

REPORT ON PROCEEDINGS BEFORE

**LEGISLATIVE ASSEMBLY SELECT COMMITTEE ON
REMOTE, RURAL AND REGIONAL HEALTH**

**THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2
RECOMMENDATIONS RELATING TO THE DELIVERY OF
SPECIFIC HEALTH SERVICES AND SPECIALIST CARE IN
REMOTE, RURAL AND REGIONAL NSW**

At Macquarie Room, Parliament House, Sydney, on Friday 31 May 2024

The Committee met at 9:05.

PRESENT

Dr Joe McGirr (Chair)

Mrs Leslie Williams

PRESENT VIA VIDEOCONFERENCE

Mr Clayton Barr

Ms Liza Butler

Ms Trish Doyle

Ms Janelle Saffin (Deputy Chair)

Mrs Tanya Thompson

* Please note:

[inaudible] is used when audio words cannot be deciphered.

[audio malfunction] is used when words are lost due to a technical malfunction.

[disorder] is used when members or witnesses speak over one another.

The CHAIR: Good morning, everyone. Welcome to today's public hearing of the Legislative Assembly Select Committee on Remote, Rural and Regional Health. Today's hearing is part of our inquiry into the implementation of Portfolio Committee No. 2 – Health recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional New South Wales. The hearing is being broadcast to the public via the Parliament's website and we have a combination of witnesses appearing in person and via videoconference. 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 of the Eora nation 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.

Ms ALISON WEATHERSTONE, Chief Midwife, Australian College of Midwives, before the Committee via videoconference, affirmed and examined

Ms AYA EMERY, Policy Officer, Australian College of Midwives, before the Committee via videoconference, affirmed and examined

Ms JACQUI EMERY, Chief Executive Officer, Royal Far West, affirmed and examined

Dr MARCEL ZIMMET, Chief Medical Officer, Royal Far West, sworn and examined

Mr MICHAEL WHAITES, Assistant General Secretary, NSW Nurses and Midwives' Association, affirmed and examined

Dr VANESSA SCARF, NSW Branch Chair, Australian College of Midwives, before the Committee via videoconference, affirmed and examined

The CHAIR: We will now begin with our first witnesses. I welcome representatives from the Australian College of Midwives, the NSW Nurses and Midwives' Association and Royal Far West. Please be aware that staff will be taking photos throughout the hearing. If you have any concerns, please let us know. Can 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. I'll start by confirming that with those present here today.

MARCEL ZIMMET: Yes.

JACQUI EMERY: Yes.

MICHAEL WHAITES: Yes.

The CHAIR: Can I have those online confirm that as well, please?

AYA EMERY: Yes.

ALISON WEATHERSTONE: Confirmed.

The CHAIR: Would any of the witness organisations like to make a brief opening statement, limited to a maximum of two minutes for each organisation, before we begin questions?

AYA EMERY: Thank you for the opportunity to speak at this hearing on behalf of midwives and women in remote, rural and regional New South Wales. Midwives are the most appropriate health professionals to provide primary maternity care to women and newborns throughout pregnancy, labour and birth, and postnatally. The Australian College of Midwives consulted with universities and local health districts and also conducted a survey of regional, rural and remote midwives to inform our submission to this inquiry. We found that advancement towards implementation of recommendations 19, 20 and 26—which relate to midwives and maternity services—is slow and that many midwives working in these locations are dissatisfied.

Remuneration for midwives in New South Wales is not in line with other states. In particular, the pilot annualised salary agreement for midwifery group practices pays a 29 per cent loading, which is significantly less than the loading in all other states of Australia. This also falls short of the annual salary of a full-time shift-working midwife. This is a deterrent to recruitment and retention of midwives in rural and remote New South Wales and a disincentive to work in and expand access to midwifery continuity of care. On-call arrangements for shift workers are not formalised and are poorly remunerated and managed. Professional development opportunities are limited and subject to constant staffing shortages and local workplace priorities. There are significant challenges with professional experience placements for midwifery students in rural, regional and remote areas. The Australian College of Midwives (ACM) recommends increasing and supporting opportunities for midwifery students to experience rural and remote locations and for local students to train within their communities.

Incentives intended to attract healthcare workers to rural and remote locations are overwhelmingly focused on medical professionals and nurses, and often exclude midwives. Existing incentives are not currently fit for purpose and fail to recognise the contribution and retention of midwives who already live in rural and remote locations in New South Wales. Despite extensive evidence of the benefits of midwifery continuity of care for both women and midwives, widespread implementation of midwifery continuity-of-care models has not been achieved in New South Wales, particularly in rural and regional areas. Our submission outlined both the benefits and barriers to upscaling midwifery continuity of care. Prioritising appropriate remuneration, professional development and increasing continuity-of-care positions for midwives living in rural, regional and remote New South Wales will impact significantly on the wellbeing of women, midwives and families of New South Wales.

The CHAIR: Thank you, Ms Aya Emery. I have noticed that Dr Scarf has joined us. Welcome, Dr Scarf.

VANESSA SCARF: Thank you very much. I apologise for being late.

The CHAIR: I will now move to the Nurses and Midwives' Association. Would you like to make a two-minute opening statement?

MICHAEL WHAITES: Yes, thank you, Chair. The NSW Nurses and Midwives' Association represents over 78,000 nurses and midwives across New South Wales. Since we last appeared before this Committee, we are not aware of any significant improvements in implementing the Portfolio Committee No. 2 recommendations. Members of this Committee have recently had the opportunity to meet face to face with some of our members on regional visits to hear firsthand about the ongoing challenges in rural health services, including maternity services and mental health. We made submissions and appeared before this Committee, yet our members report little progress.

We continue to work for improved wages and conditions for our members to retain the current workforce and to assist with recruitment of additional skilled clinicians. Our 2024 proposed pay and conditions claim was served on the New South Wales Government and includes a 15 per cent pay increase plus superannuation for all nurses and midwives. A decade of wage suppression must be addressed. There are also claims for greater work-life balance through improved rosters. Importantly, we are seeking an increase in the car allowance and the loading for midwifery group practice. The current loading for midwifery group practice, 29 per cent, does not compare with other states and needs to be increased to at least 35 per cent. The New South Wales Select Committee on Birth Trauma report tabled this week also calls for actions to address the midwifery shortage, including "ensuring competitive pay and working conditions for New South Wales midwives". That is recommendation 29.

The claim is crucial if we want to have any hope of being competitive with the other states and territories in recruiting and retaining a sustainable nursing and midwifery workforce. Currently at the entry level we are the lowest paying state out of all eight and at the top of scale we come in fourth. The incentive scheme to attract regional, rural and remote staff to those areas remains uneven. Some reported successes have been undermined by the inequity and the impact on morale. It also fails to have specificity. An example is Tamworth maternity. This site only attracts a \$10K incentive; however, it has not had the desired impact. They remain chronically short-staffed at that site. A request that the incentive be increased to \$20K has been declined due to the boundaries of the Modified Monash Model. A further review of that policy is needed.

As part of the hearing is focused on maternity and paediatric services, we would like to table a confidential supplementary submission from the association on behalf of members who are child and family health nurses. It speaks to the lack of paediatric services in rural, regional and remote communities. Significant and widespread childhood conditions have been identified, but the lack of paediatricians means that interventions and specialised care cannot be accessed, leading to a lifetime of problems for these children and their families. We require that this supplementary submission is confidential for two reasons: foremost to protect the identity of the clients referred to in the case study; and, secondly, to protect our members who experienced acts of intimidation when they advised their manager that they wanted to speak out.

The CHAIR: Ms Emery and Dr Zimmet, would you like to make a brief opening statement on behalf of Royal Far West?

JACQUI EMERY: Thank you for inviting us today. This inquiry is so important to the many thousands of families and their children living in rural and remote New South Wales. Since we last appeared before this Committee in December, the feedback to Royal Far West is that the situation has gotten worse in regards to access to paediatric and allied health services for children living in rural and remote New South Wales with developmental challenges. Our most recent survey of parents for our child and family Manly development assessment service covering the past 18 months found that over 80 per cent of parents and carers surveyed said they experienced difficulties in accessing local speech therapy, occupational therapy or psychology services; over 70 per cent said waiting times for local services were too long; nearly 60 per cent said local services were inconsistent; a third of parents surveyed said local services were too expensive; and 30 per cent said travel time and no local services were the main difficulties.

A shortage of specialist GPs and allied health clinicians in rural areas, coupled with significant increased need for services, has meant that many paediatric specialists working at public hospitals have closed their books to non-emergency patients, particularly those with developmental and mental health conditions. The result is waitlists of between 18 months and up to six years in some rural centres for children referred for language delay, ADHD, autism, anxiety and learning difficulties. The alternative is to see a private practitioner, which is often a prohibitive cost for many families.

We need other avenues to alleviate the waitlist and lack of services on the ground in rural New South Wales. If this doesn't happen, the cycle continues. The child who doesn't speak well at the age of two to three years is missed. They arrive at school delayed. They are bullied or become the naughty kid, and they get into trouble. The behaviour gets worse. Then they leave school early and possibly get involved in crime, unemployment and drugs, and the cycle begins all over again. This is a repeated story that we hear over and over. We need to work together to break this cycle.

The CHAIR: I'm going to focus, in the first instance, on midwifery and obstetric services. My question, therefore, would probably be to Ms Aya Emery at the start, and Mr Whaites. Ms Emery, you mentioned slow progress in the implementation of midwifery group models. I am interested to know what progress has been made and what you see as now needing to be accelerated. I'm also specifically interested to know whether there is a statewide approach to this or whether it is a matter of the Local Health Districts (LHDs) trying to implement this on their own. I have the same question for Mr Whaites.

AYA EMERY: I would like to throw to Vanessa Scarf, if I can, because she's our New South Wales representative and is probably best placed to answer this one.

VANESSA SCARF: They are really good questions. What we've heard from our rural and regional colleagues is that the slowness of the progress for midwifery practice has a number of influencing factors. There is always the workforce factor, although that can be resolved. Taking midwives to midwifery group practice does not reduce the workforce in that area. I think that, in some ways, there is a statewide desire for this to be rolled out. However, you're quite right: LHDs are left to make decisions around how workforce is allocated in their particular LHD and also their particular hospitals. Some of the barriers are related to the fact that midwifery leadership is deficient in regional areas and management is often more nursing oriented.

Directors of nursing, and potentially even directors of women's and children's health in these areas, are often led by nurses rather than a person who has nursing and midwifery, or midwifery, qualifications. So the understanding of the role and scope of a midwife can be limited. Having heard from our regional colleagues, I have regular contact with midwives from regional areas in New South Wales through my role as the chair of the New South Wales branch. These midwives report to me that they are regularly putting forward their desire to open up models of care in their small and larger hospitals. However, it's met with resistance, largely from the management, perhaps all the way up to the general managers of the hospitals in the regions. A big issue is a lack of understanding of how it could work in these small centres and larger centres in regional New South Wales.

The CHAIR: Thanks, Dr Scarf. Mr Whaites, do you want to make any additional comment?

MICHAEL WHAITES: Yes, thank you. I'm aware of at least two new midwifery group practices that have been established recently, in 18 months or so. Both of them were slow to establish as we negotiated to ensure that there was good fatigue management and the right number of staff on shift, so you didn't have a midwife working in isolation by themselves. I think that one of the things that we have been advocating for is midwifery-led models of practice and midwifery-led and nurse-practitioner-led clinics established in a coordinated way across the state that could provide many wraparound services for women and their children, sexual health services and a range of other things. We're yet to have or see serious discussions around any such models being set up. I think a coordinated process to do that would help accelerate that. One of the key barriers, as I've mentioned in my opening comments, is attracting midwives to the midwifery group practices. It's the way they want to work but we need to get the fatigue management and the pay right for them to join those systems and stay.

The CHAIR: Thanks, Mr Whaites. Ms Weatherstone, do you have your hand up?

ALISON WEATHERSTONE: I do. I just wonder if I could add to this question, if possible.

The CHAIR: Yes.

ALISON WEATHERSTONE: Thank you. We know that continuity of midwifery care improves outcomes for women and babies and, if established in the preconception period and through early access to these models of care in the antenatal period, they will reduce the experiences that Ms Emery discussed in her opening presentation—not from the college, sorry; the other Ms Emery—around developmental and behavioural challenges for children into paediatric, but also the burden of chronic disease later in life. New South Wales has a Blueprint for Action document and that outlines access to continuity of midwifery care. However, it doesn't set targets and, because of that, it doesn't have an associated implementation plan, which nationally we see is a barrier to local health districts implementing midwifery continuity of care.

Just in terms of the commentary around fatigue management that Michael discussed, one of the barriers around continuity of care, which is case load model, which is care by a known midwife throughout pregnancy, labour and birth and the postnatal period, is that leave is often not backfilled in these models. Instead of a midwife

having their existing case load of women, they're also taking on the burden of additional case load, which makes it unmanageable, untenable and unattractive. These models of care need to be reviewed by midwifery leaders that understand the model of care to make it attractive because, in particular, early-career midwives want to work in these models but they can't access it. It's also about an equity piece for women and children.

Ms JANELLE SAFFIN: The question I have is around the on-call arrangements for nurses and midwives. I note that the Nurses and Midwives' Association said there were still issues with that, and the Australian College of Midwives might want to comment on that as well because that's a real workforce issue that has been presented to us, and one we hear about locally.

MICHAEL WHAITES: In a lot of the smaller sites in remote and rural settings, there is no formal on-call system for nurses and midwives. Instead, what happens is, every day, multiple times throughout the day, every nurse and midwife that works there gets a text message saying, "Hey, we're short. Can you come in for extra shifts?" Because of their obligation to their peers, they do it. An excessive amount of overtime and extra hours is being worked. What it effectively does is put our members on an unpaid on-call system. It's unjust. We asked for that to be addressed in previous award negotiation rounds, but the wages cap was a barrier to any movement on that.

The CHAIR: Does anyone from the College of Midwives wish to comment on that question?

AYA EMERY: I can comment on that. The survey that we conducted of rural, regional and remote midwives—we had quite a lot of feedback around those on-call arrangements for shift workers and how they were being very poorly managed. A lot of examples were given, like that people were told they were on call but then their start time was not until they were actually called, so they were on call but not being paid for it for large periods of time. There were also examples of managers changing an on-call shift to a regular shift once they had been called in, to avoid paying on-call fees. And there are lots of examples of midwives being asked to be on call the night before they had leave or days off so then they were up all night and then their leave was ruined. There are lots of examples of it just not being well handled and not looking after the wellbeing of the midwives.

Ms TRISH DOYLE: Thank you all for being with us today and speaking your truth. As you know, we're looking at where particular recommendations may have been implemented or where there are steps towards implementation of recommendations. A lot of what we have heard is quite damning. I'm just wondering whether you each might be able to comment on any improvements at all that you might have seen in services provided for Aboriginal mothers and infants in terms of maternity care, obstetrics or paediatrics. If you have seen that, what sort of progress is being made in implementing birthing on country, for example?

The CHAIR: Ms Weatherstone, I think?

VANESSA SCARF: I'm happy to speak to that.

ALISON WEATHERSTONE: I will start and then I will throw to Vanessa. I think the best example of birthing on country is currently Waminda. They've just opened for birthing and actually now have visiting access into their local hospital. They have experienced their first continuity births, where they provide intrapartum support in the hospital. This is something that really needs to be rolled out across all of the state and, in fact, all of Australia. There needs to be the barriers removed to visiting access for both privately practising midwives and private midwifery practices such as Waminda. This will not only increase access to services for women but it also talks to a workforce piece because, once they're orientated to the hospital, they follow the woman through and provide the intrapartum support they require. Vanessa?

The CHAIR: Dr Scarf, did you want to add to that?

VANESSA SCARF: Thank you for the question. I was going to mention Waminda as well. I think that they have blazed a trail for New South Wales and in fact for the nation around how to successfully run an Aboriginal community-controlled health organisation that is not just maternity focused. In fact, Waminda has services that extend far beyond the pregnancy period, pre-conception and then child support as well. One comment that I would like to make is that just on the weekend we heard from Melanie Briggs, who is the manager of that unit. The challenges that they faced in achieving this incredible service were really unreasonable and extraordinary.

We hope that, because they were able to get the visiting rights for the midwives into the hospital and jump through an enormous number of hoops to achieve that, that means there will be some truncation of that process for other services that would like to open up. We know there are big Indigenous communities in centres like Wagga and Dubbo and in regional New South Wales that are absolutely crying out for this sort of service. Melanie Briggs and her team have done an extraordinary job in implementing visiting rights to hospital, which is probably one of the biggest barriers. If that could be implemented across the state and indeed the nation—they

certainly do it in Queensland. Alison is right. It improves workforce and it also improves the services for Aboriginal and Torres Strait Islander women and families.

Ms TRISH DOYLE: From a union perspective, Mr Whaites?

MICHAEL WHAITES: I think the comment that I would make is that we all want to reference Waminda. It's one service, and I think that answers your question. Waminda has been establishing itself for some time now. Have we seen any vast improvements in the number of services being provided? We're still pointing at Waminda. We need more examples.

Mr CLAYTON BARR: My question is to the Royal Far West. In your opening comments, you described that things haven't improved, in terms of access, for those remote communities in the two years since the previous inquiry handed down its report. Could you expand on that and maybe give some examples without going into it too deeply? Just give some broad brushstroke examples of how it's worse in 2024 than it was back in 2021 or 2022.

JACQUI EMERY: I will also refer to my colleague Dr Marcel Zimmet around this, but I'll start with a couple of examples. What we're seeing is that waitlists across the state are growing. We also have seen paediatricians leaving places in rural and remote. For example, in Dubbo there have been two paediatricians that have left that area and have not been replaced—they haven't been able to replace them. Also, we're effectively seeing not only waitlists grow but also paediatricians closing their books for children with developmental challenges. So there's just no response.

There are lists given of where you can potentially access services for different types of developmental challenges, but it's basically "go away". That's really concerning from our perspective. In Tamworth, it's now a six-year wait. We have had families report to us that, 'Your next best option is to go to Coffs Harbour'—it is quite a way from Tamworth to Coffs Harbour and there's also a two-year waitlist in Coffs Harbour—or be referred to Royal Far West. Of course, our referrals are increasing dramatically but we have no additional funding to support that increased need. We also are seeing and having reports from local paediatricians around explosions—and that's their words—in the complex behavioural and mental health challenges that children are presenting with at younger ages. Marcel, do you have anything to add?

MARCEL ZIMMET: Just to add to that, I think something that's happened underneath all of this is the post-COVID effect. There are some drivers including post-COVID effects—build-ups that didn't really get cleared in waitlists over COVID. Then you've had cost-of-living pressures putting pressure on families; that leads to family problems and behavioural problems in kids worsening if the child has ADHD, for example. For rural communities, of course, you have environmental problems from bushfires to floods that have also been driving things. These things have longer term impacts and drive some of the mental health and developmental problems or layer them. It's not the only cause, but it layers them.

I think that there's been, unfortunately, limited capacity building in the last few years to bolster the skills and the expertise in developmental and behavioural paediatrics in the rural regions. Not only are staff not staying, but there is increased workload of kids with these issues. There hasn't been a system in place to help support the local paediatricians or allied health teams to be upskilled in how to support and service these kids. Another point to make is that I think there may have been an increasing challenge from the National Disability Insurance Scheme (NDIS), which partly drained some staff to work privately and provide therapy only, like occupational therapy (OT) and allied health, in some rural regions. They're moving away then from assessment services and certainly moving away from community-based health services. So we have some of the state and federal issues coming into play as well. Lastly, there are some issues with coordination within a state-based framework across health education and child protection services for the very vulnerable, complex families that we serve.

Mr CLAYTON BARR: Are there any datasets that you could share with the Committee that show this growth?

MARCEL ZIMMET: It's a good point. One dataset that is available nationally is the Australian Early Development Census. The latest published data from that goes up to 2021, so it includes COVID. It does suggest that New South Wales has increasing vulnerability in several key developmental domains for kids at five, compared to other states. In terms of more focused data in those outcomes, they are not available. There are teams working on that. Some developmental services are trying to map that out. What data specifically would be helpful, just to make sure we are answering the question as best as possible?

Mr CLAYTON BARR: I think you just referred to one, which is the dataset in terms of the increasing need and demand. For Royal Far West, it is the dataset in terms of the increased number of referrals that are coming your way as the workforce, by the sounds of it, is plummeting out there in the west.

JACQUI EMERY: It's interesting, because we have seen our referrals increase by about a third in the past 12 months. We also measure complexity. I think that is another really important measure here, because we're seeing children attend with increasingly complex issues. We had an interesting example—and this goes to the coordination but also the complexity issues—where we had a letter from the outpatient clinic in Dubbo, just this week, back to one of our paediatricians. We had assessed a child that had been referred to us. We have completed that assessment, and that child is on medication and needs to be transitioned back to a local paediatrician. We basically got the standard letter back, that clearly stated we are not seeing children with developmental challenges and here is where you could go to—basically referring back to Royal Far West. Within that list, it outlines where you can go to for various services, it really breaks out different types of developmental challenges.

I think the other important factor that we are seeing here—again, off the back of some of the events of recent years that Dr Zimmet talked about—is children are presenting with multiple challenges. It's not just ADHD. It could be ADHD, potential autism, oppositional defiance disorder or a whole range of different things. I suppose that what we are seeing is the need for a tertiary level or a tier 4 specialist service like Royal Far West, which really doesn't exist on the ground in rural and remote communities. There is just greater need for that kind of service because of this layering that Dr Zimmet talked about.

Mrs TANYA THOMPSON: My question is to everyone. Given the opening remarks and submissions, I just wanted to ask if there have been any positive changes or anything at all that has come out of the recommendations in terms of midwifery, obstetrics and paediatrics? Has there been anything positive at all that you have seen implemented or change because of the inquiry and the recommendations?

ALISON WEATHERSTONE: I would have to suggest no, given the 43 recommendations that were handed down this week out of the New South Wales birth trauma inquiry—the New South Wales blueprint for action. It has been quite difficult getting any sort of oversight as to what the special action group that was stood up as a response to the last inquiry at the end of last year—ACM is definitely not seeing improvements, and that is also anecdotally from our member surveys and contact from members.

The CHAIR: Anyone else? Mr Whaites, would you like to make a comment?

MICHAEL WHAITES: Our impression is that there is a willingness and an intent to try to improve things. For our members, though, the key barrier is just having enough staff on shift, having the roster filled and having the people with the right skills and qualifications being available to work. When we look at midwifery, we are seeing, increasingly, registered nurses backfilling midwives. We are seeing assistants in nursing backfilling midwives. We see assistants in nursing backfilling registered nurses. Until we can improve the recruitment and retention, the significant changes for our members aren't going to be felt. For the improvement in delivery of services, that is a barrier as well because you can't provide good services when you don't have the staff available. When you listen to the comments from my colleagues here, the absence of enough staff to see the increase in demand is a key barrier. So we might see incremental improvements in policies or intent, but it's going to take a while to turn this ship around.

Ms LIZA BUTLER: Good morning, everyone, and thanks for your time today. Waminda is in my electorate and they are amazing. If members would like any further information, I'm more than happy to get that for you.

The CHAIR: Thank you.

Ms LIZA BUTLER: My question leads on from Dr McGirr's question about the slowness of rolling out maternity services and midwifery group practice, and it's probably to Dr Scarf. When birthing services at many regional and rural hospitals were removed, I feel that it was around budget, because you remove maternity services and then you lose lots of other services. Do you think the reluctance to reintroduce this midwifery group practice is around budgetary controls?

VANESSA SCARF: Yes, I think that that is probably the largest present barrier. I think that in terms of developing midwifery group practice—and, in fact, I was just having a discussion about this yesterday—there needs to be significant investment in supporting the midwives. Alison brings up an excellent point that midwifery group practices are developed and then necessary leave is taken by midwives and those positions are not backfilled, so those case loads are then put onto the other midwives, as an example.

Regional services that have been closed would be ideal for midwifery group practice settings. Many of them are reasonably close to another, larger centre, so there is no reason why there couldn't be a midwifery group practice operating out of those smaller centres. Just springing to my mind are Parkes, Forbes—those smaller centres like that. I think that the biggest barrier is the financial support for the midwives working in these areas. The pay and conditions are substandard—and Michael has covered that for us from the union—and also the material and notional support from the management, in terms of perhaps having educator support for midwives

who are upskilling and training to work in that more autonomous model. I think that because it is an autonomous model, and midwives are well capable of being autonomous practitioners, there does have to be support for them to then work to their full scope of practice. I think that any initiative needs to be backed with money.

Ms LIZA BUTLER: In my particular area health service, we have one of those smaller hospitals that birthing services were removed from about seven years ago, and now we have women giving birth on the side of the road on a regular basis. But one of the big arguments is about risk. What do you say to that?

VANESSA SCARF: Midwives are very good at identifying risk early. Midwifery continuity of care enables midwives to understand and develop a very good relationship with women from the beginning of a pregnancy. It means that midwives can identify, and women have the trust in the midwife to report to them, if there are any health issues emerging. I believe that that is probably one of the main reasons why midwifery group practice and midwifery case load actually reduces preterm birth and other adverse outcomes, because the events leading up to those sorts of things are identified early. Most certainly, midwives—

The CHAIR: Ms Weatherstone has her hand up.

VANESSA SCARF: Sorry, that's finished.

The CHAIR: I'm sorry, Dr Scarf.

ALISON WEATHERSTONE: I just wanted to add to that. There's health economics—we've produced many papers that continuity of midwifery care is 22 per cent cheaper to the health system than standard fragmented care. There is also a piece of work where the Office of the National Rural Health Commissioner is refreshing the national maternity consensus statement, which is directly related to access to maternity services in rural, remote and regional areas of Australia. That also talks to the cost impact not only to the hospital but to women and families when they have to relocate for birthing. There is significant evidence that the continuity of midwifery care model should be all risk. The approach to risk needs to be really understood because a woman's perception of risk, a midwife's perception of risk, a doctor's perception of risk and a health service's perception of risk are all different. There is a piece of work that needs to be done there.

The CHAIR: That is very helpful. I have a couple more questions that I would like to ask. I'll come to Royal Far West in just a moment. I just want to finish off on this issue of obstetric and maternity services. The Committee has seen, even in the space of the Committee's work, services threatened and closing, despite conversations for the last 10, 15 or 20 years about the need to preserve services and build capacity. There is a recommendation about local health districts developing and implementing plans around midwifery services. I'm not hearing from you any evidence that there's a lot of planning going on. Mr Whaites, you talked about staffing levels being a barrier. I think that's pretty understandable—although, of course, health services are spending a lot on agency staff to plug gaps.

I'm forming the impression that the rural LHDs are really battling to keep services going and to stay within budget, and there's not a capacity to do the planning that is actually necessary to break this cycle. With some foresight and planning, we could implement, as you've said, safe and much more efficient models of care, say, in obstetrics. Yet the LHDs are just struggling. It's an impression I have that they are struggling to meet budget and staffing levels that are under constant churn. Is that a reasonable position to take, or have I overstated that? I will go to you first of all, Mr Whaites, and then come back to you, Dr Scarf. I do want to also finish off with the Royal Far West on another subject. But can we have a discussion about this first, Mr Whaites?

MICHAEL WHAITES: Whilst I can't speak for the LHD management systems either, I think your impression is correct: It's as if they are in crisis mode and don't have the space or the funding in order to sit down and do that long-term planning. We are getting a lot of pushback when we start talking about "You could be doing this" or "You could be doing that." It's "Where will the staff come from? We don't have the staff." We see a number of LHDs at the moment, both metropolitan and non-metropolitan LHDs, who are exceeding their budget. Their response to that is to pull back on providing nursing specialists, to pull back on overtime, to pull back on extra hours. All that does is increase the fatigue of the workforce that is there and drives them out the door. It's shortsighted, but what else do they do? They bring in the agency only when they can financially afford it. I think you're right: What we need is the circuit breaker to allow that evidence-based planning to be put in place. They could do that with consulting the parties that you have before you today, who have some great ideas around what those models might look like.

AYA EMERY: I just wanted to add a piece to this staffing picture. One of the big issues at the moment with midwifery staffing is the fragmented model of care. Newly qualified midwives are graduating full of passion and enthusiasm, wanting to do women-centred care and wanting to do these continuity models of care. They're going out into placements, into the real hospital world, which is predominantly a fragmented model of care. They're experiencing vicarious trauma from what they're seeing happening to the women who are being cared for

in this fragmented model of care and they're leaving the workforce. New students are scared. They're coming back traumatised from their shifts, experiencing that out in the workforce. Midwives who have been working in the workforce for 10 years are burnt out because they can't work in the model of care they believe in. They hate what they're seeing and they're leaving the workforce. I think the more we can make more women-centred care, particularly more continuity of care, the less trouble we're going to have with the workforce.

The CHAIR: My final question is to Royal Far West. It has two aspects to it; the first is a comment, I suppose. You've talked about access being reduced to services for people with significant developmental challenges. It's my impression that the more vulnerable in our community are actually the ones that miss out. Is that actually true?

JACQUI EMERY: Absolutely, that is true. Although there are some local health districts that are prioritising First Nations families, again, even with that prioritisation there are still at least 18-month-long waitlists. In Wagga they are prioritising First Nations children, as well as families that are on a Health Care Card. But, again, all of those other highly disadvantaged families are not actually being even seen. They don't even get onto the waitlist. Certainly we see the most complex families that are also experiencing domestic and family violence are not getting access to these supports and services. It is absolutely the most vulnerable missing out. That is backed up again by the Australian Early Development Census, where we know that the children that are the most vulnerable and that are the most developmentally delayed are in the most socially and economically disadvantaged areas across the state.

MARCEL ZIMMET: I'd just add to that that I think the GP shortages—the further away from a rural centre you go, as many of you would know, the less access to GPs. Often the training of those GPs in child development may be variable. You're out in a small town a couple of hours away from a rural centre, so you're already starting at a disadvantage there; then even getting into a GP who may know how to support kids with development; and, thirdly, then being able to refer to a paediatric service from there.

ALISON WEATHERSTONE: I didn't want to miss the opportunity on the previous question to identify that recently Queensland appointed a chief midwife. That came with the delegation and accountability to make decisions and work directly with the health Minister, local government and health services. They have committed to increasing access to publicly funded homebirth. They will be implementing ratios in maternity wards in the postnatal area. They are increasing access to continuity of midwifery care. They recently opened Weipa birthing in Far North Queensland and they had their first baby just this week. They are already seeing results from this outcome.

VANESSA SCARF: I also wanted to add to that point that we were talking about earlier. A fundamental part of good midwifery and maternity practice is collaboration with our medical colleagues. One of the biggest barriers is that the medical oversight in many of these smaller centres—and even some of the larger ones—is patchy. It's absent. There are lots of fly-in fly-out locums, obstetricians and GP obstetricians. If we're going to look at improving the services for regional women and families, the conversation needs to be across all disciplines, and that midwives work very closely in collaboration with our medical colleagues, who obviously oversee the women who fall outside our scope of practice.

The CHAIR: Thank you to all the witnesses for appearing before the Committee today. We may send you some further questions in writing. Your replies would form part of evidence and be made public. Would you be happy to provide a written reply to any further questions?

MARCEL ZIMMET: Of course.

JACQUI EMERY: Yes.

MICHAEL WHAITES: Yes, Chair.

AYA EMERY: Yes.

ALISON WEATHERSTONE: Yes.

VANESSA SCARF: Yes.

The CHAIR: Thank you very much. Again, my sincere thanks to you for appearing both online and in person.

(The witnesses withdrew.)

Mr CODA DANU-ASMARA, Industrial Officer, Australian Paramedics Association (NSW), affirmed and examined

Mr GARY WILSON, Delegate and Former Secretary, Australian Paramedics Association (NSW), sworn and examined

Ms TARA RUSSELL, Chief Executive Officer, Community Transport Organisation, sworn and examined

Ms TANYA MITCHELL, NSW President, Isolated Children's Parents' Association, before the Committee via videoconference, affirmed and examined

Ms BRITT ANDERSON, NSW Publicity Officer and Health and Wellbeing Portfolio Second, Isolated Children's Parents' Association, before the Committee via videoconference, affirmed and examined

Ms TANIA DiNICOLA, Delegate, Australian Paramedics Association (NSW), before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome our witnesses from the Australian Paramedics Association (NSW), the Isolated Children's Parents' Association and Community Transport Organisation. Please be aware that staff may be taking photos throughout the hearing. If you've got any concerns, let us know. We've got witnesses both online and in the room. To start, could each of you 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?

CODA DANU-ASMARA: Yes.

GARY WILSON: Yes.

TARA RUSSELL: Yes.

TANYA MITCHELL: Yes.

BRITT ANDERSON: Yes.

TANIA DiNICOLA: Yes.

The CHAIR: Would any of the organisations or witnesses on behalf of the organisations like to make a brief opening statement, limited to a maximum of two minutes, before the commencement of questions? We'll start with the Australian Paramedics Association.

GARY WILSON: The Australian Paramedics Association would like to thank the Committee for the opportunity to appear here again and make representations and work with the Government to try to improve regional health. It's an important subject for us, and I'd like to say that we've made great strides in the last two years. Unfortunately, that hasn't been the case. In some areas, we've gone backwards. I think it's important today that we start to try to get some traction moving forwards. Once again, we appreciate your time.

TARA RUSSELL: I also want to thank you for the opportunity to contribute to the inquiry and to inform your work to improve access to health services across rural, regional and remote New South Wales. I've been fortunate to represent the Community Transport Organisation (CTO) at the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) stakeholder consultative forum and have witnessed the proactive, collaborative and positive approach taken by the Ministry of Health team and the other industry stakeholders who participate in that group. The CTO's submission to this Committee highlighted the importance of accessible, inclusive transport in supporting access to health services but also highlighted an area where we feel we could be doing some more. We encourage the Committee to remove restrictions from the IPTAAS guidelines which exclude community transport providers from delivering services under the scheme.

Community transport has the potential to play a very positive role for IPTAAS-eligible patients by increasing patient choice in how they travel and increasing the availability of travel options, especially for vulnerable, frail and isolated people. Community transport exists across all LGAs in New South Wales. It is delivered by many and varied types of organisations, from not-for-profits to councils small and large. With 68 providers, 900-plus vehicles and 2,700-plus volunteers, they deliver in excess of 1.7 million trips per annum from 100-plus outlets across the state. At least 58 per cent of these are located in rural and remote New South Wales. Community transport exists to provide transport to people who are disadvantaged, those who are frail or vulnerable, or those who find public transport inaccessible. We believe that these people living in our community could benefit from community transport being an eligible service within the IPTAAS scheme.

The CHAIR: Would the Isolated Children's Parents' Association like to make an opening statement?

TANYA MITCHELL: Thank you for the opportunity to do that. The Isolated Children's Parents' Association (ICPA) NSW is a voluntary not-for-profit advocacy group, and we have our roots firmly embedded in rural and remote regional areas across New South Wales. We believe that students, irrespective of where they live, are entitled to equitable access to education, and that also includes access to health—quality health—for those children to reach their full potential. For these rural and remote children, access to quality health services is equally as important as education in order for them to reach their potential and start school ready to learn. We have seen from the three-year-old screening program, conducted by Royal Far West over the last seven years in some of our rural and remote communities, that 80 to 90 per cent of those children received referrals for speech, OT, dental, hearing and trauma-related psychological services. Many of these children are unable to access services due to the remoteness, and, without this early intervention, they're immediately disadvantaged behind their metropolitan peers.

We have examples of children that do get access to early intervention and allied health services, who go on to do well at school socially, emotionally and academically. We also see the children who do not and quite often end up in our justice system. These children have every right to have access to these allied health services so they start school ready to learn and go on to be contributors financially and economically in our communities, instead of being a drain on the health system and our social justice system later on in life.

The CHAIR: Thank you, Ms Mitchell. We might now move to questions, and I will start. I'm aware we've got a couple of broader topic areas here in relation, firstly, to patient transport and then, of course, access to services for children. I'm going to focus, in the first instance, on transport and ask the Australian Paramedics Association. Mr Wilson, you mentioned that there'd been progress—in areas, the situation had actually gone backwards and progress had otherwise been slow. I wonder if you might expand on situations where you think things have actually deteriorated in terms of patient transport.

GARY WILSON: In terms of patient transport, from an ambulance perspective, I don't believe that there has been a great deal of deterioration. I think, primarily, it's just that there hasn't been any improvement. The deterioration has been in other aspects. We haven't had any real engagement about the changing of patient transport services to date. We note that Health has put a submission in, which would seem to confirm that. Realistically, paramedics would like to exit the space of low-acuity, non-clinical patient transport entirely. We're pleased to see that there are other groups, such as community transport, who are capable, able and willing to take up that role. Paramedics find it very frustrating not to be able to respond to emergencies because we're transporting patients who don't actually need us. We would like to work actively to remove ourselves from that space and would like the Government or Health to engage with us on that.

The CHAIR: We have had evidence of issues around patients being discharged without transport, say, from city hospitals. We also have had instances where there are systems for non-urgent transport that are developed by the LHD. It sounds as though, from what you've said, that that's not universal and that there are still parts of rural and regional New South Wales where there's a reliance on the acute paramedic services to do, as you said, non-urgent transport. Is that in fact the case?

GARY WILSON: It has been my practical experience that there has been no change at the coalface. We are still doing transports for patients to routine diagnostic appointments, for routine consultations with specialists. We're doing patients who don't require our services at all, and the services that are available in rural and regional areas have limitations on them in terms of where they can pick up and where they can deliver to. LHD patient transport services, for instance—we've had issues with them picking up or delivering to private residences; even aged-care facilities based in hospitals are considered to be a private residence. Because of those restrictions, the emergency services have been forced to take up that role. When you're in an area that only has one ambulance, having that ambulance away doing these transports for hours places our communities at risk. As I said, there are other organisations that are more than willing to take up the slack, and, ideally, we would be exiting that space entirely.

The CHAIR: Just to clarify, this is a situation where you've got non-urgent transfers to a person's home or an aged-care facility being undertaken by high-level paramedics?

GARY WILSON: Correct. You've got highly trained, dual-operator crew in a fully equipped ambulance being taken out of their community for hours to take someone to an appointment that has been made months ago because they're going to see a specialist. They don't require any treatment en route, they don't require any monitoring en route, or we're taking them home. This is not a space where I think we're being financially responsible.

The CHAIR: Are you able to help me understand why your service is chosen to do that? You just said there were other services available, so is it sometimes lack of availability?

GARY WILSON: My understanding is it's a mixture of a lack of availability because we haven't built up our patient transport services, or alternate service providers, but also—and, again, we've asked for clarification before and still haven't received it—we believe that there are barriers in place in terms of LHD agreements about where they can transport to and from. If we can remove some of those barriers, which would seem to be relatively simple and administrative, then perhaps some of those transports that we do can be taken on by other services.

Ms JANELLE SAFFIN: I wanted to drill down a bit more on transport. We just heard from the Paramedics Association about certain agreements in place with LHDs that prohibited movements here and there. Could I hear a little bit more about that?

GARY WILSON: My understanding—and, again, we've never been given a formal explanation of this from either the LHDs, from Health or NSW Ambulance; this is just from conversations that we've been able to have with parties—is that there are restrictions in LHD agreements about where patient transport services can operate in regional areas, and it varies depending on the LHD. In my area, Murrumbidgee LHD, we do transports from the aged-care facility that's based within our MPS, our hospital, and we've been told that the reason we do it is because patient transport services can't. In other instances we do them because there is no patient transport available at the time. It may be because they don't have enough resources or it may be that it's a Sunday, and whilst we're a 24/7 service, that's not the same for patient transport services. So whenever there's a lack of resourcing or where there's an administrative barrier, NSW Ambulance and paramedics are left to prop up the system, thereby increasing risk to our communities for those time-critical jobs that we need to do.

Ms JANELLE SAFFIN: I understand. I have a follow-up question. How do you get tasked? Who actually tasks you to do it? How does that happen?

GARY WILSON: The LHD has a patient flow coordinator. My understanding is it's their job to coordinate the various resources. When they need us, they approach Ambulance and we get tasked. If the administrative barriers were removed and if there are additional resources—either patient transport officers, community transport, or in some cases even a taxi—we could be entirely removed from this process. It's my view that we should not be a resource that's used by patient flow for these types of cases. I'm sure that people would like paramedics to be paramedics and not taxi drivers.

Ms JANELLE SAFFIN: I'm sure that's what people want.

Ms TRISH DOYLE: Thank you to you all for appearing before us and sharing your views and expertise with our Committee today. Full disclosure: I am the mother of a paramedic, so this is not just professional or political work for me; it's deeply personal as well. Thank you for the good work the APA do in supporting their members and speaking truth to power, especially at the moment. The APA's submission refers to a number of challenges with increasing extended care paramedics and intensive care paramedics in rural and regional areas, and it's needed. Can you expand on these challenges? If you had the Minister sitting here in the room today and he said, "How can we address this?", what would you say?

GARY WILSON: There are a number of challenges, and I might pass over to my colleague in a moment. One of the first things I would say is please stop actively deskilling paramedics and taking away our ability to help our communities. We have at the moment, as late as this week, NSW Ambulance downgrading intensive care paramedics and removing their equipment in regional and rural areas. What we should be doing is looking at innovative models and resourcing to upskill our paramedics in regional areas—not just in the large metropolitan and regional areas but also in the smaller communities, who deserve the same level of care. This is one of those backward steps that I think we've taken. To be actively deskilling the workforce is, quite frankly, offensive to a lot of paramedics.

CODA DANU-ASMARA: To add onto that—to give some clarification about the two kinds of paramedics that we're speaking about, to those who might not be familiar, we're talking about ICPs, intensive care paramedics, and also extended care paramedics, ECPs. ICPs are highly trained in more complex and more advanced areas, whereas ECPs kind of act as a way to function with non-emergency but still acute problems, such as resetting dislocations, changing catheters, those sorts of things. Both of those specialists are definitely needed in rural and regional areas—equally as much as they're needed in metro areas. The issues are, while NSW Health have in their submission talked about how they've opened up new training pathways for ICPs within regional areas—and I might have Tania speak about this briefly to discuss the difficulties, still, of those systems being open, people travelling hours just to go to training, five hours a day. I can let her speak to that after this, but I wanted to bring up the fact that ECPs still don't have any training courses outside metro areas. This is extended care paramedics.

ECPs are forced to give up managerial positions. For example, if someone was a station officer or a duty operations manager, which are two managerial positions in paramedicine, and they wanted to get specialised

training, which is very common among managerial positions, they would have to give up that managerial position in order to do that and also move to the Sydney metro area in order to work in this consolidation period without even the guarantee of being able to return back to their position and their station and their home after it's over. So there is a large amount of disincentivisation for specialist paramedics in regional areas. If you wanted to become a specialist and you live in regional or rural New South Wales—why would you want to become a specialist? There's very little incentive to keep people there, and that just causes these communities to suffer in that way. Perhaps Tania wants to speak briefly about how difficult it is for some of her colleagues to do training pathways and things like that.

TANIA DiNICOLA: Thanks for your question, Ms Doyle. Obviously there is no doubt that there is a complete inability to service outpatients to the full scope due to the lack of ICPs and ECPs that we have in the regional area. Definitely the level of specialist care depends on the region and that impacts equity of care in services. Like it was said, there is no ECP or ECP training outside of metro, to my knowledge. On the topic of ICP, in my area we have people living in Armidale or coastal areas travelling long hours to Tamworth, Dubbo, Wagga for their ICP consolidation. That means either, at best, an additional three hours of commuting per day on top of a minimum 12-hour shift for their consolidation—that is inclusive of post-night shift, adding to the issue and burden of fatigue in the ambulance service—or a three- to six-hour commute back to the coast after their last rostered shift. On top of this, it sometimes includes paramedics paying rent in the area they've been posted to for that consolidation as well as their mortgage or rent in their lived-in community. Personally, I don't see how that's sustainable. For example, for myself, I could not see a future in ICP or ECP pathways, and I can understand how that would be the same for many of my colleagues.

Mr CLAYTON BARR: I have a question for the Isolated Children's Parents' Association. Your submission discusses transport to allied health services for geographically isolated children who have specific educational needs or development delay. Can you outline some of the challenges that these children and their families experience, and whether or not transport services have improved in the past two years since the initial inquiry report?

TANYA MITCHELL: I can give you some examples. I'm based out at Bourke. We've got families out near Wanaaring, some 2½ to three hours west of Bourke. They drive their children into our local preschool two days a week so that those students have some access to education and early years learning. Some of the issues are picked up by the educators of some of these children. When they receive their referrals, the closest place for them to access some of those services is Dubbo. I have got an example of one mum whose son had some significant delays in his speech. Because of his speech, that then caused lots of self-confidence and anxiety issues. This mum used to travel to Dubbo every fortnight for her son to be able to access speech therapy. For her to travel to Dubbo, that was 430 kilometres one way. That's an 860-kilometre round trip, plus accommodation—because that's an overnight stay—plus time off work, plus she also had younger children. She did that for two years.

She will freely admit that that nearly broke them financially, physically, emotionally and mentally. That little boy, that was back when he was four or five. He is now one of the school leaders in his year 6. There's the change in that child. We see the outcomes for those that have access. This is a mum who had means. As I said, it nearly broke them financially as well, but this is someone who had the drive and the means to be able to do that for her child. For many of our families out here, particularly our vulnerable, our Aboriginal families, they do not have that same access, so those children go without. They're the ones that we're seeing constantly with worse outcomes because, obviously, it's exacerbated the longer that those issues go on. And then they're not diagnosed, perhaps, until they're in primary school.

Some of the children that we're looking at with antisocial behaviour are now in the justice system. When you look at it, there could have been simple things done for those children when they were smaller that could have provided different outcomes. For that family, yes, we have IPTAAS, but if we have a visiting specialist out to, say, Bourke—we're very fortunate that sometimes we do—their books are already full. They have no more capacity to take on anybody else. What we've found is that they have been knocked back by IPTAAS because it is considered that there is a service in our community and, therefore, IPTAAS is not available to those families. You can imagine doing that on public transport with younger children. For our families travelling to, perhaps, Royal Far West on public transport with younger children, perhaps having never been to the city before, navigating that is all too much for many of our families to take on.

Mr CLAYTON BARR: And the flying doctors, the services they offer don't extend into examples like this?

TANYA MITCHELL: The flying doctor out here—there are the clinics and then there are some, in emergencies, further out, yes, but not here in Bourke as such. There are some private organisations that will come and help with some of our children. But, again, it's navigating that whole process as well.

The CHAIR: Just to clarify there, you're saying that there have been claims for IPTAAS knocked back because a service is available, despite the fact that you can't get in to that specialist? So it's actually not available but, because it is registered there, it appears to be available and therefore the claim is knocked back. Okay, thank you.

Mrs TANYA THOMPSON: I will expand on that line of questioning in regards to IPTAAS, noting the submissions from CTO and ICPA, noting the limitations with the IPTAAS scheme. Could you both expand on those, and then maybe also how we could work through to fix those issues or offer some solutions, perhaps?

The CHAIR: We might start with the Community Transport Organisation.

TARA RUSSELL: Thank you for the question. Community transport as an industry currently is not an eligible service provider under IPTAAS. Community transport is a very diversified industry. There are some wholly volunteer-run organisations dotted around—they're your traditional, very volunteer entrenched in the community. They're quite limited in what they can do. They're not necessarily the industry of providers that I'm talking about today. There is a vast network, as I indicated in my earlier statement, of providers that exist across New South Wales that are currently cut out of the IPTAAS program because the guidelines state that any organisation that receives any other government funding cannot be eligible under IPTAAS.

There are a couple of reasons why I think that is the case and that is why the guidelines say it is, and I think initially the concern would have been around double dipping, which is something we see when there are funded services. Often that requirement sits at the individual level and not at the organisational level. But what we experience as an industry is that a lot of our clients come to our services to ask advice around IPTAAS, and our staff will help them with the forms and sometimes help them submit the forms and help them understand the service and how to access the service. But then they have to tell that person they need to get transport elsewhere in order to be eligible for the subsidy.

We have examples in our industry where people who are assessed through Commonwealth funding to need transport, need support with their transport, go away and use their own private car to drive their IPTAAS-eligible journey, which is potentially not safe and/or not comfortable for that person. We already have some crossovers in this. Our industry is very familiar with the scheme because we do support the scheme within our communities and we support our current clients to access the scheme when they need that, but we just aren't able to deliver the transport under the scheme, which I think is something that we really should think about doing, because it would really help with—certainly all of IPTAAS is distance but we deliver a lot of transport with a health outcome anyway.

We are a skilled and heavily regulated industry regulated by the Aged Care Quality Standards and also regulated by the Point to Point Transport Commission within New South Wales under Transport for NSW. We are a resource with infrastructure that can support people with wheelchair-accessible vehicles or with mobility issues or with cognition issues. We already do all of this work as a part of other funded work. We have technology systems that support our clients being allocated to a certain funding source so we can manage concerns around double dipping.

Because the eligibility for IPTAAS sits with the patient, it doesn't extend the state budget at all to include community transport in the scheme, because all it is doing is providing another choice for patients to travel. It expands availability of options within the community. A lot of our providers across the state are registered under the school assisted mobility transport scheme. While a lot of our work is with elderly people, it would be a mistake to think that community transport can only drive elderly people. We are quite diversified. We're growing; we're modernising. We are innovating to try to respond to community-specific issues. I think that IPTAAS and the entry into the IPTAAS scheme would only serve to help patients who need to travel.

Ms LIZA BUTLER: My question is to Ms Mitchell. In the barriers for children accessing allied health, is it only transport, or do you see other things that need to improve? If so, what are they?

TANYA MITCHELL: No, it's not just transport. Ideally, it would be great if we had some of these services in our community. Bourke is the hub for many outlying remote villages and rural properties. There are lots of other communities—I'm just using this as an example. It's not just the transport; access to those allied health services is virtually non-existent in our community. At the moment, we are looking at fly-in fly-out allied health services and how we might be able to fund that through NDIS plans for our children to be able to have those early intervention services. There is currently an organisation that flies from Adelaide to Bourke. They fly in and see the children. They have OT, speech and psychs. We're looking to try to tap into that for those screenings. With the funding for Royal Far West finishing up, those screenings won't take place in our community anymore for those three-year-olds. So we're looking at ways to try to continue that. There should be universal screenings for three-year-olds. Four- and five-year-olds is too late. If we can get onto those children when they're three, we

can address some of those issues for those children before they start school, instead of them being identified at seven, eight, nine or older.

Ms LIZA BUTLER: Too late.

TANYA MITCHELL: Yes. It's actually access. I understand how hard it is to get those services into these isolated communities. Of course, telehealth is great. Royal Far West have been able to provide some of that, and there are some other providers that our families are able to utilise. But navigating those whole pathways and getting those diagnoses or getting those referrals in the first place are some of the hardest things that we need to overcome.

Ms LIZA BUTLER: To use NDIS funds, the child has to be over six and diagnosed, so it doesn't help those nought to six-year-olds?

TANYA MITCHELL: Yes. I'd have to speak to someone who is more involved with it than I am, but there is a way that you can get younger children onto a NDIS plan. But there is a process for that, and it does involve those screenings and referrals by specialist clinicians.

The CHAIR: Ms Mitchell, I'd like to follow up, if I could, on a couple of aspects of that. The first is we've heard from the Royal Far West about an increasing demand for assessment services in relation to development. Is that something that members of your association are aware of and would confirm? Is that something you're seeing? That's my first question. My second question is in relation to access to primary care services. That relates to the Committee's witnessing what we think is a significant decline in GP services in rural and remote communities. First question: Are you seeing an increase in demand for assessment and treatment in relation to children and development? Secondly, can you make a comment from your association's point of view about access to primary healthcare services?

TANYA MITCHELL: Yes, we are seeing an increase in the need. There was a government announcement around Brighter Beginnings that we thought was going to replace what it was that Royal Far West was already delivering to rural and remote services through philanthropy. We have since found out that it's up to what is available in the community. If you only have a child and family health nurse, then those screenings all of a sudden become perhaps a height and weight check for a four-year-old the year before they start school. It is not that universal screening by specialists that can then provide those referrals. Whilst we welcome any of those early intervention pathways, that is great, we're certainly seeing—as I said earlier, 80 to 90 per cent of those screenings that Royal Far West came and did with our children, over seven years, was the number of referrals. Say, for instance, 30 children were screened; there was in the vicinity of 75 referrals over, as I said, speech, OT, psych, hearing, dental et cetera. Certainly seeing an increase, possibly because we actually have had access to those screenings.

The CHAIR: So a greater awareness?

TANYA MITCHELL: That's right. If the children aren't being screened or they aren't being picked up until later on, then we don't have those same figures. But while those children were being screened, we were seeing certainly the demand and the need for those children to access services. The second question—yes, we absolutely support Royal Far West in what they are now proposing to do. Whilst they can't come out to all of our communities, they are proposing assessment hubs in, say, the likes of Dubbo or Wagga and some of those bigger regional areas, which is fantastic. It means that there will be at least something ongoing for those children. But then we run into, again, the transport and those children from, like, Wanaaring or Enngonia out towards Broken Hill getting to those services.

The CHAIR: The second part of my question is about access to primary care more generally among your members.

TANYA MITCHELL: Yes, sure.

The CHAIR: And, I suppose, a declining number of GPs and general practices.

TANYA MITCHELL: I can tell you at the moment I'm not feeling terribly well, but I can't get into my GP for two and a half weeks. Also, I'm looking at an example—the likes of Balranald will be without a GP. For the first time in a hundred years, they will be without a GP. The medical officer at the hospital servicing what is a major highway—there seems to be some bureaucracy within the health department where they have silent staff and no-one's telling anyone what's going on or what the plan is.

But of all of the six other health services in Far West health district in New South Wales—so Broken Hill, Wilcannia, Menindee, Ivanhoe, Wentworth, White Cliffs and Balranald—we'll be the only one without face-to-face access to a doctor because the Royal Flying Doctor Service do not service Balranald but they do service the

other areas. Of course, this will have negative impacts on young children's access to primary health and referrals to allied health. Often the allied health in that area is serviced over the border in Victoria because they're so close to the border. But, due to cuts on that side, the medical officer, I think it is, will only attend Balranald, which is a 230-kilometre round trip, if up-front payment is made. There's no medical officer at the hospital and no GP in town. That's a real concern for people in that area.

BRITT ANDERSON: I'd like to comment on what Tanya had touched on with the early intervention. There are also issues going through once the child has started school. How it is affecting areas such as the Far West in particular is that school psychologists are unable to diagnose. Therefore, a lot of the kids in the small communities aren't able to be diagnosed with things such as dyslexia, speech issues and learning difficulties, and that is affecting how they can then attend school. The school psychologist, because they are unable to diagnose, is then making the efforts longer for parents to be able to get their child diagnosed and then a pathway for their education to continue. This also affects their mental health and how they contribute to their communities where their self-esteem is so low because they aren't receiving the help. I just wanted to make that comment that, although the screening is exceptionally important, once the child does start school, there are issues there with being assessed and pathways put in place.

The CHAIR: I have one more area I'd like to explore back with the Paramedics Association. Mr Wilson, I think you used the term "active de-skilling" of paramedics. I may be wrong about this, but I think you referred to the removal of equipment and facilities. Are you able to clarify that for us a little bit further?

GARY WILSON: We've been talking about ECPs and ICPs. ECPs are a valuable resource to help keep people out of hospitals and reduce loads on hospitals and reduce waiting times and those sorts of things. ICPs are an incredibly valuable resource in that they allow the early advanced treatment of patients prior to them arriving at hospital, which can have massive improvements on not only patient outcomes but also reducing in-hospital costs and length of duration of stay and those sorts of things. What's currently happening is that ICPs that transfer from, say, metropolitan Sydney to regional areas are being forced to give up their ICP ranking and NSW Ambulance has actively driven around the station and removed ICP equipment from stations where those officers are.

The CHAIR: Do you know the reason why? Is it that the station is not supposed to have an intensive care paramedic? What is the thinking there?

GARY WILSON: I would hesitate to try and guess Ambulance's thinking on most things. But I would imagine that there are no funded ICP positions at those stations—so there is a funding issue—and also that there is a view that it's difficult to maintain skills at smaller rural communities. That's where my comments previously about looking at innovative models for training and providing additional educators that can go around—it's certainly possible for registered medical professionals to maintain skills in remote communities. Doctors do it all the time. Nurse practitioners do it all the time. I don't see why paramedics would be any different. It just requires funding and effort. We have an ICP who, a week ago, could practice their full range of skills and who now can't do any ICP skills because they've been told they're not allowed to and their equipment has been removed from the station. It's not even that the equipment wasn't there to start with; it was removed deliberately.

The CHAIR: To tease that out a little bit more, presumably if there was equipment there already, there must have been some practice at some point before that paramedic arrived.

GARY WILSON: What's historically happened is, when ICPs have moved around the state, they've been allowed to continue to be ICPs wherever they went, whether or not there was funding. In my area, we've had ICP equipment for at least the 19 years that I've been there. This is a new action. That's why I'm saying this is an active de-skilling and removal of equipment, and it's taking the ICP out of a small community where the closest funded ICP is an hour's standard drive away.

The CHAIR: Is the ICP seconded to the community, are they transferred to that community or do they select to go to the community?

GARY WILSON: In this instance, the ICP chose to go to that community. They'd worked very hard for quite a number of years in metropolitan areas, and it was time for a change. We were very excited to have an ICP back in our community to provide those advanced skills which we were lacking. It's very disappointing to have someone who has the knowledge and the skills and the experience—years of experience—now being told, "No, don't do that." We service a large area of the highway. We have farming communities where we have horses, bikes, quad bikes and industry. We have potential for very serious injuries with long response and transport times, but we don't have an intensive-care paramedic anymore.

Mr CLAYTON BARR: At the risk of asking you to repeat yourself, surely there is a magnificent opportunity for other paramedics to work on the truck with an ICP and be exposed to some of their skills and talent. Surely that's a good thing?

GARY WILSON: Mr Barr, I like your thinking. The fact that it starts with "surely" probably indicates how obvious a solution it is as far as we're concerned. The paramedics on station—a couple of us have 20 years of experience, and we were still excited to have an ICP coming to the station as a clinical mentor because it's a changing field. We have dramatically increased our scope and we're doing far more invasive procedures now than we've ever done before. To have an ICP at your station so they can guide you and help with your training in an ongoing way—the Government has spent a lot of money putting high-tech training manikins in every station. If they're not going to let us do the training and if they're not going to let us have the skills, then why spend the money?

The CHAIR: Not to mention the difficulty of attracting people to a community if they're not allowed to practice at the top of their scope of practice. Ms Mitchell, you had your hand up?

TANYA MITCHELL: I just wanted to add that I know we've had some cases in our area where an ambulance has been called to a remote property, and the difficulty in one finding and accessing that property or having a vehicle that they then say is not suitable to be on a dirt road, which the majority of our roads out here are. I just wanted to mention those couple of things. Out here, because it does take so long for medical help to actually get to people, those first responders need to be highly trained because what they come across, as previously mentioned, can be all manner of things because of farming equipment or road accidents or families—babies being born in these very remote areas.

When I say regional and remote and very remote, I'm talking hours from anywhere or from the nearest medical help. I'm not talking about somewhere along the coast or Dubbo, Griffith and Wagga and those sorts of places. I'm talking about where even neighbours can be 40 or 50 kilometres apart and where you have no mobile service. So those paramedics that we're relying on—I can't say enough about them for what they do—are faced with some of the most difficult situations with limited resources.

Ms TRISH DOYLE: I was wondering, for our APA team here today, whether you'd be able to verify some alarming stories that I have heard of students on placement with various stations in regional, rural or remote areas. Because of staff shortages and some of what you talk about here—the pressure on the very limited specialists available in these areas—the students, depending on their level of skill and the stage that they're at, are often having to step into precarious situations. I heard a story, for example, of a student being dropped off at a very small private hospital because there were no nurses or doctors. Are you able to verify if these sorts of stories are common or rare?

GARY WILSON: One of the struggles that we have at the moment is, because we've historically been so understaffed—and we've been very pleased to have the massive increase in staffing, and we thank the Government and political parties for that. One of the problems we have is that we have so many trainees coming through the system now that we struggle to find qualified officers to place them with. Where, historically, you would normally be a qualified officer before you'd even work with an intensive care paramedic, just the other day I saw a probationer, a first-year paramedic, working with an ICP in a major centre. It's certainly not surprising to hear those horror stories. We are placing trainees in areas with very limited support and backup long distances away. Mentally, that can be shattering because they still feel the burden that the responsibility is theirs to save that life, even with the limited training that they have.

When you're talking about many regional areas where you have a crew of two, where one is qualified and one is probationer training and you have multiple patients, these people are being left in charge of patients with limited supervision because the qualified officer will be dealing with the sickest people. If we look at the BHI data, it seems to be suggesting that we're responding to sicker people more often and it's taking us longer to get there. So by the time we get there, those students are having to deal with people who are now critical, under limited supervision.

The CHAIR: We will bring things to a close there. I would like to thank all of the witnesses for appearing before the Committee today. We very much appreciate your time. We may send you some further questions in writing, and 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?

TARA RUSSELL: Absolutely.

GARY WILSON: Yes.

The CHAIR: Once again, I thank you.

(The witnesses withdrew.)

(Luncheon adjournment)

Ms ELYSE CAIN, Policy Lead, NSW Council of Social Service, affirmed and examined

Mr BEN McALPINE, Director, Policy and Advocacy, NSW Council of Social Service, affirmed and examined

Professor MYFANWY MAPLE, Director, Manna Institute, before the Committee via videoconference, affirmed and examined

Dr JILLANN FARMER, Chief Executive Officer, A Better Culture, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome our witnesses today from A Better Culture, the NSW Council of Social Service and the Manna Institute. Could all witnesses be aware that there may be photos taken throughout the hearing. If you have any concerns, please let us know. Can you each 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?

BEN McALPINE: Yes, Chair.

ELYSE CAIN: Yes.

The CHAIR: And those online?

JILLANN FARMER: Yes.

MYFANWY MAPLE: Yes.

The CHAIR: There's usually an opportunity for each organisation to provide a two-minute opening statement, and I will get you to do that. I'll start with the NSW Council of Social Service.

BEN McALPINE: Thank you, Chair. Good afternoon. I'll start by acknowledging the traditional custodians of the land on which we meet today, the Gadigal people, and pay my respect to their Elders past and present. The NSW Council of Social Service (NCOSS) stands in solidarity with First Nations people and communities in their fight for justice and self-determination. NCOSS thanks the Committee for the opportunity to provide evidence today. As the peak body for non-government organisations in the health and community services sector, we work alongside our 400 members to progress social justice and shape positive change towards a New South Wales free from poverty and inequality.

I commend the Committee for its interest in the progress on recommendations since 2020. Our submission to that previous inquiry referred to our 2020 patient experience and economic disadvantage research, which found that, unsurprisingly, it is people living in regional and remote areas of New South Wales who face greater challenges in accessing timely and affordable health services, particularly for GP, dental and medical specialist care. We are currently in the process of updating that research with the latest census and patient experience data, and we will release it in the latter half of this year. However, as we all know, people in regional, remote and rural New South Wales—particularly those experiencing poverty and disadvantage—continue to face significant barriers accessing health care.

Preliminary findings from our latest cost-of-living research on those in low-income households and living below the poverty line shows the worsening impact on health and wellbeing. Almost half of people surveyed in regional New South Wales are having to go without prescribed medication or health care due to rising living costs, and that rate has doubled since 2020. The Government must prioritise solutions to address these barriers for the most vulnerable, including improved transport affordability and virtual care options.

Finally, one of the biggest challenges the Government faces in improving outcomes for the most disadvantaged is that these are often the people who have fallen through the gaps in the system, are not captured by the data and are systematically excluded from service planning at local and statewide levels. Services within our sector know who these people are, understand their specific and complex needs and hold trusted relationships with them. The Government must recognise that to improve outcomes for the most vulnerable, agencies must work closely with our sector—the place-based social and community-based services that are deeply connected with and embedded within the communities we support. Joining me today is Ms Elyse Cain, one of NCOSS's policy leads, who assisted with the submission. Thank you again for the opportunity. I look forward to answering any questions.

The CHAIR: I might now go to Professor Maple from the Manna Institute. Professor Maple, would you like to make a brief opening statement?

MYFANWY MAPLE: Thank you, Chair. I'm coming to you from Gumbaynggirr lands. The University of New England is the lead institute for the Manna Institute, which is on the unceded lands of the Anēwan people.

The Manna Institute is a collaboration between the seven Regional Universities Network partners across eastern Australia. In New South Wales that is the University of New England, Charles Sturt University, Southern Cross University, the Australian National University and we have partners in Lifeline Direct, based in the Hunter, and Everymind, also based in the Hunter. This collaboration came together to really look at the evidence specifically around the experience of people with mental ill health across Australia and to really understand what evidence there is and the way in which place-based solutions can address issues in the community. We welcome the opportunity to join you today.

From our point of view, our goals are really to work with rural communities around what issues they see and address those at the local level in a co-design framework; to reduce morbidity and mortality associated with mental health challenges, mental illness and suicide; and to really look at the ways in which workforce development over the whole trajectory can be developed from obviously being university-based from the very beginning, right through to people working at the top of scope of practice. Our submission really focused on the need for outcome measures driven through implementation from the beginning of design right through to evaluation, so that we know that the right services are appropriate for the right people at the right time, and so that they are easy to access.

Our prior research that has been undertaken for the National Mental Health Commission across Australia demonstrated that distress elevates by the time people are starting to access services. We need to be looking at people earlier so that the trauma that goes along with increased distress is commencing at the time of engagement with services. The escalation of acuity is quite rapid. That obviously means that there's a bigger impact on an individual's mental and physical health once they start accessing services. So in what ways can we start at the very community level right through to crisis care and clinical care that is required, and improving the evidence base there. We really welcome the opportunity for any questions. Again, I thank the Committee for the invitation to present.

The CHAIR: Dr Farmer, would you like to make a brief opening statement?

JILLANN FARMER: Thank you very much. In October 2022 the Commonwealth Department of Health reached an agreement with the Royal Australasian College of Medical Administrators to repurpose some unspent funds from RACMA's Specialist Training Program. The repurposing was to address the year-on-year findings of bullying, harassment, racism and discrimination that were reported through the Medical Board of Australia's Medical Training Survey. The original badging of the project was "the culture of medicine". For many years the MBA had collected data about work and career plans to support workforce planning, and in 2019, for the first time, a comprehensive medical training service was offered that included questions about workplace culture. That first survey demonstrated high levels of bullying, harassment and discrimination, with 22 per cent of trainees reporting that they had experienced these behaviours directed at them during the previous 12 months.

Unfortunately, in the 2023 survey, published in December last year, that number is still at 22 per cent, with racism included as a separate item in the 2022 and 2023 surveys. Across an entire generation of doctors in training, and despite significant efforts at addressing the issue, the results remain stubborn. The 2023 data is different in breakdown from 2019, with improvement in the reported proportion of cases that involve other healthcare staff, but there is an increase across that period, unfortunately, of people experiencing behaviours at the hands of patients, family members or carers. Senior doctors, peers, and nursing and allied health staff are, to varying degrees, also identified as sources of adverse behaviour. That persistent rate of 22 per cent for all of these behaviours can be benchmarked against, for example, the Australian Public Service data that reports a base rate of 9.7 per cent.

In New South Wales, notably, NSW Health has had a rate, in the most recent published data that I could find, of 16 per cent, compared to 12 per cent for the education department, 10 per cent for the Department of Enterprise, Investment and Trade, and 9 per cent for the Department of Premier and Cabinet. The data of bullying and harassment within NSW Health across the board, as published and publicly available, appears to be significantly worse than across the board for health. In other words, health services are outliers with higher rates. I provide in my written submission to the Committee a breakdown of how a sampling of rural and regional services compared. While doctors are a large cohort, their numbers are swamped by nursing, allied health and operational staff. We therefore contend that this is a cultural problem across health that needs multidisciplinary engagement and significant investment to address. Thank you for the opportunity to appear.

The CHAIR: Thanks, Dr Farmer. Just so that everyone's clear, Dr Farmer's work is around culture within the health sector. The other submissions are going to be dealing with issues primarily around mental health services, although also access to care and a number of aspects to it. I will ask my first question to Dr Farmer, for her to expand on her work, and then the rest of the Committee will come to the other witnesses. Dr Farmer, I'd like you to extend your presentation and describe to the Committee the work that you have been doing in relation

to beginning to address these issues of culture within health, and also any observations about interaction with NSW Health in that work.

JILLANN FARMER: Thank you very much. The project, as I mentioned in my preliminary comments, started at the beginning of 2023. We established a suite of a dozen reference groups, which were designed intentionally to cover all aspects of intersectional disadvantage. We intentionally established the reference groups to present different voices to those that are traditionally at the table in medical consultation. We established an advisory board, which has medical representation on it but also has nursing, allied health and community leadership from a number of eminent Australians.

We're now moving into our final six months. We've established five working groups that are going to be dealing with what our reference groups and other institutional stakeholders have told us are some of the drivers. Working group number one is going to be looking at cultural safety, in particular the uptake of culture safety training amongst senior medical staff, where we have been led to believe that, in some jurisdictions, cultural safety training is either given lip service or not necessarily taken up by people who lead services. We also are not clear at all that cultural safety training is focused on the experiences of Indigenous workers. It has very appropriately been focused on the experiences of Indigenous patients, but Indigenous colleagues are sometimes left standing at the by-side.

Leadership diversity—it's a well-documented fact across the world, and also in Australia, that although 75 per cent of the healthcare workforce are women, they are under-represented in leadership. If you extend that to culturally and linguistically diverse populations, the inversion of leadership versus workforce is even higher. We have a working group that's going to look at workplace behaviours, both colleague-on-colleague and leadership behaviours, through a workplace health and safety lens; a working group that's going to be looking at individual remediation and safe reporting pathways for junior medical staff; and a working group that's going to be looking at curriculum for career-long learning and development across all of these aspects.

In terms of interaction specifically with NSW Health, it has been a difficult journey across the board. The jurisdictions by and large have not been particularly willing to engage with us through the main focal area that we've been presented to them, being the Health Workforce Taskforce. We are about to write to all of the directors-general again, the director-general of NSW Health as one of those, to seek better engagement. It seems to us that the workforce taskforce is not the appropriate forum because of the nature of the issues that that group is considering. We are hopeful that by making direct approaches to directors-general, the level of engagement from all jurisdictions, including New South Wales, will improve.

The CHAIR: Thanks, I will leave it there. We may come back to you. I appreciate that presentation; it's very valuable. I will now pass to the Deputy Chair, Ms Janelle Saffin.

Ms JANELLE SAFFIN: We're going now to mental health.

The CHAIR: That's what I'd anticipated.

Ms JANELLE SAFFIN: The report is quite informative. My question to do with the mental health is a general one and it's to both NSW Council of Social Service and also Manna Institute. Have you seen changes in terms of the response to the recommendations in the Legislative Council inquiry in relation to mental health services? Have you seen any outcomes from that? Have you seen them implemented? If you could comment on that, please.

BEN McALPINE: Thank you for the question. Probably the best data that I can point towards is the research that we did called Aftershock through the pandemic. What that really showed was a significant increase, still, in the number of people across the State that were presenting for mental health issues. Then I would also make reference to our virtual care research, which showed very clearly—particularly through the pandemic and as we came out of its worst situations—really positive experiences when it came to the use of virtual care. Mental health supports was one of those areas that was regularly referenced by participants in that piece of research, but what it still showed was immense issues with the digital health divide and also major gaps still in the system around access to supports. Those are probably the best two references I could make to the work that we have. Maybe the Manna Institute has some other things to add.

The CHAIR: Thank you. Professor Maple, would you like to comment on changes that you've seen in regard to mental health?

MYFANWY MAPLE: We would probably echo NCOSS's findings in that obviously there's increasing demand for services, and what mental health looks like has changed. The increasing early distress around the changing environment, the social and economic pressures and the situational crises are still not well addressed because mental health is seen primarily through a medical model, which doesn't address that broader distress that

people are feeling over a longer period of time. From the work that we do, what we see is that access to services is still incredibly difficult. The digital issue remains an important one to consider because it's not going to be the panacea for everybody.

The push from the Federal Government through strengthening Medicare is definitely welcomed and having GPs as a central point of care is very good, but across regional New South Wales, access to GPs is near impossible. By the time people are seeing a GP—if they can—their level of distress has increased and then they're more likely to enter into a mental illness diagnosis. The problem that we see across our research, time and time again, is that people are led to believe that, at that point of diagnosis, things will get better. In fact, in our research what we see and continue to see is that that's when things get worse because a diagnosis does not mean that the right treatment will be found at the right time. Often the situation around people doesn't change and so the fragmentation of services, the fragmentation in the way that services are funded and, really troublingly, the short-term funding cycles for many of the community supports for people mean that initiatives appear and then disappear. People may find something that works for them and then it will be gone again, or they're poorly evaluated and not funded again or that funding stream just disappears. So we're not seeing very much change in the way that people report their journey through systems.

Mr CLAYTON BARR: If I can stay on mental health as well, a lot of workplaces offer mental health access in a variety of forms. Is any of the work that you are doing showing that people are using that or specifically not using that? As a supplement to that, if people are seeking to use that, particularly in regional, rural and remote areas, do they genuinely have access to that or does it fundamentally come down to a telehealth sort of model? I guess I would direct that at Manna and/or NCOSS.

MYFANWY MAPLE: Certainly we have seen a massive increase in the number of workplaces that are offering mental health support, and that goes in two ways. Obviously, the EAP systems have been ramped up, which are more often than not telephone support for employees. But the other stream of that is around increasing the mental health literacy of employees through, for example, offering mental health first aid, which has a strong evidence base, and offering some of the LivingWorks suite of programs around suicide awareness and intervention skills.

There's no compulsion for anyone to take those, though. There can be high uptake if the workplace is already under enormous stress, so people see a reason for wanting to undertake that sort of training, or, alternatively, because it's somebody that is actually interested or has their own personal experience. They might want to further their own skills. The point that I made earlier, though, still holds in that awareness is one thing, but then being able to actually support somebody into a service remains really problematic. That can put further strain on the person who is trying to be the community helper or the zero responder—the person that's there at the time.

BEN McALPINE: Putting aside the absolutely accurate comments just made, I would add that we need to remind ourselves that those people who are the most vulnerable—facing the most exclusion and disadvantage—either won't have access to these because their workplace doesn't offer them or may not be able to access them due to the quality of the support. Or, as we mentioned before, they don't have the access to the digital support that they require to really take advantage of the benefits there, be it that they don't have access to the technology, that they can't afford the technology or that they don't have the capabilities. I absolutely support what was shared in terms of the increase to access, literacy and utilisation, but we need to remind ourselves that there will be large portions of the community—those facing the greatest levels of disadvantage—that could never take advantage of that.

The CHAIR: Dr Farmer, is this issue of providing support within the health system through services available to employees something you've come across? It's a bit like putting the ambulance at the bottom of the cliff: you provide supports when you really should be trying to tackle issues around workplace culture. Any reflections from you, Dr Farmer?

JILLANN FARMER: I'm happy to comment on this because, of course, there's a nexus between exposure to bullying, harassment, racism and discrimination, and the mental health and fitness of healthcare workers. There was an excellent study performed in 2022 by the Commonwealth Fund that was published looking particularly at primary care physicians, showing a significant dissonance between levels of distress and need for services and their willingness to access it. Australia was included in that study, and it showed that only about one-quarter of the primary care doctors who needed support were actually getting it. That's a real issue for rural and remote doctors. Access to health care for themselves and their families is something that really does need to get much better consideration.

There's also—and I think this is not unique to doctors—a level of distrust of accessing employer-sponsored employee assistance programs, despite the best assurances of confidentiality. People are always concerned that

that confidentiality is not absolute. And then, the mandatory reporting provisions in the regulation relating to the Medical Board of Australia have created a degree of hesitancy in doctors to seek mental health support, lest their condition trigger a mandatory notification and the regulatory actions that flow from it. The entire landscape of seeking and obtaining health care for healthcare practitioners across the board is very complex.

Ms LIZA BUTLER: I would like to ask about drug and alcohol services. Since the initial report and the recommendations were rolled out, have you seen any improvements in the delivery of drug and alcohol services in rural, regional and remote New South Wales?

ELYSE CAIN: Around the implementations of those specific recommendations related to alcohol and other drug (AOD) services, we would need to defer to our colleagues at the Network of Alcohol and other Drugs Agencies. However, what we heard on the ground from our members when we held forums in Taree late last year and also in Dubbo is that certainly gaps in AOD services, particularly for young people, are still a huge issue in regional and remote areas—not enough detox beds, not enough services specifically tailored for youth as well. That's just some of the anecdotal evidence that we've been hearing. Certainly the issue continues to grow and is exacerbated in regional areas for a whole range of reasons, including a lack of availability of services and being unable to easily access those services where they are available.

The CHAIR: Thank you. Professor Maple, would you like to make a comment on that area?

MYFANWY MAPLE: I wouldn't be able to make any specific comment other than anecdotal sorts of experiences, as outlined by NCOSS. I wouldn't like to say anything more specific than that. I don't have the evidence at hand.

Ms TRISH DOYLE: Hello, everyone. Thank you all for your work in a very tough space and for very vulnerable people. It's appreciated. Thank you for speaking with our Committee today. I want to go to the submission from the Manna Institute, which notes that NSW Health planning documents, such as the health workforce plan, lack quantifiable targets for measuring progress. How would you like to see developing the regional health workforce measured? What are your suggestions?

MYFANWY MAPLE: Thank you so much for the question. Obviously, coming from a research institute, we want to be able to see that things are measured, that money is spent appropriately and that we can see the outcomes that we're trying to achieve. How we would look at that, generally, is to look at a program logic model where we're looking at what's the beginning point and what are the outcomes that we're trying to effect change in. Workforce is a really difficult one, though, because it's obviously complex. There are a lot of players and different funding streams that go into both the initial pre-service training, right through the life span of that particular individual, and with the push to work at the top of scope of practice.

When we have really complex issues like student poverty also pressuring pre-service, right through to some of the issues outlined by Dr Farmer, there are a number of ways in which properly evaluating is really difficult. What we do know is that if there is a medical team and allied health team in a community that is stable, that's when the best access happens and the most reduction in distress occurs across a community. How we measure stability of teams is really important, and the single-employer model will help to alleviate that over time. The biggest problem with any of these initiatives, though, is that the length of time between an idea and a policy being funded to when we actually see the change is often through at least one or more cycles of government.

That goes to my earlier point about the funding cycles being too short to be able to properly evaluate any of these things that might actually see to fruition the sorts of ideas that were at the beginning. I think, from the point of view of a research institute, what we would always like to see is that at the very beginning the measurable outcomes, what we hope to see in terms of targets, stay there regardless of change in government, change in funding cycles and the change in the way in which the state and federal funding—which is obviously complex, particularly in primary health care—the way in which that nexus is dealt with is also looked at across the implementation cycle and evaluation.

Ms TRISH DOYLE: I wonder whether Dr Farmer or NCOSS wanted to provide an answer to that question also.

BEN McALPINE: I absolutely want to echo what Professor Maple just spoke about then, and also make sure that we're really clear on the importance of, yes, we need to invest in the workforce within, say, NSW Health, but those same arguments go then to investing in the workforce in the community and health services sector. The types of things that we were just talking about—what would lead to better outcomes, longer-term funding contracts, greater flexibility in terms of how those funding contracts can be utilised, greater investment in NGOs so that they can invest in their workforce, and highlighting the real importance of that strong sense of trust and partnership between government agencies and the sector organisations when it comes to commissioning service planning, evaluation and the like.

JILLANN FARMER: During the preparation for today's hearing, I put a call out to our reference group members and specifically asked for any members who were currently working in NSW Health or had very recent experience working in the rural and remote or regional setting. One of the themes of the feedback that came back to me was the issue of professional isolation and the challenges that people face if they do, as a specialist, decide to set up in a regional area. Two things happen. One of them is professional isolation and a concern that their practice could, over time, either actually deviate from good practice or be seen to do so because of their isolation.

The second thing that happens to practitioners who take up work in rural and regional centres is that, bizarrely, they suffer reputational damage because of a concept that's starting to be talked about in medicine at the moment called geographic narcissism. There's a default assumption that if you work at a big centre with a fancy-schmancy building, you must be a better doctor than the person who is slogging it out looking after rural and remote communities. I've actually had a doctor almost weep with relief when I rang and asked them to be involved in a project because he said that, in the five years he'd been working regionally, this was the first time someone had treated him as though his opinion mattered. So I think very specific efforts to make sure that practitioners who work in rural and regional Australia do not feel isolated, are indeed treated as the heroes of healthcare systems that they are, and are not vilified, denigrated and talked down to would be incredibly valuable in recruitment and retention.

The CHAIR: Can I follow up with you, Mr McAlpine? You referred to the need for collaboration between Health and the community sector, and in your submission you talked about the need for planning across a range of sectors, including the Department of Regional NSW. There is an organisation that has been tasked with health needs assessments in our health system, and that's the Primary Health Networks (PHNs). Some of them have done health needs assessments. I know in my area they have. I'm just not sure how much of their work in health needs assessments gets communicated with local health districts, or any other parts of the system. Can you offer any insight into that from your perspective?

BEN McALPINE: Probably only one point. From my understanding, the PHN health needs assessments absolutely involve the community service sector, members of the population and also LHDs. But, like you, I don't have a clear view of how those needs assessments then get utilised by the LHDs to inform their work as well.

Mrs LESLIE WILLIAMS: My question relates to recommendation 44 of the report, that the New South Wales Government adopt a health in all policies framework to ensure that community physical and mental health is central to government decision-making. I am happy to take comments from anyone, but have you seen any evidence that mental health wellbeing is being considered in government decision-making?

MYFANWY MAPLE: It's a bit hard online to know whether to speak or not.

The CHAIR: I can tell that Mr McAlpine is reflecting on that carefully.

BEN McALPINE: I am absolutely reflecting. Please let Professor Maple go first.

The CHAIR: Professor Maple, would you like to speak?

MYFANWY MAPLE: I was just going to make a broad statement in that we do have quite close contacts with the division of regional health and Aboriginal health within NSW Health. Certainly the discussions that we have with them in our regular meetings are focused on the social determinants of health and looking at a much broader concept of health than the medical model. So I feel quite heartened by that. That doesn't go fully to answer your question, though, in that is there evidence to suggest that that's been taken into account. I think it goes to the earlier NCOSS point around the connection between social services and health, and taking a whole-of-government approach. I would add to that, also, education for young people because we know that earlier detection of distress through the life span makes a big difference. If we prioritise health, as whole of government, we might start to see more of the broader social and economic determinants as being more important in health. But, certainly, as I said, I feel heartened by those conversations that we have in our regular meetings with NSW Health.

Mrs LESLIE WILLIAMS: Did you have anything to add, Mr McAlpine?

BEN McALPINE: No. Although, if you are interested, I would suggest that the Mental Health Coordinating Council—the peak body for mental health organisations—would be a useful place to start, as well.

The CHAIR: I might finish off with a question specifically to NCOSS. You made the comment about the workforce recruitment and retention strategy and the need for that to be implemented; we're not clear that there is a strategy around that. In your instance, I suspect it probably reflects concerns around mental health services, but it may be more broad than that. Would you like to expand on that?

BEN McALPINE: There would definitely be comments made across the community services and health sector, but certainly that would include mental health organisations. What we regularly hear from our members

and from their workforce is that they are struggling to maintain a sustainable, thriving organisation. So what might that look like? Retention is a real issue. We heard that last week in Dubbo. There are immense challenges for those local—particularly smaller—organisations to try to retain their workforce. It's important to articulate why that is a worthwhile goal. One of the simplest things that we heard in that workshop last week was how long it takes to build trust in a local community. If you have a workforce that is constantly churning, it not only makes it much harder for the organisation to meet its KPIs, which is important in terms of contract management but, more importantly, it makes it incredibly difficult to maintain good outcomes with the community, be it mental health, drug and alcohol, domestic and family violence, whatever it might be.

When we're talking about a workforce strategy and the outcomes, all of that needs to make sure we come back to supporting those people who are most systematically excluded, disadvantaged and vulnerable. While admittedly there are pockets of good practice and we hear good stories, it is not done consistently. We regularly hear from our members of the immense challenge that they're having in not just maintaining their workforce but maintaining a workforce that has the professional supervision, the learning and development supports that they require. It is an immense challenge in our sector and something that we know needs to be worked on in partnership with the Government.

The CHAIR: Can I just clarify? It sounds as though you're saying that's particularly a concern in remote, rural and regional communities. We know how difficult it is to recruit workforce. I think you're making a point around the need to sustain that workforce in a positive way.

BEN McALPINE: Yes, absolutely it is something that we hear from our regional, rural and remote members. I don't know if I could comment on whether or not it's worse, but the challenges are different. For example, we were hearing from someone in Dubbo last week. They were struggling to attract the workforce of a particular qualification, whereas that's not necessarily always the challenge in metro. But, also, the challenge that is a bit different in regional areas is that it is a very small pool of workforce, so the competition for that highly qualified, engaged workforce is different to what you'd see in metro. There's certainly some data that would suggest that the workforce challenges are more acute, but it's also important to understand that the way in which those challenges appear day to day is also quite different.

The CHAIR: I think we might bring the session to a close at this point. I thank the witnesses for appearing. We may also send you further questions in writing. Your replies will form part of the evidence and be made public. Would you be happy to provide a written reply to any further questions?

BEN McALPINE: Absolutely.

The CHAIR: Professor Maple and Dr Farmer?

JILLANN FARMER: Yes.

The CHAIR: Once again I thank you for your efforts in the submissions that you've made and for appearing today. We very much appreciate it.

(The witnesses withdrew.)

Mr ALEX GREEN, Chief Executive Officer, Arthritis NSW, affirmed and examined

Ms KIRSTY BLADES, Chief Executive Officer, Palliative Care New South Wales, affirmed and examined

Ms FELICITY BURNS, President, Palliative Care New South Wales, before the Committee via videoconference, sworn and examined

Ms LORRAINE PENN, Board Member, Older Women's Network New South Wales, before the Committee via videoconference, affirmed and examined

Mrs JILL McGOVERN, Older Women's Network New South Wales, before the Committee via teleconference, affirmed and examined

The CHAIR: I welcome our witnesses from Arthritis NSW, Palliative Care New South Wales and the Older Women's Network New South Wales. Please be aware that staff will be taking photos throughout the hearing. If you have any concerns, please let us know. Can each of you 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?

ALEX GREEN: Yes.

KIRSTY BLADES: I can, yes.

JILL McGOVERN: Yes.

LORRAINE PENN: Yes.

FELICITY BURNS: Yes.

The CHAIR: As part of the proceedings, there's an opportunity for each organisation to make a brief opening statement of no more than two minutes. Would you like to do that? I'll start with Mr Green for Arthritis NSW. Then we'll move to Palliative Care New South Wales and Older Women's Network.

ALEX GREEN: Thanks for the opportunity to present today. My name is Alex Green. I'm the CEO at Arthritis NSW. Arthritis is a term that includes over 100 conditions. There are over a million people in New South Wales with some form of arthritis. Arthritis includes a spectrum of conditions that vary in terms of symptoms, from people with sore knees through to those who are chronically bedridden, and people's experiences can change on a short-term basis from day to day. There is no silver bullet. Our work is to support self-management and minimise the impact of arthritis on the healthcare system and on our clients. As part of our work, we have feedback from thousands of people and the themes we consistently hear are around arthritis being an invisible condition, being dismissed as something that is inevitable, it's often misunderstood, and particularly that there's a shortage of access to healthcare professionals that understand the needs and the challenges and solutions for people with arthritis. I look forward to presenting some of those insights today.

KIRSTY BLADES: As a peak body, Palliative Care New South Wales is a leading voice and advocate for our members and the community, and today our president, Felicity Burns, and I can share that voice with you and the feedback we have received from those on the ground. Finding 13 stated that there is a lack of palliative care and palliative care services in rural, regional and remote New South Wales. Two years on, that statement remains the same but there has been some progress. Sentiment continues to be, though, that the progress is slower than needed and is not keeping pace with the need. As one member stated to me, "We just continue to try to catch a runaway bus." To meet current and future demand the rate of progress needs to be accelerated.

We also asked our members about current service gaps and can talk to that in more detail. Positively, just over half of those we spoke to indicate that there are fewer service gaps than two years ago. But on the flipside of that, 25 per cent say there has been no change in service gaps in the last two years. This talks to the variances that can be felt from one LHD to the other, and even one region to another region within an LHD, and highlights the importance of LHDs having a leadership team that supports a well-defined, strategic focus on palliative care and end-of-life care if progress is to be achieved.

A key concern for those in rural, regional and remote New South Wales is workforce shortages directly impacting timely access to palliative care. When we spoke to our members, 42 per cent said workforce shortages had gotten worse and 33 per cent indicated they were the same, with only 25 per cent noting an improvement. Finally, AIHW data newly released has confirmed that those in major cities are more likely to receive timely specialist palliative care than those in rural and remote areas. In some of these communities, only around 15 per cent of people with a life-limiting illness received timely palliative care. We appreciate being here and being part of the discussions today.

LORRAINE PENN: The Older Women's Network would like to thank the Committee for the opportunity to share information of how older women in rural, regional and remote New South Wales face significant challenges in accessing quality health care. The lack of accessible healthcare services disproportionately affects us in various roles, both as caregivers and as users of the service. We are yet to experience comparable health outcomes and access to health and hospital services to those who live in metropolitan areas. It is common for us to incur extra expenses to travel long distances to access medical services, and the costs frequently include accommodation charges. These cost impositions are difficult for those of us who rely on the pension.

The profound changes in rural hospitals and primary care across New South Wales over the past 20 years have severely impacted the quality, safety and timely delivery of health care to our communities. We would like to sound the alarm that technological advancements which facilitate telehealth may have improved outcomes for some but these benefits remain largely inaccessible to rural populations due to the reasons of accessibility to the technology, both in terms of cost and the poor quality of the internet. A computer and a camera are not a substitute to having a human provide diagnosis of care. It is crucial that those older adults—particularly women, who are often the backbone of rural communities—have access to the healthcare services they need to live healthy, fulfilling lives. We are ready to provide further examples of how the current situation does not serve us well.

The CHAIR: Thank you very much, Ms Penn. I will start the questioning. My question will be to Mr Green from Arthritis NSW. There has been discussion in the previous report about the need to engage with community organisations. I think in your report you've described engagement with primary health networks. I wonder if you could describe the engagement your organisation has had, particularly in the rural, remote and regional context, with local health districts.

ALEX GREEN: There has been no significant engagement with LHDs over the past few years. We've found the relationship through PHNs allows us to connect with GPs in a positive way in terms of improving awareness of arthritis, supporting early diagnosis and leveraging a community of support for people in rural areas with arthritis. But we've had no significant engagement with LHDs in that time.

The CHAIR: To follow up on that, would there be an opportunity for LHDs to engage with you, or is your work more suited to engaging in the primary health care space?

ALEX GREEN: It's more suited to engagement with primary health care.

The CHAIR: Are there any opportunities for LHDs to engage with your organisation?

ALEX GREEN: I'd be interested to find out. It's not an answer I can give today.

Ms JANELLE SAFFIN: The question I'd like to ask is about the demographic characteristics of the people the respective organisations support. What are the age groups, income levels or cultural backgrounds, particularly for palliative care treatment, for arthritis? I was very interested in the Older Women's Network. I'm just getting the submission printed off, because we've just received it, and I'll read it. What I was thinking with that whole digital divide is that we almost need to have a look at a digital map of New South Wales and what services they do provide. That's probably more an observation at the end, but it is really about the demographic characteristics of the people your organisations support.

The CHAIR: We might start with you, Mr Green, for Arthritis. Then we'll go to Palliative Care and then the Older Women's Network.

ALEX GREEN: There are two main forms of arthritis. The first is osteoarthritis, which is often thought of as wear and tear, and there's a direct correlation between ageing and osteoarthritis. The second form is a group of autoimmune conditions, rheumatoid arthritis being by far the most common, which can strike at any age. We work with kids and infants with rheumatoid arthritis and their parents. That is usually a life-long condition. Across those two forms, there is certainly a weighting towards older people experiencing problems with their joints, but it is also, through the autoimmune form, something that occurs from the youngest age group. There is no direct relevance to cultural or linguistic diversity.

KIRSTY BLADES: Palliative care is for any person of any age with a progressive, life-limiting illness, from babies all the way up to those who are over 100. It is for anyone of any age. That is who we are serving palliative care and end-of-life care. From a culturally and linguistically diverse perspective, that is an incredibly large element of the work that is done in palliative care and end-of-life care. Obviously, we have a very culturally diverse population, so a lot of the discussions that are had with clinicians providing palliative care are around culturally appropriate care and how we provide that to be relevant for all cultures, including First Nations people.

LORRAINE PENN: Dr McGovern, what would you like me to respond to? There's so much there. Rheumatoid arthritis is close to my heart because I suffer from rheumatoid arthritis, and I have to travel to Port Macquarie or to Brisbane to see a specialist. That falls within the lack of specialists lists that we've got. I'm not

the only person, obviously, here in Coffs Harbour. The particular rheumatologist who I had went to Brisbane, and it's a long trip to Brisbane for me, so I've chosen to go to Port Macquarie. Again, that takes out virtually half of your day.

JILL McGOVERN: I would also like to add that in Yass the biggest issue for obtaining care is really travel. We are only an hour away from Canberra but there is a very limited bus service of about twice a day into Canberra city from Yass. Other than that, it's your own personal car. There's nothing going to Goulburn and they're the two areas where we would have to seek help for arthritis conditions.

Ms TRISH DOYLE: Thank you all for being here and for the work that you do. I am just interested in finding out your perspective in relation to recommendation 23 from that inquiry that suggested that NSW Health work alongside peak bodies and urgently establish a palliative care taskforce to look at a whole range of issues ensuring culturally appropriate palliative care services are available to First Nations peoples—that sort of mapping across the state and in different communities to understand who is providing palliative services and where those services are offered. Have you seen any evidence of that suggested taskforce work happening in the last couple of years?

KIRSTY BLADES: I'm happy to respond to that. We are not aware of that taskforce having been formed and are not aware of that work that has happened. There are slight indications of some of that type of work but we are not aware that that taskforce was formed. In terms of the mapping of palliative care services, in Palliative Care New South Wales we do host the New South Wales service directory, which you can search by postcode or by area to find a service in your area. That currently lists 164 services across New South Wales. In terms of the collection of palliative care data, which was also referred to in that recommendation, again we understand that that has not been actioned. The closest would be the Palliative Care Outcomes Collaboration (PCOC) or Palliative Aged Care Outcomes Program (PACOP), but these are voluntary programs, and Australian Institute of Health and Welfare (AIHW) does also do data which is somewhat going to some of those benchmarking measures.

In terms of that culturally appropriate care and ensuring there are appropriate palliative care services to First Nations people, this is an area we are seeing some progress in. Seventy-five per cent of those we spoke to did indicate that culturally appropriate palliative care for First Nations people has improved. The focus on the employment of Aboriginal healthcare workers in palliative care is absolutely making a difference, but recruitment has continued to be challenging, as it has in other areas of palliative care. Palliative Care New South Wales supports Aboriginal and Torres Strait Islander healthcare workers with access to these professional memberships as a way to ensure that there is that connection amongst all of our members and that their voice is represented as well.

There was one other element in that recommendation. It was from the original report, which spoke to volunteers and that there was no real understanding of the size of the volunteer network. I can talk to that because Palliative Care New South Wales does host the Volunteer Support Services Programme. We can advise there are currently 38 volunteer services in New South Wales with over 1,100 volunteers currently, but that number of volunteers and services has still not returned to pre-COVID levels and we're still around 40 per cent less than where we were pre-COVID.

The CHAIR: Before we move on, just to clarify that, that sounded as though there was some positive information there in regards to First Nations involvement both in terms of staffing and awareness. Is that correct?

KIRSTY BLADES: Yes, correct. Definitely, the commitment that NSW Health has made—and they've established the Aboriginal palliative care network. They have recruited for Aboriginal palliative clinician positions and that is making a difference. We are seeing those indications from across rural, regional and remote areas in New South Wales.

Ms LIZA BUTLER: Thank you, everyone, for your time today. Recommendation 24 of the previous report was for NSW Health and the rural and regional local health districts to expand the Far West palliative care end-of-life model to other rural and remote areas across New South Wales. Have you seen any expansion of this model of care since 2022?

KIRSTY BLADES: We do understand that that information has been shared. It is publicly available on the PHN website. Those tools are easily accessible and there have been conversations between local health districts in terms of this model. Ultimately, those decisions remain at an LHD level, if those types of models of care and those programs are adopted. While there is an indication that some have, some have also indicated that it's not necessarily fit for purpose in their particular LHD. It's worth also noting that I think the relationships with PHNs and LHDs when it comes to palliative and end-of-life care is very positive. That program was actually funded through the greater choice for at-home palliative from the PHN, so federally. However, that funding is coming to

an end in June next year. But there have been some very positive programs across the state that have been established by PHNs supporting the work in palliative care and end-of-life care that should be acknowledged.

Mr CLAYTON BARR: I wanted to follow on about that positive stream around Indigenous palliative care and maybe explore a darker side of that data and statistic. If you're going to expand and improve palliative care for our Indigenous communities, the easiest place and the largest volume might be somewhere like Redfern or in and around Sydney hospitals. But we also know, of course, that our Aboriginal people are the most widely dispersed. Given that this Committee is looking at rural, remote and regional, is there any data and any sense and any evidence that we are doing better in getting palliative care out into those far flung parts of the state as opposed to a metro environment?

KIRSTY BLADES: Yes, definitely. When I referred to those positions, they are positions that have been put in place across New South Wales in each LHD. In particular, if I could talk to Tamworth, they have some amazing Aboriginal palliative care nurses there that are really working hard around that provision of culturally appropriate care to First Nations people. We're definitely seeing that move towards helping support First Nations people return to country as they approach end of life as well. There is positive work being done. Of course, there is still a lot of work to be done, but I definitely feel that it is progressing and is positive. I don't know, Felicity, if you have anything else to add to that.

FELICITY BURNS: Nothing on that point, thank you, Kirsty.

Mr CLAYTON BARR: That is magnificent to hear.

The CHAIR: Can I stay with the palliative care theme just for a moment. There was an announcement by the previous Government of a considerable increase in funding in palliative care. Since that time, there has been debate about a reduction in the amount of the increase. But, nevertheless, there has been an increase and not an inconsiderable increase. Are you seeing the impact of that increase in rural and regional areas?

KIRSTY BLADES: Again, it is varying across the different LHDs in those rural, regional and remote areas. Absolutely in some LHDs they are indicating that they are seeing significant improvement and some are saying some improvement, but then a percentage are saying no improvement. We are continuing to see this variation via LHDs and that funding and how that funding is being implemented. But, generally, there is a sense that there is more money coming into palliative care and that it is starting to have an impact. It is now just thinking about how much of an impact we need to have and that there is significantly more work to be done. The sense has been that there's been a slowdown on what that progress could have been with some of that reduction in funding and uncertainty around some of that funding.

Ms TRISH DOYLE: I've been having a look through the extra material provided to us by the Older Women's Network and some of the commentary around virtual care technology, which is heartening and also amusing. I'm particularly interested in hearing what your understanding is of communities who have been providing feedback about virtual care technology. My son, for example, is working with Ambulance on virtual care technology to paramedics in regional, rural and remote areas. But you talk to a wonderful innovation called Wally, which is a robot operated by a registered nurse. You're saying that Wally is a godsend to parents with sick children. What other sort of feedback are you receiving about this kind of technology from communities in rural areas?

JILL McGOVERN: I related the story about Wally. Wally was introduced some time last year. Yass Hospital faces challenges in having an emergency department (ED) doctor from time to time and also being overwhelmed from time to time with the amount of presentations at the emergency department. Wally was devised and is in concert with, I believe, the Far West LHD, and there is a pool of about 30 ED specialist doctors who are online. Wally allows a lot of examinations of ill people. It can't help critically ill people, but it can help—why I mentioned parents is that in most of the young families here, mum and dad work in Canberra. They come home and find their child has got a fever or is not well, and there are few choices. Most GPs finish at 5.30 p.m. and there is no after-hours GP service here. You have one option, really—one is to go to the Yass Hospital or, alternatively, drive back into Canberra, which is an hour's drive.

Wally allows the doctor on duty to actually perform what he's doing—looking after people in the hospital and possibly more critical cases. Wally can be operated by a trained registered nurse, and it connects with a remote doctor who can perform the examinations, through the robot, of different things. It's not just childhood illnesses. I related that one of my vets said he was bitten by a cat and needed help. He was able to take advantage of Wally to get the necessary antibiotics and what he needed after-hours. It has a really excellent way of mitigating the patient demand on a very busy doctor from time to time. Does that help? Is there anything else you'd like to know?

Ms TRISH DOYLE: No. I'm glad to hear that there is not just a novelty approach that is received well for less serious cases. I'm presuming, Jill, that it highlights the fact that where you do actually need more urgent or serious attention—technology like Wally highlights what you don't have.

JILL McGOVERN: It does, but I think it is an excellent thing to adopt when we are facing a shortage of specialised emergency doctors. This allows these two local health districts, southern New South Wales health district and Far West, to actually call their emergency doctors in this exercise. It's a pilot at the moment, but I think it has enormous promise in terms of helping folk where there are real limitations on getting care after hours.

Ms TRISH DOYLE: Thank you, Jill and Lorraine, and thanks for drawing that example to our attention.

The CHAIR: Ms Penn, did you want to add a comment there?

LORRAINE PENN: Yes, I just wanted to make a comment. Through accessibility here, seeing a doctor here takes three weeks. I am autoimmune compromised, as I mentioned before, with rheumatoid arthritis, and I had an infected hand after having cancer removed. It was badly infected and I couldn't get to see the doctor. I was able to use the North Coast Health Connect, which is hospital driven, and a doctor in Melbourne sent through, to my chemist, antibiotics. That's fine if you've got the technology in front of you. That's not the case up here in Coffs Harbour for everyone—for the Mid North Coast.

The CHAIR: Can I just follow up, because that is quite an important discussion? There is a big message about a lack of primary healthcare workforce, particularly GPs, throughout rural and regional New South Wales. Despite considerable efforts, it's not clear that is going to be easily resolved, frankly. NSW Health has adopted a range of virtual care technologies in different parts of the system, and the technology around that is becoming increasingly sophisticated. What you have just described is a situation where you found the use of that technology reasonable—in fact, better than reasonable. You actually found it quite good to interact with.

LORRAINE PENN: Yes.

The CHAIR: In the context of there not being doctors, I am getting a sense that you are quite positive about it, particularly in regard to Yass hospital.

LORRAINE PENN: No, I am talking about Coffs Harbour.

The CHAIR: I am sorry, Coffs Harbour—Ms McGovern was talking about Yass. Is that right? Is there a perception there that it is a positive?

LORRAINE PENN: Yes, it is a positive if you are able to use the technology. Not everyone, especially older women—and I'm talking about the Aboriginal community and culturally and linguistically diverse (CALD) people as well. They don't all have computers in front of them.

The CHAIR: Yes, absolutely. As a final part of this particular panel, I just want to touch on the issue of transport. It has been discussed a little bit earlier, and I think it applies to each of you. I have alluded to the fact that there is an issue in accessing services in rural and regional areas, particularly in regard to primary care. Ms Penn, you spoke about accessing specialist care and the travelling you have had to do. Do you have any reflections on the availability of transport in rural and regional areas and how that affects access to services? We have heard a lot recently about the availability of community transport and some of the constraints on that. Does anyone want to offer us any reflections in terms of gaps or suggested improvements in that area?

ALEX GREEN: I don't think it's anything I can comment on. We hear about the distances and time involved, but I don't have insight into the transport network.

KIRSTY BLADES: I would just comment that some of that transport is being covered by those community organisations and charities. They are an incredibly important part of the palliative care service provision, but I can't comment any further on other transport-specific items.

The CHAIR: Older Women's Network, any comment on transport, more broadly than the comments that you've made so far?

LORRAINE PENN: We do have community transport here but it's limited. It might be able to get you from your retirement village or wherever it is to the hospital and to a specialist, if a specialist is available, but that's about it. It's not a very large fleet of facilities. If you have to go interstate—obviously, it's mainly Brisbane, but some do go to Sydney for various issues—you have to use your own vehicle or fly.

JILL McGOVERN: For us, for here, I'll give you a patient's story of a friend of mine, a young lady who was three months pregnant who started having a difficulty. She presented to Yass hospital and she needed an ultrasound. She presented in the morning. She waited most of the day for transport to take her to Goulburn hospital. By the time she got to Goulburn hospital, the ultrasound was closed at Goulburn. She was basically released and

told to find her own way home, and she had to ring her partner to come and get her. The following day, she went into Canberra, spent five days in hospital and was finally released. Ultimately, she had a lovely, beautiful baby boy. But I think this shows that—we're an hour away from Canberra, and it is just simply unacceptable, in my view, that this should happen.

For older folk, we have a wonderful organisation called Can Assist here that looks after cancer patients. The convenor of patient transport said to me that the situation is desperate to get people to be able to access the care, the chemotherapy and the specialists that they need to see to look after their condition. So transport is a huge issue for people in Yass, and yet we're an hour away from Canberra. I think that is really sobering information, sadly.

The CHAIR: Mr Green, do you have any reflections on the use of technology and remote virtual care, or remote access to medical advice, in terms of arthritis care?

ALEX GREEN: Yes, thank you. I think we stand at a really interesting time. All the challenges that have been described around workforce shortages, challenges around internet connectivity in remote and rural areas—all of those things are true, but I believe that technology presents some real and immediate solutions for many people with health conditions. We've invested time, money and energy in the development of an AI-powered app that we think can be quite transformative. The tech can be applied to any chronic condition in order to keep people well and minimise engagements and those necessary trips to remote specialists. The time is now to invest in that sort of innovation, I think, to help people at scale. Certainly, the guts of our pre-budget submission to the New South Wales Government was around accelerating the development of tech solutions, which include telehealth, but also harnessing the power of AI to help people and minimise the impact on the healthcare system.

The CHAIR: And that represents a real opportunity in terms of the management of a range of chronic and complex conditions?

ALEX GREEN: Yes, absolutely. Not a conversation we could have had two years ago, but now is the right time to accelerate that use of AI.

The CHAIR: Not a conversation we could have had two years ago?

ALEX GREEN: No, because AI was too nascent two years ago. Now is the right time. There's a greater degree of security and comfort around the use of AI, and that will build over the next couple of years, I expect. I think non-profit organisations have the liberty of greater freedom, as opposed to government, and so I'm very interested in that nexus, that connection, between health and non-government enterprises in terms of creating and piloting this use of tech.

The CHAIR: I think that's actually quite an interesting insight for the Committee, can I just say, Mr Green, particularly your observation about the last two years and the use of AI. My observation would be, as I have recently said, that the workforce challenges are quite complex and quite difficult. I suspect the old workforce models and roles aren't going to be attractive to people coming into the health workforce now, and we do need to look at different solutions to that. I am picking up from this discussion some acceptance in rural communities about the advantages of virtual care, and you have pointed to the possibilities of the use of AI. I think that is something the Committee should reflect on.

ALEX GREEN: Yes, there's a massive opportunity in front of us. There is some great innovation happening. If we can harness that, it will address a lot of the issues which would otherwise be insurmountable.

The CHAIR: Of course, it will depend on connectivity being there and making sure that people can access it, both physically in terms of connectivity, but also in terms of their skill levels and access to the technology and so on. I'm going to finish shortly. Ms Burns, I'm conscious that you perhaps haven't had an opportunity to say anything. I want to give you an opportunity to make any comment or observations that you would like to.

FELICITY BURNS: Thank you, Chair. For palliative care in regional and remote areas, and particularly the variances across different local health districts in regard to the way that resources for palliative care are allocated, there doesn't seem to be a level of rigour around decisions that are made. I think that needs to be something that has better oversight from NSW Health when we look at what are the key priorities and needs of that group. I still think there remains a significant gap in community care as well as subacute care. That is something really important to call out for regional and remote areas. There are subacute palliative care services sitting in metro areas, but very few in regional and remote areas.

The options for those living in regional and remote areas tend to be home, if that is possible, or to die in an acute hospital. I think that's a major gap and something that we need to not lose focus on, going forward. In regard to virtual care, I would like to chime in. I think that the opportunity is really there for palliative care too. It is interesting, around connectivity—whether there's an opportunity for us to have virtual hubs. So we run virtual

clinics if there are challenges for individual people at home. I think there are lots of opportunities ahead. Thank you for the chance to speak.

The CHAIR: Thank you, Ms Burns. On that note, I am going to bring this session to a close. I thank all of the witnesses who have appeared. We would like to ask you follow-up questions. If you do provide us with a response, your response will be included in the evidence. Are you happy to reply to any follow-up questions that we have?

ALEX GREEN: Yes.

KIRSTY BLADES: Yes.

The CHAIR: Thank you. I might ask you to withdraw at this point. Our next panel starts at 2.30 p.m., so the Committee will take a short break. That will allow our next panel to run a little bit longer, so we won't take a break at 3.15 p.m. Is that clear to the panel? Once again, I thank the witnesses who have appeared.

(The witnesses withdrew.)

(Short adjournment)

Dr VANESSA JOHNSTON, Director of Cancer Information and Support Services, Cancer Council NSW, before the Committee via videoconference, affirmed and examined

Ms BRENNA SMITH, Manager Community, Cancer Information and Support Services, Cancer Council NSW, before the Committee via videoconference, affirmed and examined

Mr BRAD GELLERT, Manager Policy and Advocacy, Cancer Council NSW, before the Committee via videoconference, affirmed and examined

Mrs MEGGAN HARRISON, Southern Highlands Cancer Centre, affirmed and examined

The CHAIR: I welcome our witnesses, from Cancer Council NSW and the Southern Highlands Cancer Centre. Mrs Harrison, thank you for travelling up and being here in person. That's excellent. Please be aware that staff will be taking photos throughout the hearing. If you have any concerns, please let us know. I ask each of the witnesses to please confirm that you've been issued with the Committee's terms of reference and information about the standing orders in relation to examination of witnesses.

MEGGAN HARRISON: I have.

VANESSA JOHNSTON: Yes.

BRENNA SMITH: Yes.

BRAD GELLERT: Yes.

The CHAIR: Would any of the organisations like the opportunity to make a two-minute statement to commence?

MEGGAN HARRISON: I would. Good afternoon, Chair. Thank you very much for this opportunity. I'm here as a member of the public living in the Southern Highlands. I have a significant understanding of both solid tumours as well as blood cancers. I open with a statement of facts. Currently in the Southern Highlands there is a public-private partnership with Ramsay Health, a monopoly in the area in this treatment space, who set their treatment pricing structure and bill back to NSW Health for all public patients. There was a public cancer centre in the initial master plan for stage two of the Bowral Hospital redevelopment. However, this was shelved and put into an unfunded stage three with an undetermined start or end date.

The median age in the Southern Highlands is 48 and the population, by 2041, is expected to be 65,000. This population data does not include the development along the Hume corridor. It is estimated that approximately 50 per cent of the highlands population do not have private health insurance. Keeping the above numbers in mind, I compare data pertaining to cancer services in the Southern Highlands with Bankstown for reasons that will become obvious. In 2023 Bowral had 320 new patients with solid tumours; Bankstown, 350. Over and above the 320 new patients, 177 new cancer patients were sent to Liverpool and another 177 sent to Campbelltown, where they received their treatment. The chemotherapy treatments at Bowral were 4,153; Bankstown, 6,060. Bowral has one—I repeat, one—full-time oncologist; Bankstown, 2.5 full-time equivalents. Behind these statistics there is a human being who will suffer the treatment side-effects of nausea, vomiting and diarrhoea. There is one toilet at the truck stop between Mittagong and Campbelltown. The Southern Highlands Cancer Centre is in urgent need of a publicly funded centre in the grounds of the Bowral Hospital.

The CHAIR: Thank you, Mrs Harrison. We might now hear from Cancer Council.

VANESSA JOHNSTON: Thanks, Dr McGirr, I'll take that. Good afternoon. I'd like to start by acknowledging the traditional custodians of the land on which I'm meeting with you today, the Dharawal people, and I pay my respects to their Elders, past and present. Australia has the lowest cancer mortality in the world but, within Australia, we know that there are stark differences in cancer outcomes depending on where you live. The chance of dying from cancer increases in parallel with the distance from major city centres. This shouldn't be the case. Poor cancer outcomes for those in regional and remote New South Wales can be partly attributed to poorer access to high-quality cancer care, clinical trials, diagnostic services, supportive care and palliative care. Even when these services are available, our researchers told us that people may opt out of treatment or skip treatment due to the cost of the service or the transport and other indirect costs to attend for treatment.

We commend the Committee for keeping a focus on remote, regional and rural health, and we're here today to highlight what we think has improved since the previous inquiry. That includes the improvements made to IPTAAS, the removal of out-of-pocket costs for public cancer patients in Wagga Wagga and the continued work to integrate existing cancer services into virtual care. We're also here today to emphasise that more action is required to improve equity for people with cancer in remote, rural and regional areas. In particular, we believe that community transport can still be more equitably delivered if pricing benchmarks are set, current policies and

grant programs are reviewed and not-for-profit community transport providers such as Cancer Council NSW are included in planning and coordinating transport services.

We also suggest that the New South Wales Government seeks to understand if and where there are additional out-of-pocket extra costs for public patients accessing private services in other regional, rural or remote areas. We provide support services to reduce the financial burden of cancer treatment, but the demand on these services remains high and is increasing. We want to ensure that our support services are connected into existing healthcare networks and these services remain available and accessible to all who need them. Lastly we believe the importance of ensuring access to early palliative care across New South Wales. Reducing the inequity of regional and metropolitan cancer outcomes requires sustained effort, innovation and collaboration between public, private and not-for-profit service providers. We stand ready at Cancer Council NSW to work with government to grow and further support people who are affected by cancer in rural, remote and regional New South Wales. Thanks so much, Mr Chair and the Committee, for the opportunity. I'm very happy to answer any questions.

The CHAIR: Thank you so much to both organisations for appearing today. I will start the questioning and then members of the Committee will, in turn, ask questions. I'm going to start on a positive note. Dr Johnston, you did mention that there have been a number of positive outcomes, particularly in relation to IPTAAS. You did reference out-of-pocket costs at Wagga. We're not quite there yet—a reminder to the Government that by the middle of the year they need to have that one sorted, as promised. I wonder if we could focus briefly on where there have been achievements, because I know we need to delve into where we need to improve. Perhaps I can start with you, Dr Johnston, on that.

VANESSA JOHNSTON: Certainly we know that for many patients in remote and regional areas, access to services can be challenging—access to primary care and to specialist treatment, chemotherapy and radiotherapy services. And we do know that there are instances where public patients have been paying significant out-of-pocket expenses for quite some time to access these services because they simply have no other choice. We really commend the Government. Yes, we're not quite there yet; we hopefully will be. But we really have received very positive feedback from the community in relation to those changes in Wagga Wagga where we have community presence, and we have a joint venture partnership with Can Assist with our accommodation facility there. We have received really positive feedback. Similarly, the increase in the IPTAAS funding has been incredibly well received. I think it really highlights the need for ongoing continuous funding for that service. I know we're trying to stay on the positive here, but we still have unmet need for community transport. That's a really significant factor that we'd like to bring to the Committee's attention. To my other colleagues, is there anything else in community that I've missed?

The CHAIR: Can I just follow up on this issue of out-of-pocket costs? There may be a number of other centres being established on private models, particularly in relation to radiotherapy, because of the way the Commonwealth has done tenders around this. It leaves the state in the position of having to pick up the out-of-pocket costs in quite a complicated system. Are you aware of those other sites in New South Wales where this is an issue? I think Eurobodalla might be being flagged as an issue.

VANESSA JOHNSTON: We're not. Well, personally, I'm not. But I do think it's beholden on the Government to explore and understand how widespread this is as an issue. As part of our submission we did recommend an audit or a stocktake across local health districts to understand where public patients are in a position of having to pay these significant out-of-pocket costs because of these private centres. In particular, you mentioned radiotherapy. I think there is more work to do in uncovering where this is happening across New South Wales.

The CHAIR: Mrs Harrison, the Southern Highlands Cancer Centre is a public-private partnership. Is that for chemotherapy?

MEGGAN HARRISON: Only chemotherapy, yes. They travel to Campbelltown for radiotherapy because there are three radiotherapy centres in Campbelltown at the moment. To go back to that previous question, I was told on Tuesday this week that the billing is exactly the same in the private centres as it would be in the public. There's no difference in the price that is charged back to NSW Health in terms of radiotherapy—but it's only radiotherapy.

The CHAIR: At the Southern Highlands Cancer Centre, are there out-of-pocket costs for people accessing chemotherapy?

MEGGAN HARRISON: Significantly. If you are a public patient, yes—significantly. There are patients that are being charged \$340 for a consult.

The CHAIR: Okay, that's important. Thank you for that. I'm going to hand over to the Deputy Chair, Ms Janelle Saffin, for the next question.

Ms JANELLE SAFFIN: It's okay, Chair, because they were the questions that I wanted to ask, so it's covered. I'm well aware of the out-of-pockets. Thank you.

Ms TRISH DOYLE: Thank you all for appearing before us today and also for your work across the state and in a variety of communities, addressing need and talking to us about, hopefully, a bit of progress but also speaking truth to some of your frustrations. I think that's important. Recommendation 30 of the report that came out of the previous inquiry looked at New South Wales committing to a number of workforce improvements—investigating telehealth cancer care models, for example. Have you seen any improvements to access to cancer treatment for people in regional, rural or remote areas via some sort of telehealth model and what has been the feedback, if so? It's open to anyone who would like to jump in.

BRENNA SMITH: I'm happy to jump in, Ms Doyle. We have heard, particularly across the western New South Wales footprint, that cancer patients have consulted with clinicians via telehealth and that that has provided a greater level of access to expertise treatment. But we still believe that that's still not enough, and it's not enough to ensure that patients are feeling well supported in their local community where they live and work.

BRAD GELLERT: If I can add to that, Ms Doyle, I agree with my colleague's comments. I do want to add that we also understand that there has been some significant progress in the rollout of virtual clinical trials. We're quite pleased about the progress here. There is a really significant disparity when it comes to access to potentially lifesaving cancer clinical trials between people living in metro and people living in regional populations. We're really pleased to see that the New South Wales Government, through the Office for Health and Medical Research, has invested in a cancer clinical trial virtual program. I wanted to make sure that that was known too.

Ms TRISH DOYLE: Thank you. I wondered if there was anyone else who wanted to jump in on this. This is the talk of the day, spruiking how fantastic telehealth is. It would be good to know from those of you who may have seen it on the ground or have got some feedback—for the record, for our inquiry, we need to actually note down your views here.

MEGGAN HARRISON: Could I maybe say something? Anecdotally, what I found—and this came up in the Eurobodalla, probably maybe a year ago. It's Ms Harrison here. You can't hear me?

Ms TRISH DOYLE: I don't think any of us online can actually hear. It's all completely broken up.

The CHAIR: We will get some technical expertise here.

Mr CLAYTON BARR: Interestingly, for all of us online, I think we can all hear each other clearly but not back to base.

Mrs LESLIE WILLIAMS: We're having a look at it now. How ironic when we're talking about technology.

The CHAIR: Yes, how ironic. Mrs Harrison, let's try and go.

MEGGAN HARRISON: Let's try. This is anecdotal. I was in the Eurobodalla probably a year ago, where post-COVID they were getting a lot of patients that were presenting because they had had the telehealth GP visits throughout COVID. All of a sudden there were a lot of lung patients presenting. It was because during COVID the patients were saying to doctors, "I've got a cough. I've got a cough." They were writing out a script but they were not able to be checked to see what was causing that cough. Technology is wonderful, but it needs to be at the right time to form a diagnosis and within the treatment algorithm for these patients. We need to be really careful about implementing technology without thinking very carefully about it in this cancer space.

Ms LIZA BUTLER: I would like someone to describe a typical experience for someone who lives in a regional or remote community and requires treatment for cancer, either in a regional centre or a metropolitan area. Maybe Mrs Harrison?

MEGGAN HARRISON: Sure. I would take advice as well from the Cancer Council. Most often a patient will be first seen by a GP. They will then have various tests done—they'll probably be blood tests—and they will then be referred on to an oncologist. If it's potentially a breast patient, they will go straight to surgical. They won't go to an oncologist first. If it's lung, they will go to a respiratory physician, where they will have biopsies done to understand what sort of lung cancer they have. They will then go on to an oncologist, who will make the decisions as to what their treatment paradigm will look like. The oncologists very often, in certain cases, will also then bring in radiotherapy. So it will be a multidisciplinary group that will be between oncology, radiotherapy, surgical and any other auxiliary support that a cancer patient will need.

For instance, after COVID we had a lot of patients that presented with stage three metastatic disease. Those patients are treated immediately, and that is urgent. If it is a neoadjuvant, the treatment is not as urgent, and they

can maybe wait a couple of weeks, maybe even a month or maybe two months. So it depends on the staging of that patient and then where they go and what their trajectory is from there. If you're going to do radiotherapy, for instance, you may have long-term radiotherapy, which is every single day for five weeks. Your chemotherapy—probably not as long or as arduous. It will be once every two, three or four weeks and that may go on for years. Particularly with immunotherapy, it will go on for at least two to three years.

Ms LIZA BUTLER: If you lived in Bowral, for instance, and you were undergoing that treatment, can you have that done locally or do you have to go to Sydney?

MEGGAN HARRISON: Good question. If you're a brain cancer patient, you will go to Sydney. They don't have the capabilities to treat brain cancer in Bowral. In all honesty, if we had the space and the clinicians, they could all be treated in Bowral. Currently these patients are sent down to Campbelltown and Liverpool. That is where—from an earlier discussion—transport comes in and these patients are transported down. They then have to wait until the transport comes back, which could be six hours.

The CHAIR: Does anyone from the Cancer Council want to add to that picture?

BRAD GELLERT: I'm happy to hear from my colleague Ms Smith as well but I wanted to add to how important transport is. While most of the more common cancers can be treated locally if there is a local centre with sufficient staff, for people who have more complex, more rare cancers who need really complex surgery, they must go to major metropolitan centres. It's much safer and they will have much better clinical outcomes if they're treated in a major tertiary hospital. What we don't want is for a surgeon who does one surgery a year operating in a small regional hospital. We want those people to go to centres of excellence. That's where it's critically important that transport is affordable, because those people have no choice.

BRENNA SMITH: I agree with everything my colleague said there. The only thing that I would add to that is across regional and rural New South Wales we know that people are travelling vast distances to receive cancer treatment where there is a lack of public transport, ridesharing and community transport services. We hear often that this is an additional burden that a cancer patient faces as well as having a cancer diagnosis: worrying about how they're going to get to and from their cancer treatment. We've heard of instances whereby in the Kempsey shire a client with metastatic cancer needed to travel to the Mid North Coast Cancer Institute for cancer treatment and was quoted \$90 for a return trip, which was unaffordable for the client. The client then used Cancer Council NSW Transport to Treatment service 22 times. It would have cost them just shy of \$2,000 if they had not been able to access Transport to Treatment.

We know that, in addition to a cancer diagnosis, cancer patients are also having a financial burden and having to work out how they're actually going to physically get to and from their cancer treatment. That's the role that we play in the not-for-profit sector in providing some assistance with Transport to Treatment. But we feel that community transport could be more equitable in terms of pricing benchmarks, because we do see a discrepancy across community transport providers with pricing benchmarks. We really welcome the opportunity to work with LHDs and other community transport providers to try to overcome some of the transport challenges that regional and rural patients are facing.

Mrs LESLIE WILLIAMS: I have a question. It's probably for both groups but I will go to you first, Mrs Harrison. Thank you for sharing the information that you gave us. It's obviously incredibly frustrating being in the Southern Highlands. This Committee is really focused on the previous PC2 report. My question to you and to the Cancer Council is have you seen any inkling that there have been changes made by the New South Wales Government in the approach to these issues—let's say, transport?

MEGGAN HARRISON: No, there hasn't been anything in transport. There's absolutely nothing that I can see.

Mrs LESLIE WILLIAMS: I'll come back to the Cancer Council. Have there been any communications with NSW Health to try to address some of these issues that have been raised, particularly, again, around transport? That is probably the real impediment when it comes to cancer treatment in the regions.

MEGGAN HARRISON: No, there hasn't. Not that I am aware of. In saying that, the fact that there was a cancer centre planned for stage two in the Bowral hospital, obviously the New South Wales Government is aware that there is a desperate need for this treatment within the Southern Highlands, particularly with the growth expected in the area. It's probably more important to be looking at putting in the facilities rather than the transport.

Mrs LESLIE WILLIAMS: Cancer Council, do you have anything to say in relation to any conversations or improvements in relation to transport issues that have been raised and were raised in the previous report?

VANESSA JOHNSTON: I think that we've already commented on the IPTAAS funding. That is definitely an improvement. The complexity for transport is this very fragmented, patchwork framework with the

Commonwealth funding services for cohorts that are over 67 through the aged care, but also through NDIS. And then we've got the community transport organisations and the not-for-profits. We haven't yet seen the type of collaboration, coordination and communication across all of those services that we would like to see. We certainly had very fruitful and encouraging discussions with New South Wales, as Mr Gellert has highlighted, in terms of virtual care and thinking about how we better integrate some of our Cancer Council NSW supportive care services into referral pathways and how we utilise data and information from New South Wales to inform our service planning. In terms of transport from Transport for NSW, no, we probably haven't seen the progress that we would like to have seen.

The CHAIR: You flagged transport as an issue, so we've begun that discussion. I want to come back to the virtual clinical trials, but let's discuss transport. We have heard evidence in relation to a number of issues around transport. The issue of fragmentation is one. The issue that has come up today is that community transport organisations aren't eligible for IPTAAS payments because they're funded by another government source, yet, on the face of it, that would seem to be a logical, fairly inexpensive mode of transport that you would think IPTAAS could support. That's one option. That's the issue around funding. I have also heard—I think in one of the submissions—that the Cancer Council itself has its Transport to Treatment program with volunteers. It has been hugely important. I know that in the region I come from it has been hugely important for people getting access to treatment. But I understand that you've had to restrict that recently, or there has been a large demand that you have not been able to meet in that area. Perhaps you could expand on those two issues, both about the funding and also your own capacity for transport and what impact that is having.

VANESSA JOHNSTON: Perhaps I'll start with the funding and then pass to my colleague Brenna around our T to T service. I think we can all agree that there is continued unmet need. Certainly, that has been our experience at Cancer Council NSW. Current government grant programs for community transport, we believe, do need to be reviewed to ensure that that funding is sufficient, given that ongoing unmet need. We also really think, as Mr Gellert has highlighted, that we do need these benchmarks and guidelines around how services should be priced to ensure that there's equity. We do think that there is the opportunity to review the Transport for Health policy, with input from NGOs like ourselves, and that that should incorporate questions around ongoing and sustainable funding and the best models for that going forward. I might pass to Ms Smith to talk to our current changes in our Transport to Treatment service and why we've needed to implement them.

BRENNA SMITH: Cancer Council delivers 22 Transport to Treatment services across New South Wales, and they are all delivered through a team of wonderful volunteers that put their hands up to drive patients to and from cancer treatment. Our T to T services were always designed to complement existing transport to treatment providers, but people were relying heavily on our services when they couldn't afford the co-payment charged by community transport providers to be able to access community transport. So we had to introduce some eligibility criteria that prioritises people with the greatest need of assistance to ensure that we can keep our volunteer-based services sustainable across New South Wales.

As a consequence of that, there has been fewer trips than previous years in terms of us delivering Transport to Treatment. But in saying that, our volunteers are close to dedicating nearly 10,000 hours of transporting patients to and from cancer treatment. But what we can say is now we feel more confident that for those people in regional and rural communities that have no other transport options, Cancer Council is there to be able to support them to get to and from their cancer treatment.

BRAD GELLERT: If I could add one thing to Ms Smith's statement, it's just to reiterate the point that our Transport to Treatment service, which provides up to a million kilometres of transport in New South Wales a year, is entirely funded through donations. So we don't receive any government or public funding for this service.

The CHAIR: A million kilometres per year, did you say?

BRENNA SMITH: Yes.

BRAD GELLERT: Yes.

The CHAIR: And it's completely unfunded. But what you are saying is—I presume because of limited resources, particularly people—you've had to restrict access to that. So what do people do in that circumstance if they can't access your service? Presumably they pay, do they, for community transport to reach their treatment?

BRENNA SMITH: In those cases, where we're unable to help them, we encourage them to work with their healthcare provider in the local cancer treatment centre to find another alternative solution. It may mean that it requires that patient to come and stay at an accommodation facility located closer to a treatment centre rather than travel back and forth for cancer treatment. It may mean that that client is referred to some of Cancer Council's supportive care services, whereby we might assist with some financial assistance to support them with that

co-payment to community transport. But it really does significantly disadvantage cancer patients. We can only do what we can do with the services and resources and volunteer pools that we have to deliver T to T.

The CHAIR: Can I just come back, Mr Gellert, to the issue of clinical trials. You indicated there had been an improvement in access to clinical trials for regional, rural and remote people. I think you referenced a virtual program that improved that access. Have I got that correct? Can you provide some more detail on that?

BRAD GELLERT: Sure. What I will do is clarify. [Audio malfunction] evidence that there has been an improvement in access to clinical trials. I think what I intended to say was that there had been positive movement from the Government to set up a system that would enable greater access to future trials. Cancer Council NSW recommended, as part of the original regional inquiry, the adoption of something called the Clinical Oncology Society of Australia (COSA) tele-trial model. What we understand is that NSW Health has, through the Federal Government's Medical Research Future Fund scheme, been awarded about a \$30 million grant to improve access and restrict barriers to participation in clinical trials for people in regional areas. So there is a pot of funding in New South Wales and there is a program of work that's ongoing. I don't have any more information than that, other than we're pleased to see that there has been some progress. I'm not aware of any improvement in the numbers of people in regional New South Wales that are able to access clinical trials as a result.

The CHAIR: To summarise: some positive discussions and indications rather than anything concrete just yet. But you've also referenced the possibility of funding from the Commonwealth for the COSA tele-trial program.

BRAD GELLERT: To clarify, the Office for Health and Medical Research within NSW Health has received a \$30 million grant from the Commonwealth Government to support clinical trial access for people in regional New South Wales. That's the positive thing that has happened in the past two years, which is great. We will wait and see what happens with that funding.

The CHAIR: I think we might make a note to follow that up with NSW Health.

MEGGAN HARRISON: May I comment on that?

The CHAIR: Yes, Mrs Harrison.

MEGGAN HARRISON: I'm very aware of that \$30 million. If we are going to follow up, there is a group of regional oncologists who have recently got together to coordinate between themselves how they work with this. This is being spearheaded by Dr Rob Zielinski in Orange. If we are going to follow up, he would be a perfect person to bring into this discussion, because they don't believe that there will be a full \$30 million. It will probably end up being \$12 million. They're modelling the tele-trials on what is being done in Victoria, because Victoria has an excellent model with telehealth clinical trials. That is where they are. The group was put together probably six months ago. It does include major stakeholders in regional oncology throughout New South Wales.

The CHAIR: That's excellent. I want to reiterate how important access to clinical trials is for regional and rural people and what a significant disadvantage it is that they don't have access to that trial network. It sounds like it could be a very positive development. Thank you for that information, and we need to pursue that with NSW Health. We're always looking for the positives. The last area I wanted to touch on is palliative care—again, a subject of recommendations in the inquiry. There has been some political debate about funding that was promised. Not quite as much as what was promised has been rolled out. We've had some feedback that there have begun to be improvements in palliative care. It is an issue I know Cancer Council has some links to. Mrs Harrison, you might have some comments on it as well. Are there any reflections from Cancer Council on improvements or initiatives in relation to palliative care or end-of-life care through NSW Health for regional, rural and remote communities?

VANESSA JOHNSTON: Unfortunately, Mr Chair, we can't comment specifically on that progress made in relation to the specific recommendation regarding palliative care, except to reiterate the absolute importance of accessible, early and well-funded palliative care services in remote, rural and regional areas. Apologies that we cannot give you more detail there.

MEGGAN HARRISON: Yes. I apologise, too. I cannot comment with any sense of knowledge.

The CHAIR: Do any other members of the Committee have questions? Are there any other comments, Mrs Harrison, that you would like to make to the Committee, or the members of the Cancer Council who are online? First of all, Mrs Harrison.

MEGGAN HARRISON: Thank you very much. Really, what I'd love to see is more emphasis being put on the cancer centres themselves rather than us having to transport patients around the country, if we could. We've

got cancer centres in Cooma, which is close to Canberra. Why can't we have more of those where there is population growth in New South Wales as well, right here?

The CHAIR: Are there any closing remarks from the representatives of Cancer Council NSW?

VANESSA JOHNSTON: I don't have anything in addition to what we stated but, Brenna, you looked like you were about to speak.

BRENNA SMITH: Thank you, Vanessa. The only thing that I would like to say is that we would really welcome the opportunity for not-for-profit transport providers, such as Cancer Council NSW, to be included in the LHD planning and coordination of transport services, just to ensure that those regional and rural cancer patients and their families can have equitable access to cancer services.

The CHAIR: That's an interesting point about who does the planning around transport services because, of course, we have HealthShare in New South Wales. The LHDs' precise involvement around those services is something we probably need to clarify, I think. At that point, I thank the witnesses. We may send you some further questions in writing and your replies would form part of evidence and be made public. Would you be happy to provide a written reply to any further questions?

MEGGAN HARRISON: Yes.

BRENNA SMITH: Absolutely.

(The witnesses withdrew.)

(Short adjournment)

Dr ROBIN WILLIAMS, Western NSW Primary Health Network, before the Committee via videoconference, sworn and examined

The CHAIR: Welcome, Dr Williams. Can I 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?

ROBIN WILLIAMS: Yes, I have.

The CHAIR: Would you like to make a brief opening statement, limited to a maximum of two minutes, before we begin our questioning?

ROBIN WILLIAMS: Thank you for the opportunity to appear before you. I'm the chair of the Western NSW Primary Health Network and have been since 2019. Prior to that, I had a number of roles. I was chair of the Dubbo Plains Division of General Practice, I served on a Medicare Local and I served as chair of the RDN and also as chair of the Western NSW Local Health District for six years. The most important role I've had is being a rural GP and Visiting Medical Officer (VMO) the last 27 years in New South Wales, the last 17 years in Molong and Yeoval and, prior to that, 10 years in Gulgong. And I was a GP in North Wales, where I hail from, for 10 years prior to that. I have 37 years of rural general practice experience. This year will be my forty-third year as a medical practitioner.

Before I plan to retire at the end of August this year from clinical work, I plan to carry on doing PHN work, which I think is very important. In all that time, I've never seen the problem of the recruitment of workforce into primary care be as bad as it is now. Certainly when I qualified, which is now a long time ago, 60 per cent of my cohort went into general practice. I think the last figures I saw were 14.7 per cent. There's been a huge decrease in the number of new graduates coming through into primary care, and this is causing a huge issue down the track to all levels of health care. I think that's the primary thing that we need to try and address, and there's a number of things that need to be done to do that. Thank you.

The CHAIR: Dr Williams, I have to say that your comments reflect what this Committee has probably observed in its deliberations. In fact, in the two years since the inquiry recommendations were handed down and in the two years before that, when the inquiry was doing its work, I think the situation with primary care and with general practice in particular has deteriorated even further and represents an urgent crisis. There's a number of issues that we would like to ask you questions about, but can we start with what you think needs to happen to address that situation?

ROBIN WILLIAMS: I think the urgent issue is that the funding for primary care is not fit for purpose. General practice has traditionally been a lot of little cottage industries [audio malfunction] practice all standing on their own and not really being a part of the whole continuum of care as it should be—not as integrated as it should be. I think that what we need to do is look at the funding models of general practice and also the whole model of how general practice runs. Obviously, most of general practice is funded by the Commonwealth through the MBS, but in a rural community, like where I work as a GP VMO, that's funded by the NSW Government. There's too much of an opportunity for a blame game between the two bits of government and nobody taking real ownership of primary care.

I think that what we need moving forward is for state and Commonwealth governments to set up, rurally, a primary care entity which can take responsibility for the funding and delivery of care based on population needs and based on what the communities need so that there is some equity across the system. It means a root-and-branch reform of the funding of primary care, the development of a much better seamless service between primary care and secondary care and much more integration across practice teams of allied health, doctors and nurses so that we can all work in tandem around the most important part of the health system, which is the actual patient.

The whole of the system is not designed around patients. It's designed around these silos of care, which often cannot work effectively together. That needs to come under one health authority, which would mean Commonwealth and state working together. If there isn't an appetite at the Commonwealth level to do this, I don't know—there is talk around thin markets where the system is failing. But since the state health rurally is becoming the default provider of care whenever traditional primary care fails, it's probably incumbent on the state health, in its own interests, to develop greater primary health care services so they're not just providing a bandaid solution in their ED departments, which are being overwhelmed. They need to be able to have oversight of the whole of the primary care system, which is obviously a much greater thing than just episodic care. It's about longitudinal care and it's about chronic disease management and prevention of ill health so that maybe we can make some inroads into the obviously worse morbidity and mortality the more rural that you go.

The CHAIR: Dr Williams, you have made a quite radical suggestion there, and I just want to clarify. I interpret what you have said as a Commonwealth and state jointly funded body would run primary care in rural

and regional areas, and I think I picked up a suggestion that we move from a fee-for-service model into a different sort of model to provide a more attractive employment model but also to reward care that is critical in relation to chronic disease and prevention. Moving away from a fee-for-service model like that is quite a radical suggestion. Have I interpreted that correctly? Do you think there is an appetite for that now amongst your colleagues in rural and regional areas?

ROBIN WILLIAMS: I think that the way that it can be brought about is by staging it in such a way that, obviously, fee-for-service does some help with activity—which isn't always the best activity, having said that. But it does mean that if you work harder you do get remunerated for it. But it doesn't have to be the whole picture. We already get PIP—practice incentive payments—and the like to support good practice. There's no reason why block lot grants couldn't be developed further so that we can develop and enhance services. In my practice, for example, if the practice nurses see a patient, they'd have to see me too in order for us to earn any money on the MBS. There could be a different way of funding that. It still could be episodic funding for certain things. I'm not saying that we go away completely from fee-for-service, because it does have some advantages, but I don't think it's the answer for everything. I do think we need to have a blended payment system which involves fee-for-service and block funding to bring about good practice and allow an enhancement of what we serve.

The CHAIR: And that clearly involves not just medical practice. From what you have said, it sounds like we need to employ a range of health professionals—can I put words in your mouth and say—working at the top of their scope of practice, perhaps, in rural areas.

ROBIN WILLIAMS: Absolutely. I am very fortunate in where I work in Molong. We're co-located with community health—nurses, a speech therapist, a physio, OT, a dietitian and also my practice team—and we work collaboratively around the patients. I think that integrated approach is the way forward so that we all try and work at the top of our scope to provide wraparound care for patients. Certainly, when we were in the early stages of the integrated care project, which Minister Jillian Skinner brought about, we found that that made a huge difference to our patients with chronic disease in trying to keep them out hospital. The old days of a GP being the sole provider are long gone, and I'm pleased for that because my colleagues who are in allied health have far more expertise than I do in a number of areas, and it's very important that, as part of a team, we work together.

Ms JANELLE SAFFIN: One of the questions that I would like to ask, Dr Williams, is about the PHNs' direct relationship with LHDs. I know Dr McGirr has touched on some of this, but our understanding of PHNs is that their work was to do all the health needs assessments and work out where gaps are and then work closely with the LHDs. I know that's broad, but I'd really like to hear from you because I imagine you've got a lot of expertise and experience in this.

ROBIN WILLIAMS: Yes, thank you. Certainly that's a sort of primary area for the PHN, but we in Western have very strong links with both Far West and Western LHDs. We try to work together and try to plan services together. This sort of work is really in its infancy. But since the beginning of this year, we have set up a subcommittee at a board level of board directors from both the two LHDs and the PHN to try to work on common areas of issues to try to plan, together, service provision. The problem that we have there, of course, is that we have a different master inasmuch as we report to the Commonwealth and the LHD reports to the State Government. That's why I think in small communities, where primary care is so important because they are the only providers of care—well, there's primary care and there's secondary care, but it's usually done by the same people. It's so important that we develop those services, moving forward. To do that, I think that's why we need to have a common paymaster, as you were, from both branches of government.

There are other players in this, as well, in local government who are very supportive of any innovation that can be brought in to try to enhance services at the local level. What I'd like to see more of is a local-based, local community-driven service, because quite often in the past I think all levels of government have been guilty of having thoughts about what our communities need and then it being imposed in a top-down way. I feel that, probably, we need to be looking at it in a completely different way and saying, "Well, let's ask the communities what they really need and what is important to them, and then try to provide that." Obviously, the bucket of money is not endless, and it has to be done in such a way that it is affordable. So we should be listening more to our communities, which is something I think that both the PHN and the LHDs are keen to do.

Ms JANELLE SAFFIN: Thank you, Dr Williams. That's music to my ears. I've worked in disaster recovery, so I know well.

Ms TRISH DOYLE: Thank you, Dr Williams, for being with us this afternoon and for pointing out the need for community-driven initiatives to be supported across the different bodies. In your view and from speaking with your colleagues, have there been any improvements in the past couple of years—any progress made on the recommendations that came out of the last report? Can you point to any, and where can we build on those? As you acknowledge, there's not an infinite bucket of money.

ROBIN WILLIAMS: I think there has been a lot of planning done, but I haven't seen any real boots on the ground or any real changes made as yet. I think that the problem with all of health planning—and that goes back to my days as chair of the LHD and now as chair of the PHN—is that to try to really get change, it takes such a long time to really move things forward. Part of the reason for that is that, quite often, when we're trying to make a whole-of-system change, there are so many key players that have to be brought in in order to bring the whole thing together that it's very difficult to get a consensus. By the time that you do get that movement moving forward, either there is a change of government at the federal level or there is one at the state level, or circumstances change, such as COVID-19.

Obviously this all means that we can't be nimble when we're looking at trying to plan services. That's why I feel that in my patch here in western New South Wales and Far West New South Wales, those smaller communities can be far more nimble in that you're only looking at a relatively small population, and a relatively small amount of money could make a huge difference if we were allowed to really develop a service locally. Instead of trying to reinvent the wheel for all of health throughout New South Wales, maybe we should be trying to do it at the areas which need it most. Our footprint of the PHN covers 53 per cent of the state, but we've only got 350,000 or 360,000 people. At an LGA level, some of those communities are only a few thousand people. A relatively small amount of money, on a global consideration, could make a huge difference to communities like that, which are facing very limited services. To do that, I think we have to take control of a failing market.

I think that primary care in more remote areas is certainly a failing market. I think that that area where the market is failing is encroaching closer and closer to metro areas as well. I always say that general practice primary care is a cheap solution to the problem because it's a lot more cost effective to do preventive care, to do good chronic disease management, to look at the social determinants of health and try to work from the bottom up, rather than waiting for somebody to need some hugely invasive cardiac or cardiothoracic surgery in a tertiary centre. That is why I think it's so important that we try to get some changes on the ground now. While I agree with just about everything in the report, it's trying to reorganise the whole system. Sometimes you've got to start slow and get some wins where they really matter. Where I think they really matter is where the morbidity and mortality rates are so high, and that's rural and remote.

Mr CLAYTON BARR: Dr Williams, I find myself here nodding my head all the time. It's like we're in a media conference and I'm standing behind you and you're making all the important announcements and I am just going "yes". I don't have any questions but I want to thank you for your service and thank you for your time and wisdom today.

Ms LIZA BUTLER: You said earlier that you have never seen the workforce so low in your whole career. What makes you think that community-driven and block funding will entice practitioners to go to regional and remote areas?

ROBIN WILLIAMS: Looking at my personal experience in Molong, we have registrars. We pay them a salary, a fixed rate. They are guaranteed what they earn. They don't have to worry about having a throughput of patients in order to pay for their mortgages at the end of the month. If they see more patients than that base level pays, they get paid that as extra. But we do that to take the pressure off them in order that they can study for their exams and get their fellowship, which is what being a registrar is really about. It shouldn't be looked upon as an answer to a workforce issue. A small community would probably accept a GP not there all the time if there was a good primary care team working in tandem with a shared medical record and with remote support. That could work very well. It doesn't have to be a GP-driven model; it's a team approach.

Again, when I talk to my allied health colleagues, they can't be certain that they're going to get the work. We need to have different models of care where people are allowed to work across different sites. Maybe there's co-working between practices, or between an LHD and a practice. That's why I think a unitary authority running primary care could say, "Right, we can guarantee your terms and conditions. We can guarantee your placement. We can guarantee your supervision and we can guarantee that support you really need as you develop your career. You don't have to put any investment in to go into work in a small town because the infrastructure is already there. It's owned by the entity—or the combination of the entity and local government—and you can come in, you can provide a service in a supported way and then, when you're ready to move on—or move back to the metro—you can do that." I think that is what's needed: that flexibility and support to give young graduates certainty that the experience they have—they'll not be left out to dry and be expected to do things that are beyond their capabilities. They can be nurtured.

Having seen that with my registrars, three of my registrars who have come through in Molong have returned as associates. Now, I know geography has helped that greatly, because they can live in Orange and it's only 35 kays away, so they haven't had to disrupt their private lives, their personal lives and their family lives. But the fact that they come back because they like the model of care, in which it's a team approach and it's an

integrated approach—that's the future. When I retire at the end of August from clinical care, they're going to take on this practice. They will run it the way they want to run it, obviously. I am going to step away. I'm not going to be hanging around like Banquo's ghost, saying, "This is the way I would've done this." I'm going to give them free rein. They will take over. But they are willing to do that, and I think that's because of the model of care, the support and the fact that it's not about a sausage factory—all about having a churn of patients—but providing holistic care. Again, that comes back to the finances.

Mrs LESLIE WILLIAMS: Thank you, Dr Williams, for sharing your insights with us today. I'm a bit like my colleague; I just find myself nodding my head. I actually know all about your integrated model of care at Molong. I've been out there and visited you. It just makes such perfect sense, particularly in more remote communities, to have placed-based models—let the community work out what's going to work best for them. The other thing I really like about it is the support that you're able to provide each other as colleagues, whether you're in the allied health space—so well done to you. It's great to hear it's all still going ahead. I want to ask you, though, about the single-employer model, which obviously was highlighted in the report. One of the report's recommendations was that they should expedite the implementation of the single-employer model. Have you seen any movement on that? Do you think there's any kind of impetus for that to actually happen?

ROBIN WILLIAMS: I haven't heard a great deal about it, other than I think the idea is a very good one, inasmuch as when registrars come out of the hospital system and go into GP land, they take a drop in income. When I talk to my registrars about that, I find that very strange. When I was training as a junior doctor a long time ago in the UK, I actually had an enhancement in my income when I became a GP registrar from being a junior hospital doctor. The idea that we move forward with transferring all the benefits et cetera to follow the clinician is a very good one. I haven't seen a huge amount of progress as yet but I think the idea of it is a very good one. Again, if we could enhance what GP registrars earn and not make it based on the individual remuneration packages of a practice, then I think that we'd find a few more takers for people going into general practice. A lot of them can't afford to do that because they can earn more as a CMO in an ED department than they could studying for their fellowship. That's part of the thing that we need to really address.

The CHAIR: We've created a workforce of locums around hospital jobs. The alternative of practice in primary care isn't attractive, but we have come across models of practices—in a couple of Aboriginal medical services, for example—which have been very attractive and have been able to sustain a workforce. But, as you say, Dr Williams, those models are not so much fee for service as a collaborative arrangement within a supportive organisational structure. That model is attractive and it's become an urgent item for us to tackle, to be honest.

I want to return, if I could, to your comments around the Commonwealth and state. The PHN has begun to work with the LHD. I picked up that you didn't think, at that level—let me put it this way: You commented that you had different masters and that that actually made collaboration in this area difficult. I think, from your earlier comments, you envisaged some sort of Commonwealth-state joint funding body for this work, which would not be asked to run primary care but perhaps to develop a pool of funds, perhaps out of state and MBS items, that might be available to communities to establish models of primary care that involve a range of health practitioners supported by virtual care and wouldn't depend on fee-for-service payments, for example, and could build up these attractive models of care. Have I understood your thoughts around that correctly?

ROBIN WILLIAMS: Yes, that's exactly right.

The CHAIR: That is quite a radical suggestion in terms of the healthcare system, I'd suggest.

ROBIN WILLIAMS: It's not as radical as not having any primary care in rural communities, which is what we're facing. We do need to have a radical rethink of healthcare funding in rural areas. If we don't do that, then what'll happen is there will be no primary care, which means that, in my area, the four hospitals of Dubbo, Orange, Bathurst and Broken Hill will have to deal with everything else if there is no primary care in the small communities. Everything will get sucked into those towns, and the problems of ramping of ambulances at those hospitals will be far worse because there will be no primary care.

At the PHN we've identified 37 small towns which are at risk in the next five to 10 years unless there is a fundamental change in the way primary care is delivered. Molong was one of those, which is why three years ago I started to plan for my retirement by actively recruiting and having a business model that was attractive to incoming young doctors. We need to be doing that in all the small communities, and if the communities can't do that—if the practices themselves can't do it—we need to move away from general practice being everything but an integrated primary care team approach to delivering service. If we do that then we can all work at the top of our scope and actually provide the care that our communities need. So, yes, it is radical but it's not as radical as the alternative, which is there is no primary care.

The CHAIR: In fact, it's actually urgent. I think you've made the comment—

ROBIN WILLIAMS: It's very urgent.

The CHAIR: It's never been as bad as you've seen it, and it's never been as bad as I've seen it, to be honest. I think I'd agree with you.

Mrs LESLIE WILLIAMS: Dr Williams, are you aware of any other smaller communities like Molong that have adopted a similar integrated approach?

ROBIN WILLIAMS: Not in our patch, but I know that there are different models around Australia where they are looking at different ways of doing things. It's not rocket science, what we are trying to do here. All we are trying to do is work collaboratively in a way that enhances care for our communities. It's taking a leap of faith away from the traditional model, but that's what I think we need and that's why we've tried to implement that. But the funding for here is still very traditional—Medical Benefits Schedule (MBS) for the general practice. I'd like us to move away to a blended system. In many ways maybe we are in a slightly blended system already inasmuch as Cabonne council, who own the building, are very supportive in providing the premises for us. They supported us in opening a surgery at Cudal and they've contributed towards the staff costs and also the computer costs.

NSW Health have provided us with two rooms in that building for free so that we could open up Cudal. I go to Yeoval once a week. UPA Yeoval have a nursing home there, so they are happy to subsidise the nursing and reception staff and also provide me with rooms, again, for nothing. It means that our margins are such that we're not losing money providing a service out to more remote communities. That's sort of leveraging locally with local players, and that's something that every community can do. When you look at a small community, all the people who live in this community have a vested interest to support provision of health care, and they're very open to helping us in that way. I think that is the way forward really.

Mrs LESLIE WILLIAMS: Agreed.

The CHAIR: I think, Dr Williams, you have described a model in which you've brought all those different players together, but I suspect you've brought those players together and that it's taken a lot of wrangling on your part and with your considerable expertise. I'd suggest that there aren't many communities that have a person with your knowledge of the different parts of the health system and your capacity to do that—what I call wrangling. Those communities need a way forward. It's all very well to—you could argue with local government, NSW Health and the Commonwealth to duplicate Robin Williams and put him in all these different communities, but that expertise isn't everywhere. I raise that because it is possible to do this but it does need, I think, Commonwealth and state to come together and agree on some funding that will make it easier for communities to access so that they don't have to do the wrangling at least so much. I guess that is by way of a comment.

ROBIN WILLIAMS: I certainly agree with that. That is probably where the PHN can come into the picture as commissioners of services, and we could probably help with that wrangling. When I retire from clinical practice at the end of August, I am going to stay on the PHN board and I will have more time to do more wrangling, I guess, in other communities.

The CHAIR: Dr Williams, thank you once again for that really important evidence, can I just say. It's really important for our work. Thank you very much. We may want to send you some questions, and your replies would form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

ROBIN WILLIAMS: Absolutely. It's been a great pleasure to talk to all of you.

The CHAIR: Thank you very much, Dr Williams. On that note, I will conclude our public hearing for today. I want to thank all the witnesses who have been here. I'd also like to thank the Committee members, Committee staff and Hansard for their assistance in the conduct of today's hearing. I wish everybody the best for the weekend. I ask Committee members to stay on while we finish our deliberative meeting.

(The witness withdrew.)

The Committee adjourned at 16:05.