spent on if the state and feds in the past were doing their job. We hope that there is change to address this in the future because these councils are struggling financially. They want to make sure there is access to health care, but for them to do this it means that there are other services that they can't invest in. I just need to be very clear about our concerns.

Mrs TANYA THOMPSON: Just in light of the desperate situation that Inverell find themselves in and the fortunate situation that Coolamon find themselves in, perhaps you could share, because you've done such broad work—where did you start? It would seem that they've got everything that they need in terms of spirit and wanting to make change there, but where did you start? You would obviously have a broad scope of things that need to happen. Where's the starting point exactly?

TONY DONOGHUE: The unfortunate answer for Inverell is we started in 1993.

Mrs TANYA THOMPSON: Correct. Very different times, yes. I would imagine that.

WENDY WILKS: We can't start younger.

TONY DONOGHUE: We built a precinct and designed a precinct that was all in the same area. Ironically I flew to Inverell to look at their dementia wing in about 2003 and we designed a dementia wing to our aged-care facility based on Inverell. We would welcome them down to meet with us and have a look at the facilities that we have—absolutely.

WENDY WILKS: Thank you.

The CHAIR: I think Councillor McCann made a comment earlier that was a bit of a clue to this. I think you said that the relationship you have with the LHD is one where you can work on problems, rather than negotiate rules of engagement.

DAVID McCANN: Very true.

The CHAIR: I just wonder whether there is something in that about getting that relationship past the point where everyone is saying, "It's not my job. It's someone else's job", or, "It's the feds' job", and actually committing to designing solutions. On that note, it's 5.00 p.m. on a Friday afternoon. I commend everybody for being so sharp at this point in time. Thank you for appearing before the Committee and thank you to those who travelled to be here. It has been very valuable—both your submissions and the discussion. We may send you some further questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions? People are nodding—thank you very much.

(The witnesses withdrew.)

The Committee adjourned at 17:00.