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 Jubilee Room, Parliament House, Sydney, on Monday 3 June 2024

The Committee met at 9:00.

PRESENT

Dr Joe McGirr, (Chair)

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, and 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 recommendations relating to the delivery of specific health services of specialist care in remote, rural and regional New South Wales. I am Dr Joe McGirr, member for Wagga Wagga, Chair of the Committee.

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 the 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.

Dr TONY SARA, Secretary, Australian Salaried Medical Officers' Federation NSW, sworn and examined

Dr MICHELLE MOYLE, Assistant Secretary/Treasurer, Australian Salaried Medical Officers' Federation NSW, sworn and examined

Mr IAN LISSER, Manager of Industrial Services and Senior Industrial Officer, Australian Salaried Medical Officers' Federation NSW, affirmed and examined

Professor PETER O'MARA, Chair, Rural Doctors Network, before the Committee via videoconference, sworn and examined

Mr RICHARD COLBRAN, Chief Executive Officer, Rural Doctors Network, sworn and examined

Mr MIKE EDWARDS, Chief Operating Officer, Rural Doctors Network, sworn and examined

Dr LILACH LEIBENSON, Obstetrician and Gynaecologist, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, affirmed and examined

The CHAIR: I welcome our next witnesses. Please be aware that staff will be taking photos throughout the hearing. If you have any concerns, please let us know. Can you each please confirm that you have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses? Yes, everyone is nodding. Would any of the witnesses like to make an opening statement on behalf of each organisation, limited to a maximum of two minutes, before we commence questions? I will start with ASMOF.

TONY SARA: My colleague Dr Moyle has prepared a two-minute statement.

MICHELLE MOYLE: Thank you for the opportunity to speak to this Committee. ASMOF's submission clearly articulates in our conclusion the strategies that we think are of most importance in improving health outcomes in our rural, remote and regional communities. We feel very strongly that, in order to improve health outcomes, we need to actually develop a strategy that is both sustainable and collaborative in the long term, and we need to address the root causes of the workforce shortages and equitable access to health care. NSW Health needs significant award reform for staff specialists across the board to ensure both recruitment and retention of staff, but nowhere is this more needed than in the rural, remote and regional areas.

Attracting doctors with these specialist skills to these areas has become extremely problematic. If we don't improve remuneration and working conditions—our biggest problem at the moment is actually getting those who are already there to stay. Burnout is rife. Fly-in, fly-out locums are very expensive, although they do provide some relief for those who are spending vast amounts of time in the hospitals, and the New South Wales Government needs to show the doctors in these areas that they are actually valued. We need to support them to do their jobs, ensuring access to the basics of health care, such as pathology services and referral pathways, where they can both seek advice for their patients and also refer onwards. Just getting the patients to those higher centres is also rather problematic at the moment.

For this to continue and be long-term sustainable, there needs to be investment in training pathways. We need to establish dedicated, funded positions in regional and metro areas for young doctors with an interest in rural practice to both obtain and to maintain their specialist skills. They need to feel equipped and comfortable in providing medical care to their communities. We don't think the wheel needs to be reinvented. Queensland and Western Australia already have strategies in place for rural generalist training, which have addressed some of the workforce shortages in those remote areas in those States. Equitable access to specialist services does remain a problem and collaborative approaches are essential, with outreach programs and telehealth initiatives offering some hope but not the complete solution. In summary, I think health outcomes should not be determined by postcode.

RICHARD COLBRAN: Thank you for the chance to be here today. Further to the Rural Doctors Network's submission on 26 April for this tranche of the inquiry, I would like to acknowledge the information provided in that submission. This morning I would like to acknowledge our chair, Professor Peter O'Mara, who is online—a proud Wiradjuri man and GP, who has worked tirelessly across rural New South Wales and for rural Australia over many years—and also our chief operating officer, Mike Edwards. I would like to acknowledge the traditional lands that we meet on today and think about the week that has just been, with National Reconciliation Week. As we start to think about access to services, which is the key part of today's meeting, I would also like to think about the impacts of racism and also colonisation on access of our First Nations peoples to health services.

Today, to support the submission that we've made, we've prepared specifically with very direct and specific evidence around three or four critical components of the work that RDN is involved in. The first is our

methodologies for collaboration and support of integrated care models across rural New South Wales and beyond; secondly, specifically, the Collaborative Care Program for rural and remote communities, which has been jointly funded by the Australian and New South Wales governments[1]; thirdly, also the Health Access Services coordinated by RDN, which delivers over 1,200 clinics to rural New South Wales communities per annum; and then, finally, also evidence relating to workforce support initiatives that help sustain attraction, recruitment and retention initiatives. RDN is very appreciative of the chance to be here again today and to support the thinking that goes into the sustained, multigenerational and probably decades-long necessary work which is required to enhance the services to rural New South Wales.

The CHAIR: Dr Leibenson?

LILACH LEIBENSON: Esteemed Committee members, I am an obstetrician and gynaecologist. I am a senior Visiting Medical Officer (VMO) at Tamworth Rural Referral Hospital and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, RANZCOG, representative for rural and remote New South Wales. Born in Israel and gaining medical and specialist O and G training there, I've been in Australia for 13 years. Twelve of those years have been spent in rural Australia—about eight in Tamworth, New South Wales. I am married to an orthopaedic surgeon and I am a mother of three children. I am a naturalised Australian and grateful to Australia for welcoming us here. I love living in rural Australia, where I see my present and future. I am honoured to be invited to attend this hearing as a representative of RANZCOG.

As a specialist working in rural New South Wales for many years, I have concerns about the current state of affairs in obstetrics and gynaecology in rural New South Wales. In preparation for this hearing, I have been in deep discussion with senior clinicians, particularly gynaecologists, obstetricians, midwives and others in Tamworth. If allowed, I am happy to share our experience in north-west New South Wales as an example of the state of maternity and obstetric services in rural and remote New South Wales. I should also emphasise some suggestions for solutions. I have prepared copies for the Committee, so if time does not allow I'm happy to provide written notes.

The CHAIR: I indicate to the witnesses who are appearing that we have a number of areas that we're looking at in this inquiry, but in particular we are concerned around maternity and obstetric services and around primary care. The situation with primary care we believe is in crisis, and we don't think maternity service is very far behind. There are other aspects of service delivery that I understand you may wish to comment on today: palliative care, Aboriginal medical services, mental health services, and drug and alcohol, for example. We will come to that, but I want to indicate that we will start looking at maternity and obstetric services, training pathways and models around primary care.

I am going to start by asking Dr Leibenson and the representatives from ASMOF for a reflection on the situation in regard to maternity care. The Committee in its travels and in the evidence is extremely concerned that despite advocacy over a number of years for the retention and increase of obstetric and maternity services in rural and regional New South Wales, we seem to be seeing a continuing decline, particularly in terms of specialist workforce. I'm interested in the comments of both ASMOF and Dr Leibenson from the college of obstetricians and gynaecologists about that situation and what might be done to address it. I might start with Dr Leibenson.

LILACH LEIBENSON: We have seen significant decline. Though I speak for RANZCOG, I would like to mention that we see a similar situation also with midwifery and nursing. I think COVID has caused significant harm to the system, which was already broken prior. But, at the moment, as an example, in Tamworth we see a 58 per cent deficit in the midwifery staffing for the current activity. We see 50 per cent of the on-call at a consultant level and registrar level covered by locums. As an example, in regard to midwifery, it is expected that by September there will be a 64 per cent deficit in midwifery staffing. We are talking about a hospital that cares for most of north-west New South Wales. I have prepared a map as well that I will hand to people afterwards, but we have five smaller maternity units that are closed or partially, on-and-off closed most times, with two of them that should be directed towards Armidale Hospital.

Armidale at the moment is fully covered by locum consultants, which means that those patients will often be on bypass, which means that those patients will very commonly go to Tamworth. That means that we have patients driving for four hours, sometimes in their own car, to get to Tamworth. If they had access to an ambulance, that is fantastic. We need to also take the time that it takes to arrange an ambulance, as well as the fact that if the

[1] The Committee received correspondence from Dr Colbran providing clarification on this statement, which is published on the Committee's webpage.

one ambulance that is caring for the town is now taking a woman to Tamworth, there will be no ambulance available for other emergency services. The situation is dire.

The CHAIR: I will come back to ASMOF, but as a follow-up, Dr Leibenson, I am interested—the college of obstetricians and gynaecologists trains specialist obstetricians in New South Wales and Australia. Is there a training program designed to graduate practitioners for rural practice within the college? How many practitioners from that program in the last decade, say, have taken up rural specialist practice?

LILACH LEIBENSON: There is a program. With apologies, I will take on notice to answer how many have actually finished this program. My own understanding is not enough. Even with those doctors, we have problems of simple things. For example, if a registrar that is trained in Dubbo goes to Sydney, they need to arrange their own accommodation et cetera. So we see a lack of support in those aspects as well. I have partially answered your question, and I am happy to go back to that on notice.

The CHAIR: Dr Leibenson, I'm interested in details of the training program and how many training positions there are in rural and regional areas, and then how many graduates from the college have taken up practice in the last decade, because the college is the source of specialist practice. You've highlighted the issues with locum cover in the north-west, and we visited Armidale and heard this. Correct me if I'm wrong, but providing cover from locum obstetricians—entirely or partly—is a significant departure from continuity of care, is it not?

LILACH LEIBENSON: Of course, yes.

The CHAIR: And the consequences of that can be quite serious and not good for women?

LILACH LEIBENSON: Very, very serious. Also, we need to remember that for many of those smaller units, if they rely on a locum that does not attend at the last minute, that puts even more pressure on the consultant, the GP obstetrician or the specialist in this town that cannot attend, for example, the once-a-year leave that they're attending, and so on. This is a very unsafe practice that does not provide the needs—neither for the carers, nor for the patients.

The CHAIR: Professor O'Mara, I realise you have your hand up. With your permission, I am going to ask ASMOF to comment first and then I will come back to you. Dr Sara or Dr Moyle?

TONY SARA: Our submission goes into this in some detail, but essentially there's been no real change. It's still extremely difficult for our members who are providing O and G services. The college has made a number of points that we've repeated in our submission, but it's grossly insufficient. It doesn't work. It's really hard on the people there. They burn out quickly. I don't know what else to say. Dr Moyle may have something else to add.

MICHELLE MOYLE: In discussion with some members in rural communities, one which feeds into Tamworth, in fact—at this centre there's a small centre that provides obstetric services: one obstetrician and one anaesthetist—both are rural generalists in training—and one midwife in this particular centre. On the weekend just gone, both the obstetrician and anaesthetist had COVID and were unable to provide services—this is not an unusual thing—and there was no cover at all for that particular hospital. Patients within that area would have to travel the 200 to 300 kilometres to Tamworth or Moree, which, again, also have the same issues of workforce accessibility. One of the issues that that member raised, which was of particular concern to me, was that the pathology services in his local hospital are being removed offsite in the coming week or two and that the fallback for that was the point-of-care testing, which I am sure Dr Leibenson is much more capable of speaking to as to the importance of it with maternity care. But these are very basic essential services that are no longer available to the doctors who are actually in the centres trying to provide care.

The CHAIR: Dr Sara, Dr Moyle, I appreciate your statements there. The follow-up from me is this is clearly a problem that hasn't improved. We rely on a rural generalist training program to provide the necessary workforce, but the local health districts seem to struggle to provide these services. I put it to you that there almost needs to be a statewide approach to address this issue in rural and regional areas, that the local health districts themselves are struggling—perhaps through no fault of their own—to address recruitment and retention issues in this area. Would you like to offer any observations to that? I'll come back to you, Dr Leibenson.

MICHELLE MOYLE: The rural generalist that I spoke to has been in his centre for four years on a locum contract. His thoughts were that he'd prefer to be salaried. He would prefer to be paid for the services that he's delivering, which are, in essence, specialist services. Unless the conditions of both pay and the ability to tap back into other centres for updating of specialist skills were provided, he felt that his care was only going to deteriorate over the years. He came from Queensland, originally, where they have a rural generalist program.

He stated that there are about 60 rural generalists in the pipeline who have either finished or are within the three-year program that allows them to go out and practise in the rural centres, compared to New South Wales where there are about four people in those positions. He said there are people in Queensland who would like to

come to New South Wales but the structure is that pay and conditions are nowhere near as good as Queensland. In fact, WA have, apparently, better conditions. In Queensland those doctors are given a salary, they are on permanent contracts and they get access to appropriate leave to go to major centres to update their skills on a regular basis. That's the input that I've had from the members.

The CHAIR: That's assisted with significant statewide oversight and a decade of significant effort to make sure that services were preserved and enhanced.

MICHELLE MOYLE: Correct.

The CHAIR: Dr Leibenson, I know you wanted to say something. Professor O'Mara has had his hand up and we do need to pass to the rest of the Committee for questions so, Professor O'Mara, you first.

PETER O'MARA: I just want to say that part of the increased workload on our RANZCOG colleagues is the reduction in number of GP obstetricians throughout New South Wales. I'll give you a typical example of a little town that I used to work in of 2½ thousand people. There were about five GP obstetricians working there and they felt like the volume of deliveries they were doing wasn't enough to keep skills up and certainly wasn't enough to cover litigation if something went wrong. As a result, four of those dropped out and left that workload to one person, who is now carrying the load. I think that's part of the challenge. So, for me, that would be about GP obstetricians, and ongoing training, upskilling and support.

LILACH LEIBENSON: If I can just state that in relation to the options to actually push specialists into rural Australia, I think there will be no choice but to actually review many things. One of them is to review the remuneration and not to hide behind the fact that the award is so-and-so. Then we need to improve the actual—please forgive my language. We need to improve the conditions. For example, in Tamworth a 24/7 child care for all practitioners, midwives, nurses and doctors would be life changing. There needs to be a significant change to the way we pay nurses and midwives, and also talking about FIFO and agency wages. I think without actual change, significant change, we would be able to train lovely consultants but we would not be able to push them to go to rural Australia.

Ms JANELLE SAFFIN: My question is to you, Mr Colbran. It's to do with the Collaborative Care Model. Our community is interested in that because, from what we understand, it speaks to a lot of the recommendations in general and the implementation of them. Could you add a bit more about how it works?

RICHARD COLBRAN: Collaborative Care was built about five or six years ago using evidence from about 35 years of practice, not just by RDN but the whole of the health system in rural New South Wales. It was the aggregation of knowledge in relation to what we call team-based and town-based approaches but looking more at the subregional idea, particularly thinking about how to integrate the primary healthcare system with the local health district system as well. There's method behind it, which is explained in our submission. I thought today I'd ask Mr Edwards to speak to—we have five trial sites that have been operational since 2020. Those evaluations are now available, as I said, funded through the Australian and New South Wales governments.[2] We're now in a privileged position to have specific data about the benefits that they've created. Mr Edwards is going to provide you with some specific examples, if that's okay.

MIKE EDWARDS: As Mr Colbran mentioned, the five sites—which were across New South Wales over the last three or four years—all had individual characteristics which were important that were identified by those communities and also looked to leverage the strengths of what already existed in communities. It's a very important part of Collaborative Care, in terms of coming from a strength-based approach. The first model I will briefly talk about is the GP-led deliberate team-based care model, the DTBC model. That model is predominantly operating out of Canowindra looking after a cohort of approximately 160 or 170 patients over the last five years.

It was a combination of care that was led by the GP with local health district staff, allied health staff, nursing staff, paramedic staff and also pharmacy staff, so roughly around 12 different individuals. It was built on a case conferencing approach that looked to support the ageing cohort of Canowindra and the regional communities in the efforts of keeping them out of hospital for preventive or emergency department care. The evidence provided estimated it saved the system approximately $1 million over the course of five years in supporting those patients through that care.

[2] The Committee received correspondence from Dr Colbran providing clarification on these statements, which is published on the Committee's webpage.

Another model of interest would be the model that was LHD led. This model looked to bring together five towns where GPs that may have been in there for the last 30 years[3], in terms of care, have either retired or moved on and we haven't been able to find a replacement GP, particularly for those really small towns that are within half an hour of each other. The LHD-led model looked to take the COAG 19 (2) exemption and a single employment approach for rural generalists and looked to centralise the care, both physically and virtually, in a shared approach across those five towns to address that.

The program has seen success in not only building the capacity in terms of attraction and retention but also in reducing the ED presentations in those particular areas for non-urgent care, and also looking to support strengthening the supervision for the area, which is a very key component of all of the items that we need to look at today because it's not only addressing the workforce in terms of attraction, it's actually the supervision workforce that we really need to make sure we strengthen and preserve over the course of the next five to 10 years. I could go into other models but that is an example of a couple, and we can provide written evidence.

Ms TRISH DOYLE: Thank you all for your work and for being here today and speaking to the importance of this Committee, which is looking at the recommendations that came out of the previous Committee. I'm going to direct this to the Rural Doctors Network. Recommendation 30 from the previous Committee's work concerned the use of telehealth and virtual care to supplement face-to-face services. I'm wondering whether you could comment on the implementation of NSW Health's virtual care strategy.

RICHARD COLBRAN: I'll take the answer to that. RDN has worked for at least the past 15 to 20 years with a particular interest in the notion of the use of technology in the provision of service and supporting the health system as well. We feel, in today's world, you need to be able to encourage and support best practice and evidence-based practice in terms of technology services. The way that the RDN membership thinks about the design of service models and workforce models with the use of technology is to see it as being complementary to face-to-face service and locally built workforce. It should not be seen as a replacement tool in any way.

However, one of the things that we have come to learn is that very well constructed telehealth services can form part of the retention strategy for those staff that exist in rural communities. With the way the health system is moving now, the ability to tap into expertise or professional support through the technology systems and onsite add a lot of value. We're seeing from a lot of people who are well experienced in rural practice that the ability to patch in to colleagues and peers through technology—not necessarily in Sydney but in other rural communities that understand rural practice—is a key part of retention as well.

Ms TRISH DOYLE: Further to that, there's quite a bit happening in the space with paramedics and ambulance around telehealth and virtual care. How has the supplementary model informed what we're looking at, at the moment, with paramedicine working-in with you?

RICHARD COLBRAN: I'll be careful here because I don't have specific experience in dealing with paramedicine on the ground. However, the key piece of information we hear back from our colleagues is the notion of interoperability. That idea of integration of systems and file notes and the rest to make sure that there's continuity of practice, particularly in that emergency scenario, is very important. I know the system is looking at that and continues to see it as being very important. RDN would encourage that.

Ms TRISH DOYLE: Excellent. That is what we need noted.

Ms LIZA BUTLER: Mr Colbran, you're getting a lot of questions today. In your opening statement, you mentioned health care for First Nations people. Have you seen any improvements of services provided for Aboriginal mothers and infants in terms of maternity care, obstetrics and paediatrics?

RICHARD COLBRAN: If I may, I will answer very briefly, and then I will hand to Professor O'Mara, who has specific experience here. One of the things that we know is very important in considering Aboriginal and Torres Strait Islander health is the notion of supporting the Aboriginal community-controlled health sector. Not all services are delivered through the ACCHO sector but, at the same time, the notion of providing safe and culturally responsive care in local communities and that are tailored to that community is absolutely critical. It's often overlooked in terms of the way services are designed and the way that workforces are developed. That is a critical part.

One of the case studies that Mr Edwards will be getting to shortly relates to the Collaborative Care Program in Wentworth—the local government down on the south-west border of New South Wales. That's where the local

[3] The Committee received correspondence from Dr Colbran providing clarification on these statements, which is published on the Committee's webpage.

community, including the local health district, has got behind the Aboriginal community-controlled service there, Coomealla, to deliver the general practice and primary healthcare service on behalf of the system. All of the players have got behind that organisation, which has led to significant recruitment in that area, which had a dearth of GPs and other health professionals at some point. That's a very significant part of the story about the idea of collaborating together. If I may, I might throw to Professor O'Mara, who, on top of the question that you've got, has a very important example around workforce training out of his experiences at the University of Newcastle.

PETER O'MARA: I want to start by saying that when we get it right for Aboriginal people, those models can be applied across the country and improve the health outcomes for everyone. On average, Aboriginal and Torres Strait Islander babies are 200 grams lighter than the rest of the population. If you subscribe to the Barker hypothesis, that low birth weight babies are more likely to have significant cardiovascular outcomes as adults, cardiovascular death is the biggest cause of death amongst Aboriginal and Torres Strait Islander people, so it's really important to correct that.

What we have seen over time is that when we engage community in the right way and with proper consultation, that community can get their needs met in terms of maternal services. Out of the Aboriginal communities across the country where I have seen this happen, we're easily able to turn those birth weights around and improve outcomes for the baby, the mother, the family and the community, with proper consultation. It's not necessarily about having specialists at the end; it's all that stuff beforehand that makes a significant difference.

Ms LIZA BUTLER: Can I ask another question? We know that Waminda, in Nowra on the South Coast, is leading the way on birthing on country. Are we seeing that rolled out anywhere else in New South Wales?

MIKE EDWARDS: Not to the extent, I believe, that Waminda is. As part of the Waminda story, we partnered with Waminda, with Waminda leading, many years ago, around developing health access solutions for their community. They identified women's health and children's health as their number one priority. In combination with themselves, the community, the local health district, the primary care and us as well, we looked to create a solution to lever the system levers that were available to then support their long-term vision. That's a very important part of this. As Professor O'Mara said, if we lead or take their examples and actually support that through the system available, we do find solutions. However, they're long-term solutions. Quite often we find that pilots and initiatives put in place are only looking for two- or three-year solutions. Waminda's vision is for 10 or 20 years in terms of vision solution.

Ms LIZA BUTLER: Are we actually documenting what Waminda is doing so that we can blueprint that for other communities?

MIKE EDWARDS: I believe Waminda is doing some documentation around that. We could provide some information offline, if you would like.

Ms LIZA BUTLER: Thank you.

Mrs TANYA THOMPSON: My question is for both Dr Leibenson and ASMOF in relation to the obstetrics and gynaecology map. I wanted to know if you could pinpoint which areas of New South Wales are facing the most critical shortages of obstetrics at the moment.

TONY SARA: I think we should ask the college, since they did the map.

LILACH LEIBENSON: I would take the question offline, please. But the area where I live, which is north-west New South Wales, is under huge pressure. I am also aware of Orange, Dubbo and west of them as well.

The CHAIR: Dr Leibenson, where I come from, many of our specialists aren't college graduates. They actually come from overseas. You have indicated some other areas of deficit and, of course, your own region. Are you aware of any ongoing work between your college and the New South Wales health department in relation to training positions or initiatives to fill gaps in specialist obstetric workforce?

LILACH LEIBENSON: My understanding is that training is very good but that the problem is we're not able to then recruit and retain people to rural Australia because of the deficits in everything that we talked about. The workload in rural Australia, stress levels et cetera are not allowing for people to actually want to come. We know that there are, in a way, too many trainees that are staying in metropolitan compared to not enough in rural Australia.

Ms TRISH DOYLE: We've had a bit of fun in previous public hearings with this question: Imagine that, instead of the Committee, you had the Treasurer, the Premier and the health Minister, and each organisation was asked to identify one initiative or one change that would make some difference right now, and you could determine that; what would it be?

TONY SARA: Our position is fairly clear. It has been clear for some years. Significant award reform is required. It's 25 per cent more money to go to Queensland or Victoria. The colleagues in Queensland perceive they're better valued. They don't feel that they're at the end of the queue for everything. Our submission makes it quite clear that that's worse in the bush than it is in the country. There are a number of groups under significant pressure in New South Wales—the intensivist anaesthetists at Sydney Children's, Westmead. The psychiatrists are in crisis, and that has partly made it to the press. It's significant award reform. It's not clear to me that it will happen, but if we had them there—we've already said that to the health Minister and the Minister for Mental Health. I said it to the entire front bench of the Labor Party before the election: This is what's required. So our public position is fairly clear.

PETER O'MARA: I'll just make a brief comment, up-front. If we're talking about the medical workforce across rural, regional and remote New South Wales, the one thing that I would do is ensure that we're picking the right people to represent the communities that need representation, who go into medical schools. At this end, the problem is at the other end and we're going to see more of this over time. We need to choose the right people for medical schools who want to have a career in rural health.

LILACH LEIBENSON: I second the remark about the total change of the award and also what Professor O'Mara has stated. At the moment children in rural Australia are disadvantaged when they apply to medical schools. They have been made to go rural, including some of them being prevented from being allowed to attend metropolitan rotations. That is all in a way to push them into rural Australia. The way to push medical students into going to rural Australia is to take the kids that are already in rural Australia and allow them to come back home. But make sure that the training process up to then is especially good for them so they will come back home as fantastic doctors who care for the environment that they grew in.

RICHARD COLBRAN: Would you mind if I add one extra point? From our experiences as the Rural Doctors Network, we believe that potentially one of the most important investment areas is in relation to evidence-based coordination to integrate the Federal and State systems. We have demonstrated evidence now which shows that, when you can coordinate and bring people together and manage and design things, not for short-term pilots but for five- or 10-year thinking, you are able to build things that people will come to and build systems that end up paying back. We would recommend that be considered.

Ms LIZA BUTLER: I'm not sure if you've mentioned it, but my question is about losing GP obstetricians from small towns and then providing ongoing upskilling and training for GP obstetricians. Is there a reluctance from the area health services to provide that upskilling? What is the problem there?

LILACH LEIBENSON: This is an extremely professionally dangerous profession. At the moment, most doctors would not want this lifestyle of being committed to one small town for the rest of their lives without being able to take leave, when each and every mistake would cost them their licence. People are not wanting to go this way. We have lovely GP obstetricians. They would be happy to sit in antenatal clinics, but they would not be happy to do the on-call when you have limited exposure. Because of that limited experience as well as the lack of support, some GPs are actually—one of my suggestions for assisting in that is to allow GPs that are credentialed in one hospital to be credentialed to the whole area. The other thing is to help them gain skills and reassurance. But this is an extremely difficult, hard and dangerous medical profession, legally, so we need to understand that as well.

The CHAIR: Dr Sara, you mentioned the situation with psychiatrists just then. You made a comment about psychiatry. One of the special areas that we're looking at is mental health services. I wonder if you might elaborate on your reflections in regard to the psychiatry workforce.

TONY SARA: Psychiatry has long been an orphan of the medical profession in the big hospitals. It's far less worrisome and far less medico-legally difficult to go into private practice. Being on call and being asked, when there are not enough beds, to discharge people who may be suicidal is risky, politically and professionally. If you can make significantly more money in other States and in the private sector, then it's really difficult to be a staff specialist psychiatrist. There's very little right to private practice, so you can't do anything about increasing your income.

It has been in the press in the past few weeks—Natasha Robinson in *The Australian* and someone in the Herald. There is a significant deficit—there are large numbers of vacancies. I don't want to appear to be inflammatory about this, but there are numbers in the article, I think, that are something like 60 to 70 vacancies, as a minimum, out of 400 positions. So at least one-sixth or one-fifth of the workforce positions in staff specialist psychiatry are empty. There are large numbers of positions filled by VMOs and locums at extremely high cost. My sense is that unless something happens in the next few months, this meltdown will continue. The college is engaged with the two Ministers. ASMOF and AMA co-signed a joint letter to the two Ministers. There have been

ongoing meetings. It's not clear what the outcome is going to be, but the psychiatry workforce is in crisis in New South Wales.

The CHAIR: You've pointed to the need for award reform, but you've also alluded to issues around contracts, time for recruitment and culture. I take your points about award reform. Both you and Dr Moyle have referred to issues around psychiatry, maternity and rural generalist practice. Leaving aside award reform—take it as a given that there needs to be a substantial work there—are there other factors in the system that also need to be addressed?

TONY SARA: One particularly for mental health is on-call. One of my colleagues is a child and adolescent psychiatrist north of the harbour. If he's on call for a weekend, he may get five, 10, 15 or 20 calls because he's providing an on-call service for other parts of New South Wales. One of the proposals put up by the college was to have a single statewide on-call roster for adult psychiatry to make it less onerous. Some VMOs do not like to do on-call in psychiatry because it's risky. Some of the districts, in contracts to put on VMOs in place of staff specialists, draft, "Do not ask them to do that on call." That is something the college has put forward.

Increasing the number of junior doctors in the space is something that colleges also asked for. That is probably going to be addressed by the ministry in the next couple of months. It's really difficult to do teaching research support of trainees if you're so busy seeing patients that you can't do anything else. In New South Wales this year there was an undersubscription of young doctors going into psychiatry. In Victoria and Queensland there was an oversubscription. More people applied than there were positions. In New South Wales there were less applicants than positions because they perceive that if they want to specialise in psychiatry, they're not going to be given the support, supervision and training that they need, because everyone is working so hard seeing patients. There are not enough beds. It won't be long before beds will start to close. It's about our terms and conditions, it's about support of management and it's about being perceived as being valued. Some lay managers don't understand what psychiatrists do. There's a whole lot of factors. Dr Moyle, is there anything else you'd like to add?

MICHELLE MOYLE: No, I'd just like to reiterate the importance of support networks for all healthcare workers in the bush. Some of the feedback we've had from our members is that being able to attend updates for their own clinical skills in other places is fraught because there just aren't the numbers on the ground in the centres that they're in to continue to provide a service. One of our members was on call for a weekend where he had a very sick patient with an acute leukaemia present and a life-threatening emergency referral to a bigger centre was required. The patient wasn't able to get there because it took two days to get a flight organised because there were no pilots available.

I think that there are shortages across the board, in all sorts of ancillary services, that affect the ability of those doctors who are providing care in those remote centres to get their patients to appropriate centres. Why would you go to the bush when there are plenty of positions in metro areas and plenty of others to help you and support you with clinical decision-making? Why would you go to the bush where you're a lone wolf and making life-threatening decisions on a daily basis with no immediate help available to help you make those decisions?

The CHAIR: I just want to make a couple of observations and get feedback from the witnesses. Essentially, what we've heard of is a system in terms of healthcare staff and particularly primary care, obstetrics and now psychiatry that has relied on an old model of recruitment and retention and old systems of payment that are no longer working and that are not attractive to current graduates. We don't have training programs that seem to be providing the graduates who want to go into rural and remote areas, and we're not providing an environment in those areas that's attractive to new graduates. Clearly, as Professor O'Mara pointed out, an approach to this starts with recruiting people into medical training. But it also relates to how they're trained, where they're trained, where they undertake placements in their first postgraduate years and the necessity for exposure to general practice. It relates to the need to provide models of care that are attractive. That involves not just remuneration but also, as Dr Moyle pointed out, systems of support.

It seems to me that we're talking about rethinking our approach, particularly in primary care and perhaps also in obstetrics. We have relied on an approach that basically gets one or two doctors to a town, and they go on call 24/7 and look after the town. I am not sure that that model is sustainable going forward. Mr Colbran, Professor O'Mara and Mr Edwards, you've outlined today a changed model which involves a different method of remunerating general practitioners; that focuses on recognition, at an appropriate level, of their specialist skills around chronic care and their subspecialty areas; that is supported by a primary care workforce and other disciplines outside of medicine working at the top of their scope of practice in a collaborative way; and that might provide career pathways that are attractive and, on the evidence you've provided, can provide effective care. Firstly, I want to check the thinking with witnesses on that approach.

Secondly—and you alluded to this, Mr Colbran, and it's a very important issue—is the need for Commonwealth and state collaboration. It seems to me that, at the moment, there is no-one looking after primary

care as an entity in rural and regional areas. It's been left to fall between Commonwealth and State. Unless someone takes control of it, it won't actually build up again. A similar point in relation to obstetrics services, and perhaps the same is true of psychiatry, is that unless the state takes a leadership role, the local health districts will continue to struggle to provide those services locally. In other words, these are two areas of crisis that need a coordinated high-level approach. Can I put that forward for comments from the witnesses, please? I guess that was a bit of a stump speech from me, but it's certainly a bit of the thinking that the Committee is beginning to wrestle with. I might start with you, Mr Colbran.

RICHARD COLBRAN: This is a very important point. The notion of where the cracks are, or where things are falling through, and the idea of coordination is absolutely essential at the moment—to be thinking about how to resolve these issues, not just for one or two years but for the next generation as you referred to a few times today. I think it's very important to acknowledge that there is not one person that we've ever met working in the health system, whether in the State Government, Federal Government or on the ground, who isn't turning up to give their best effort. The notion here is actually around how to bring the best of us together to get a great solution, and I would just like to reinforce that. This system is in crisis but there are people who are working very, very hard 24/7 to give their best to whatever role they're in.

A critical part here that should be acknowledged around the workforce is that recently the New South Wales Government has entered into workforce incentive structures for the staff, and we acknowledge and thank them for that. There are some observations around that and the wording and how prioritisation is given generally—not just from the New South Wales Government but also the Federal Government—and it relates to the word "regional". For us at RDN, we work off three very distinct geographical areas—being remote, rural and regional—and they're different. They need to be seen as being different, and funding schemes and programs should be seen differently to that.

Second of all, there's a huge amount of work and talk at the moment about people working at top of scope—highly trained assets for the nation, being health professionals of all different craft groups, being able to work at their top of scope. An area at the moment that we think should be paid attention to is that it's not just about the pharmacist or the physio or the allied health worker working at top of scope; it's also about enabling the doctor to work at top of scope. Working through models of care that allow them to be at their best and not be caught up in administrative duties and other things—we think that's quite important.

The final point here, if I may, is there is a lot of conversation at the moment around how our system is constructed—whether it's metro-based people designing a system which then influences rural communities. There's conversation at the moment and papers being written around the notion of rural proofing our health policies and our health construct. RDN is researching at the moment—and we'd be happy to bring this back as well—forgoing the notion of rural proofing, which is a defensive strategy, to actually having rural for rural policy: rural design by rural for rural. Understanding the nature of the remote, the rural and the regional sector is very important and not to have metro dropping things onto rural design. That will be something that you will hear more from us in the coming months.

TONY SARA: I'd like to pick up on the section 19 (2) exemption that was raised by my colleagues to my right. Section 51 (xxiiiA) of the Constitution provides a very strong fault line between Commonwealth and State. I think that it's been brought to our attention that it is particularly the case in small rural communities where you've got a GP who can make enough money from fee-for-service to support his family and have some GP VMO work—and that's great. But if there is not enough work there for them to maintain an income and support their family, then a section 19 (2) exemption might be a way to go. That allows for an employee of the New South Wales public health system to bill Medicare. The exemption has been sought and gained in respect to the single employer model—registrars in Murrumbidgee, Queensland, South Australia and Tasmania.

I think in our previous submission, we did sort of say that where fee-for-service GP VMO models are not sustainable, serious consideration needs to be given to a salary model of employment by the state and with the resources of the state—the allied health and the other facilities that are not available easily to a general practitioner in private practice. If the rights of private practice don't provide sufficient income—and our current submission actually makes the point that there is much less private health insurance in the bush. Therefore there is another inequity to working in the bush: the rights of private practice don't lift your income by enough to make it reasonable. So perhaps a model of GPs employed by the State, with a section 19 (2) exemption, with the resources and the integrated model of care that our colleagues at RDN have talked about—perhaps that's something that needs serious consideration in the bush.

The CHAIR: Thanks, Dr Sara. Dr Leibenson, any reflections?

LILACH LEIBENSON: If I could add, for example, from Tamworth, our services of midwifery group practice and home midwifery services post-delivery have actually both been suspended due to the lack of staff to

supervise those practices. We need to understand that in obstetrics and midwifery, most things cannot be done via telehealth. I am appreciative of the incentives that have been granted. But I am aware that, for example, for Tamworth, with a 58 per cent deficit in midwifery staffing, a request to actually increase the incentive for the top 20 grant was declined, which means that the couple of midwives that are still there, doing double shifts and onerous hours, would actually leave because they are not seen. I think even the system of regional, rural and remote needs to be considered very carefully so as not to disadvantage the units that we still have.

The CHAIR: Thank you very much, everybody, for appearing before the Committee today. We may send you some further questions in writing, and your replies will form part of your evidence and will be made public. Would you be happy to provide a written reply to further questions?

MICHELLE MOYLE: Yes.

TONY SARA: Yes.

IAN LISSER: Yes.

MIKE EDWARDS: Yes.

RICHARD COLBRAN: Yes.

LILACH LEIBENSON: Yes.

PETER O'MARA: Yes.

The CHAIR: Dr Leibenson, we're particularly seeking some further information that we'll follow up with you on. I thank everybody very much for appearing today. It has been incredibly helpful to the Committee, and I appreciate you taking your time to do that.

(The witnesses withdrew.)

Ms FIONA DAVIES, Chief Executive Officer, Australian Medical Association, New South Wales, affirmed and examined

Dr RACHEL CHRISTMAS, President, Rural Doctors' Association NSW, before the Committee via videoconference, affirmed and examined

Dr ALAM YOOSUFF, Vice President, Rural Doctors' Association NSW, before the Committee via videoconference, affirmed and examined

The CHAIR: Good morning. I welcome our witnesses. Please be aware that photos may be taken during the hearing. If you've got concerns, please let us know. Could 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?

FIONA DAVIES: Yes, I have.

ALAM YOOSUFF: Yes.

RACHEL CHRISTMAS: Yes, I have.

The CHAIR: Would the witnesses like to make a brief opening statement of no more than two minutes per organisation before we begin questions? Ms Davies and Dr Christmas would like to make an opening statement. We'll start with Ms Davies.

FIONA DAVIES: The AMA (NSW) would like to thank the select committee for the opportunity to appear today. I'm Fiona Davies. I'm the chief executive of the AMA (NSW), and I've held this role for a number of years. We're the medico-political organisation that represents doctors in New South Wales. We represent all doctors, from medical students to retired doctors. It's been almost two years since the release of recommendations made in Portfolio Committee No. 2, and AMA (NSW) is deeply concerned about the lack of progress in addressing the declining specialist workforce in regional New South Wales. In preparing for this inquiry we reached out to medical staff council chairs across regional New South Wales and to our councillors who live and work in regional areas. The submission to this inquiry identified five critical areas of need relating to the delivery of specialist care in rural, remote and regional areas. These are workforce, budget, training, industrial arrangements and culture. The shortages of doctors in regional areas place inordinate strain on the existing workforce, leading to the implementation of unfair and often unsafe rosters. We are also particularly concerned that this is having an impact on those doctors starting in the medical workforce.

The statistic that I think this Committee should be most concerned about is the feedback from Dubbo, who were only able to place two intern positions out of their 12 allocated. That is a really significant statistic for the future of the medical workforce. We are concerned that the last State budget, which imposed a significant cut on health, is disproportionately impacting on regional services. Regional services are reliant on locums and have other factors that mean budget cuts have a really significant impact on them. We are concerned that we are seeing a decline in paediatric and obstetric services, particularly since the inquiry, with most districts reporting that paediatric and obstetric services in regional hospitals have declined and access to those services has significantly declined. We are concerned about the industrial arrangements in place for all doctors working in regional and rural areas. It is our concern that doctors working in regional and rural areas in the public hospital system have generally been required to work longer hours with more onerous obligations, and we have seen a really significant change in the expectations of doctors in terms of their working arrangements—expectations that are healthy and good but that really mean that for so many people, rural and regional practice is something where they are saying, "Why would I want to do that?" That is something that we need to change.

RACHEL CHRISTMAS: Thank you for the opportunity to address this hearing. We have reviewed the recommendations and appreciate the dedication of New South Wales Parliament and its select committee, particularly Dr Joe McGirr. Progress has been made in some areas, notably with the establishment of the rural health division within NSW Health. The division has shown commendable engagement with stakeholders and a commitment to tackling complex issues. However, its current influence over rural local health districts is limited. Empowering the rural health division to effectively mediate and influence decision-making within LHDs could lead to substantial improvements.

The expansion of the Murrumbidgee single employment model pathway to all rural LHDs is a promising step. However, maintaining the collaborative approach of the original model between primary care and LHDs is crucial for helping to address the rural doctor shortage effectively. It is critical that recruitment of rural generalists continues to be monitored as an outcome of the single employer model. The creation of appropriate awards to effectively remunerate these rural generalists and to develop scopes of practice that reflect the skills of them, and

a structure within the health districts that actually allows them to collaborate with their specialist peers for service delivery, is imperative if rural communities are to benefit from this. Key performance indicators such as numbers of births and volume of procedural work in non-base hospital settings should be annually reviewed by NSW Health. Consistent monitoring of these indicators will ensure that rural health services receive the attention and resources they need to continue to improve those statistics.

Local maternity services are vital, providing comprehensive health care beyond birthing. The declining number of GP obstetricians is alarming. Urgent action is required to support and incentivise these roles beyond the rural generalist training pathway. The culture of communication between administrators and clinicians requires openness, transparency and governance in accordance with recognised pathways. The loss of this process in many LHDs has resulted in detrimental effects on morale, loss of staff and threats to service provision in many rural hospitals. Employing managers who are adept at conflict resolution; engaging clinicians in service planning, including primary care; and following up on feedback will improve outcomes in staff retention. Strengthening the role of medical staff councils to enable a forum for feedback to and communication with the administration is vital to improve collaboration and service delivery.

Looking ahead, we need to establish a framework for the next decade that holds NSW Health and the rural health division accountable for specific outcomes. Indicators should include the reopening of maternity services, increasing the percentages of women birthing rurally, and increasing procedural volumes in rural areas. This approach will ensure that rural communities receive the quality care they deserve. Our goal is to see NSW Health and the rural health division responsible and answerable to rural communities, driving continuous improvement in healthcare delivery.

The CHAIR: We do want to cover off on the issue of primary care, which has emerged as a crisis point. But before we get there, I will come back to the issue of the specialist workforce in rural and regional areas. Dr Christmas, you have alluded to issues around clinician engagement and culture. You also made a comment about the rural health division's influence over local health districts. Ms Davies, our concern with some specialist services, particularly in terms of maternity and obstetric services, is that local health districts struggle to actually address those issues individually and that there actually needs to be a focus, perhaps at a state level, and support for LHDs, because the contention would be that the workforce situation is perhaps beyond rural local health districts to resolve. That is a contention. I accept that. I am just interested in your reflections on that—and, Dr Christmas, in terms of the rural generalist. I will start with you, Ms Davies.

FIONA DAVIES: While there is a lot of focus on primary care, if you do not have solid, specialist services in regional-based hospitals, you will not be able to achieve the services at non-regional hospitals, and that is the situation we are in. I think a lot of regional and local health districts are struggling with the workforce implications. Certainly in the Special Commission of Inquiry into Healthcare Funding we have called for simple things like the process of issuing contracts to be centralised. A lot of the workforce aspects around VMOs or doctors could be centralised. I do think there is probably a need for a more centralised role in attracting and retaining the specialist workforce, possibly with a greater role from the rural or regional health district. Local health districts are critical and are working incredibly hard, but they need to be supported in knowing how to deal with disputes.

We have actually called as well for the dispute process to potentially also have much greater state level input. Managing disputes between doctors is really complex. It is even more complex in regional areas, where it often ends up involving communities as much as doctors. We do think there should be potentially more oversight there. I think there needs to be a clearer statewide understanding of how important it is for doctors who move to regional areas to have suitable access to an appropriate mix of work—elective, not just on-call. We are seeing elective work removed from local health districts to meet performance benchmarks. That's the work that's critical for people to do in their communities and with their communities. I do agree that probably the decentralised model could do with some review around how these matters interface between each other and whether that is still fit for purpose for regional districts.

The CHAIR: Dr Christmas, do you have any reflection on that observation? You spoke about the rural health division and it perhaps needing more influence over local health districts. I think that's what you were saying. I'm interested in what you mean by that. You did also make some comments around culture and engagement with clinicians at the local health district level.

RACHEL CHRISTMAS: I think the Rural Doctors Association largely has been involved with GP VMOs. We are now seeing that people are engaging more with us as an organisation from a specialist VMO point of view in rural hospitals because of that frustration in trying to engage with their local health district to provide services. There's a lot of conflict that can happen at an LHD level. I think there's a complex interplay here because we have a lot of VMO services; most of the specialist services in rural areas are run through VMOs rather than staff specialists. That's a very complex situation—I dare say that Ms Davies will know more about that than I do—

because that's a difficult area. When we're looking at contracts, we're looking at providing clinics in rural hospitals, which there is a lack of, and how do we actually make that work in the hospitals around places like Wagga, Dubbo, Tamworth and so on. What we have is a population that can't afford to go and see people privately. They need to actually get the care that they get, and one way to do that is through public hospital clinics.

However, we don't have staff specialists to do. I think that's something that's going to need support from a state level rather than an LHD level to support that happening, with good engagement from local clinicians. What we don't want to see is a conflict between the hospital and the VMOs, and I think it needs to be good engagement to see how we can provide services using the resources that we have and enhancing them with state support from within the hospital system. That's complex. I also think that part of the issue around specialist services in rural areas is the lack of training opportunities for registrars in specialty areas—so surgical and medical registrars being able to complete training in rural areas, having enough positions for them to do that and receive the adequate funding. Again, it's an area I don't know a lot of, but I do hear it on the ground from people that I just talk to and members of ours who express frustration around getting registrars out into rural areas to do the jobs and help them out.

The CHAIR: Dr Yoosuff, would you like to make a comment?

ALAM YOOSUFF: Thank you, Dr Joe McGirr, for giving me an opportunity to make a comment on this. In Australia, we have about nearly 300,000 births. Of that, 91,000 happen in New South Wales. If you look at the population statistics, nearly one-third of that should be in rural and remote settings, MMM3 and above. How many of those births are happening in rural and remote settings and how many of them are getting the opportunity to deliver their babies in their land is a question because we are seeing, with time and time, that rural maternity services are being left out and getting closed. Places such as Lithgow, Kempsey, Cootamundra and many places are on the brink of shutting down, even at this point in time. There are many rural maternity services which have only less than two GP obstetricians who are looking after them at the moment. For the whole year last year, 2023, we had only two advanced trainees who did obstetrics as an advanced training position. This year there are only two people who are doing obstetrics as an advanced training position. Even those two people were from the single employment model recruitment in our region, where Murrumbidgee is.

I think we are facing a dire situation, with another five, 10 years to come. We will have a concerted problem that, to be able to provide the necessary safe care services for our women in the region, I think it is not only just about not having enough trainees, not having enough money, not having enough specialists; it is a lot beyond that. For example, in your area, Dr Joe McGirr, Tumut delivers only about 30 or 40 babies per year in a population of about 15,000 catchment. In a population of 15,000 catchment, you need to have about 150 to 250 births. At least half of them could have been delivered in rural maternity services. It is not about how many people are there; it is about the system that is making the avenue for workforce to be grown and utilised to provide care closer to people's homes. That is the only way that we will make a difference for our communities. Hence, what Rachel was trying to allude to in her opening remark is that we need to have key performance indicators which are measured very strictly with NSW Health so that we look at it.

For example, if there's ambulance ramping, it will be on the news. If there are too many people waiting more than four hours in an emergency department, it will be on the news. If there is too much waitlist from a surgical list, it will be on the news and it will make a big fuss. That's not happening in Kempsey. That's not happening in maternity services related to what is in Tumut. Hence, I think NSW Health needs to look at having a standard KPI that is being measured and make the executive responsible for such. I will give an example of Murrumbidgee. We have 20,000 procedures—surgeries, endoscopies and all those things—happening in our whole district. Of those 20,000 procedures, less than 2,000 happen in rural and remote setting, out of non-base hospital settings. It would be a similar situation in western, southern and far west. What is it that the local health district is answerable to increase the amount of procedural work in out-of-base hospital setting? There isn't.

It is easy to bypass surgical lists, to close operating theatres, to shut down maternity centres and utilise the workforce to cover up the emergency departments, because we all face a significant workforce burden in our region. I think it's a system issue. We know there are very good people who are interested—for example, Jill Ludford, the chief executive of MLHD, and Luke Sloane, who is the rural health division deputy secretary. We know their intension and vision and how interested they are in rural health, but that doesn't translate when it comes to the grassroots level. We want to see places such as Kempsey, Lithgow and Cootamundra flourishing. We want to see places such as Tumut delivering about 150 to 200 babies every year. Tumut and Deniliquin have the same amount of population, same calibre or socio-economic disadvantage range. Deniliquin is delivering 175 babies per year; Tumut is only delivering 40 babies, less than that. There is a problem, not only the clinicians; there is a problem of the system that is not making it right.

The CHAIR: Dr Yoosuff, just to clarify, your view is that there ought to be publicly available data and perhaps performance indicators around maintaining services in smaller rural settings for the LHDs?

ALAM YOOSUFF: Correct.

Ms TRISH DOYLE: Thank you all for your work and for being here with us today. I am going to start with you, Ms Davies. The submission from the AMA describes "hospital exit block"—so where there is a lack of available community or home-based care options for vulnerable people, especially older people—in terms of preventing the patients from being discharged. How can community or home-based care options for that cohort of vulnerable people—especially older people—be improved, in your view?

FIONA DAVIES: We have seen—and this is not just unique to regional and rural—a decline in access to nursing home services, and that has a significant impact where people can't be discharged. We have had proposals put forward that we should be looking at different models to resource the care of nursing home or older patients. One of the proposals that has come up from within our council on the South Coast area is actually that GPs should be able to be working as VMOs, not to attend but to actually cover a district's aged-care facilities, because GPs who otherwise don't associate with the hospital directly—so this is a different model; they generally are in practice. Nursing home work is really difficult and really poorly remunerated. To actually look at something like a GP-on-call model could actually bring people into the system, in a way. They could potentially cover a district. I think we need to be using the contracts that we have and the arrangements that we have. We need to be looking at workforce wherever we can and particularly looking at areas—now, this will not work everywhere; in this context, we're probably talking more regional, because that's more your focus of this inquiry. In areas where there may be workforce available and they may be willing to consider models, we should be looking at something like a GP-on-call model for something of that nature.

Mrs TANYA THOMPSON: Ms Davies, the submission from the AMA noted that most regional LHDs had issues attracting and obtaining obstetricians and paediatricians. Why do you think it's difficult to attract and retain staff in these professions in remote, rural and regional communities? What do you think the State Government could do to improve the recruitment and retention beyond the existing Rural Health Workforce Incentive Scheme?

FIONA DAVIES: There seems to be a range of reasons. Particularly if you look at paediatrics, that was previously covered under a VMO model. In a lot of places now it tends to be more a staff specialist model. Different models are great for different things, but where the VMO model—that's a contractor model—is fantastic is you can put as many VMOs on as you can. It doesn't cost any more, because effectively they're paid only if they work, and they have the advantage of dividing up an on-call roster. They can also cover clinics. There's no problem with that. So it's not a matter of VMOs can't do clinics.

Looking at the nature of the way people are contracted and looking at the on-call arrangements, we are certainly hearing—and Dr McGirr will recall this as well—feedback from doctors about the on-call level. On call is a huge burden for doctors. It is a burden wherever you work, but it's particularly onerous in regional areas. The reason it's particularly onerous in regional areas is that, unfortunately, it is harder to get trainees to come to regional areas—so they're the registrars—and you tend to get more junior trainees coming. The trainee is the person who, at three o'clock in the morning in a metro hospital, will probably be reasonably experienced and able to deal with most things. In a regional hospital, you're on call more often and you're called in more often, and the differential of what you're going to be remunerated for that is quite stark now. We need to look at the arrangements people work at, how we recognise that it's going to be more onerous and how we give people more training opportunities in regional settings.

Training opportunities is not a matter of just forcing colleges to send people to places. If you don't have the work available for those trainees and the supervision—I will give you an example. For ear, nose and throat (ENT) services, you have to have both operative services and you have to have clinics. If that trainee coming isn't going to get a broad enough mix of services and experiences, then a college is going to say, "I'm really sorry. That's not a safe and good opportunity." So it's actually about building a whole system and making it attractive to people. In paediatrics particularly, we have to look at what are the models people are working on, how do we support in community and how do we support people building practices? I think obstetrics is an enormous area of concern. I think the birth trauma inquiry was really difficult for all people working in regional and remote in obstetrics in New South Wales. It's come out with some potentially reasonable recommendations, but NSW Health really needs to set a priority on attracting obstetricians to regional areas and making that a stable workforce and making it a workforce where trainees want to go. I think obstetrics is particularly going to need some real focus.

The CHAIR: Ms Davies, I get this argument that if there are not good enough services, you can't have trainees. But, of course, if you don't have trainees, you won't have workforce. I've heard that for decades, and frankly I'm fed up with it. As you've just suggested, in terms of obstetrics in regional and rural areas, it's past the

point of discussions about where you'll put a few trainees, because I don't see any college graduates going to work in rural and regional New South Wales. We hear of on-call rosters continuing to decline and the pressure on specialists in those areas—both generalists, as Dr Yoosuff, in fact, has described, but also in the regional centres where there are specialists. Many of them are overseas specialists. The LHDs are left recruiting from overseas, flying in locums. There are issues with continuity of care. We heard this morning of issues around the midwifery workforce. We can't just sit and wait. Surely this has gone past getting a few more trainees out there. It seems to me that this needs a sustained and coordinated level above the level of local health district.

FIONA DAVIES: Yes, I think it does. When I reflect back, we did a forum—which you may remember, Dr McGirr—in Wagga in 2016. That was a forum of some hope and possibility. It did have some outputs. I think colleges should not have obligations to get trainees. Regionally based training should not be too hard. I'm fully on board for that. In terms of some of these at-crisis specialty areas, it is beyond local health districts to resolve. It does need a state level. We need to look at some of the options—easy entry, easy exit. We need to look at all sorts of different options to bring in high-quality specialist care into regional centres and to not be reliant on locum models. We may need to have a period where—with anaesthetics at Tamworth, they have a really critical—obstetric services are not just obstetricians, and obstetric services are critical. Anaesthetists are now increasingly saying that to attract somebody, you want to look at a one-in-10 to one-in-12 roster. That's not the way it used to be, but actually districts may have to say, "Okay, we will look at what we can do to bring you in on the arrangements that you want," and that requires going above districts. What does it take to attract people and what are they looking for out of their career? I agree; I think we are beyond the stage where districts can resolve that problem.

Ms LIZA BUTLER: Dr Yoosuff, you spoke of a number of obstetric services closing in hospitals in country areas—either closed or about to close. Do you think that local health districts are citing staff as an issue, or low birth rates or the risk to mothers and babies, or do you think it's a way to make budget savings across their health district?

ALAM YOOSUFF: I think all of those things come into play, Ms Butler. I'll give you an example. If town X only has 40 births per year, then you could say, "Look, this is not a viable place for a clinician to get hands-on experience. It will be a safety issue for mothers. It is not a well run place in that number of cases, so we need to be looking at closing it down." That's one way to look at it. The other way to look at it is town X will only have 40 deliveries per year, but town X's catchment is 15,000 or 20,000 population. Where are these people going? So it is a multi-pronged process to address this. When you look at it as an LHD executive in a bureaucratic process, we would look at complications, clinical governance, safety and tick-a-box approaches—how to fill all the boxes and put the crosses and dots in the right place. When you look at it from a community aspect, what we need to look at is these 20,000 people in this region need to have the facility to deliver the babies safely in their region if they want to. That is the real scenario.

But what we see, and the reason why Rachel in the initial bit said that there is the disconnect between the rural health division and LHDs, is that what is it that the rural health division has in its hands to control LHDs to be able to maintain the existing service or not let it close down? They could talk and they could negotiate, but there isn't a mechanism to make it happen. They're not answerable for it. Hence, like what Dr McGirr said, I would say, Ms Butler, this needs a concerted, multi-pronged approach to look at all sides of the story and get it right. There are quite a few GPs that I am aware of—my colleagues—who are able to provide GP obstetric services, but they don't want to because of the hassle of putting up with bureaucratic processes and admin. There is that too, on top of all of this. We have the capacity to fix it if we really want to fix it, but if you look at it only on a bureaucratic process of how to balance the budget, how to fix the media and how to fix the complications, we won't get anywhere.

Ms LIZA BUTLER: Just on the hospitals that have lost obstetric maternity services, have you seen a flow-on effect to other services in that area of other people retreating and moving away to deliver services?

ALAM YOOSUFF: Correct. Invariably it ends up with more work in the base hospital setting: more workload, inability to cope with the theatre list, needing more theatre time, needing more proceduralists in the workforce for base hospitals—the base hospitals that we're talking about such as Dubbo, Orange, Bathurst and Wagga. We aren't having enough obstetricians to work either. If you look at all of Australia, 85 per cent of all obstetricians work in MM1 and MM2 (Modified Monash) areas. Only very few are working outside those areas.

RACHEL CHRISTMAS: There are two ways of looking at the questions you've asked: Is it because there's not enough people birthing or is it because there is risk and so on? There are a few things there that you can look at. Sometimes they're two sides of the same coin, a bit like Dr Yoosuff alluded to. One of the things we have to be careful about is reporting on what is actually happening—for example, the number of births in a town is going down, therefore that service is no longer considered viable. They look at that and can report that as being

a lack of demand for that service. That is incorrect. The demand is there. Women are still having babies. The population is not decreasing that much. So what is it here that we're reporting on? What we're reporting on here is that there are more women being transferred out. Is it because they're complicated pregnancies? No. They're being transported out because we are not able to provide the service for them. There will be times when there is no obstetric cover or no anaesthetic cover. We have to be careful that when we are reporting data around birthing in towns we are not just looking at a number and saying, "The number is going down therefore [audio malfunction]."

The CHAIR: You just disconnected for a moment there, Dr Christmas. Please continue.

RACHEL CHRISTMAS: We need to make sure that we are supporting a service: to say do we want that service there, are the women birthing and how do we then keep up our births in those towns? So, reporting on them. As Dr Yoosuff said, we need these KPIs. How are we going to actually make sure we are birthing the number of women that should be birthing in that town and using our referral hospitals—such as Wagga Base in my region—for women who are not appropriate for birthing in the smaller towns because of risk. We are seeing too many women being transferred or birthing in the larger towns—like Wagga—because they haven't been able to birth in smaller towns because of staffing and so on. That is not appropriate. We need to be saying, "Why are they doing that?" and then addressing it, not reacting to the fact that those numbers then reflect a reduction in demand—that's not the case.

Ms TRISH DOYLE: Before I ask my question, I want this on the record as a comment: We've heard recently, especially through the birth trauma inquiry, lots of women pointing out that they're supportive of the midwifery-led care model and that continuity of care in communities, and I'd even go so far as saying we need to look again at the homebirth model where there is lack of services in areas. Thank you for your viewpoint there about obstetrics. Can I just ask the Rural Doctors' Association about your comment that patients be transferred to appropriate services, not the next closest hospital. Does the availability of ambulances and paramedics contribute to the issues of patients being transferred to the appropriate services?

RACHEL CHRISTMAS: I would think not necessarily. What we try to do in obstetrics is anticipate who is going to need transferring. When I say transfer, I guess I'm using that a bit loosely in this context to say that maybe planning for someone to deliver in another location, rather than transferring them as an emergency in a labour situation. So that's one thing. There are situations when we may have to transfer people out in an ambulance for an emergency. We try to avoid those situations as much as possible and anticipate that but, obviously, you can't anticipate every emergency.

Ms TRISH DOYLE: Not just in relation to childbirth and obstetrics but any issue, whether it's mental health issues that require someone being transferred to the appropriate service rather than to the closest hospital.

RACHEL CHRISTMAS: Now I understand. Sorry, I misinterpreted. Yes, there are situations where we know that patients being picked up—for example, for complex mental health where there may be some aggression or violence problems in that presentation, it is most appropriate that they go to a larger hospital. We know that smaller hospitals don't have security. They don't have the nursing staff. It can be a threat to the people working there, so definitely there are situations when direct transfer to a larger hospital is appropriate. That doesn't always happen. Sometimes it is the nearest hospital, and that is difficult because ultimately those people will be transferred to a more appropriate system anyway, which is double handling, taking up more ambulance time, and it's very difficult for staff involved at that interim hospital.

ALAM YOOSUFF: Just to add a point onto it, always we treat mental health as second class. If you had a stroke, nobody will question you. Once you're picked up, you go to a place where you can do a CT scan directly. If you had a ST-elevation myocardial infarction (STEMI) or a major heart attack where you need an angiogram kind of situation, you will end up in the right place. But if you had an acute psychosis patient, you end up in a smaller hospital where there is no security, where there is no nurse, where there is no psychiatrist or anyone who can do the proper assessment and then wait for hours and hours before you get to an acute base hospital where you can do all that you need to do for that person. You get second-class treatment. Some of the times after five o'clock, the ambulance service won't transfer mental health patients, citing, "It is not our business." There is ongoing argy-bargy about what is the right way to transfer mental health patients. One of our submissions talks about that particular instance. This would be one of the points that I'd like to raise: that mental health patients need to be treated as we treat a stroke or a heart attack and they deserve proper attention.

The CHAIR: I take your point, Dr Yoosuff, that the restoration and improvement of services requires will and effort, and that in the current system the KPIs and rewards are not for that but are rather in the other direction. A very important point to finish on is we've had some discussion and evidence in relation to the need for new models of primary care. The old model of a GP in every town doing 24-hour call—there's a view that is not

sustainable going into the future and there needs to be different models of remuneration, including salaried options for rural generalists.

ALAM YOOSUFF: Correct.

The CHAIR: And collaborative care models around primary care and that the State Government has a role there with the Commonwealth, or it may have a role there and probably needs to have a role there with the Commonwealth. I'm interested in your feedback on those comments.

ALAM YOOSUFF: My observation, based on my being in Murrumbidgee for almost 20 years now, is that the state and federal divide is one of the significant detrimental factors for better health care for our people, and that allows us not to work as a proper team in certain instances. Number one, if there is such a situation where we could have collaboration, that would make a big difference to our people. Number two, there are certain places where there is no viable way of running a proper primary care service, such as in Far West NSW and some places in Western NSW, and even some places in Murrumbidgee. In that case, state and federal working together to stand up such services and provide the necessary primary care for our people is an important component. It is something that we need to embark on doing, rather than pointing the finger to this side or that side and saying, "It is your responsibility."

FIONA DAVIES: We are understanding of and support that model in areas where there is failure. The only caveat I would say is that there's such pressure on the NSW Health budget as it is that we have to be really careful that we do not unintentionally destroy private general practice, which has been the cornerstone of extraordinary health care in this country. It'd have to be carefully managed. Recognising that access to general practice is an issue not just in rural and remote but in all areas, we would need to make sure that you didn't unintentionally make those people running private general practices a non-viable model. In the end, if you are having to compete for a salaried workforce, you could find yourself in difficulty. We should be considering all options. We should be considering the right options for different places. We should not just look for simplistic models that may actually undermine the extraordinary contribution that private general practice has made to this country.

RACHEL CHRISTMAS: My comment is regarding the collaboration that you mentioned, Dr McGirr. I think, again, this is that Federal-State divide. There is a lot of funding for primary health networks, which provide a lot of the collaborative care through different areas of the State. One of the complications there is the funding models. Often, the funding we have for models is on a yearly basis, a three-yearly basis or a pilot model, so there's a lot of uncertainty around models of funding for health programs through Primary Health Networks (PHNs). Mental health is a very good example of that, where we have funding in response to suicide prevention or mental health access, but then there's no stability around that funding that we're aware of. There's lot of crossover between services, complicated referral pathways and GPs not certain about how to access these things because they change. That is one area that could be improved. That's under the Commonwealth funding models, rather than state. We know that's a blurred area when you're working in primary care in rural areas.

The CHAIR: We will bring that to a close now. I thank the witnesses for appearing before the Committee today. We may also send you some further questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions? Ms Davies is nodding.

RACHEL CHRISTMAS: Of course.

The CHAIR: Thank you very much for your time. We will now take a short break. The hearing will recommence at 11.05 a.m.

(The witnesses withdrew.)

(Short adjournment)

Councillor DARRIEA TURLEY, President, Local Government NSW, affirmed and examined

Mr DAVID REYNOLDS, Chief Executive, Local Government NSW, sworn and examined

The CHAIR: I welcome our next witnesses. Please be aware that staff will be taking photos throughout the hearing. If you have any concerns, please let us know. Can you please confirm that you have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

DARRIEA TURLEY: Yes, I have.

DAVID REYNOLDS: Yes.

The CHAIR: Would you like to make a brief opening statement, limited to a maximum of two minutes, before the commencement of questions?

DARRIEA TURLEY: Thank you, Chair and the Committee, for providing the opportunity for me to appear at today's hearing. My name is Darriea Turley. I am president of Local Government NSW (LGNSW), the peak body representing all 128 councils across the state. I am also a councillor at Broken Hill City Council. I live in a regional community. My four decades of working in health and welfare in rural and remote communities help to frame my observations. As the sphere of government closest to the community, councils play a key role in helping to maintain and improve the health and wellbeing of our residents. Local Government NSW contributed to the original healthcare inquiry, and we welcomed all 44 recommendations accepted by the Government. Our Local Government NSW annual conference resolved to seek the implementation in full. This remains one of our priority advocacies.

Access to health services in rural, regional and remote areas remains a significant issue for councils and their communities. Councils often take on an additional role and responsibilities to support their community in accessing health services in rural, regional and remote areas, despite it not being within council's remit to do so. This point is important. It's certainly great that councils do everything they can to ensure health services are available, but we have to recognise that this also comes at a cost to the council and to their communities. Councils are often having to divert funds from much-needed local infrastructure and community services. Our original submission detailed the significant impact of cost shifting in the provision of critical healthcare services and facilities to regional, rural and remote communities. An LGNSW analysis in 2021 identified nearly $2 million of direct cost borne by 21 of the smallest councils or joint organisations in New South Wales.

Our Local Government NSW budget submission calls for the establishment of an annual $5 million local government rural and regional health reimbursement scheme to ensure that rural and regional communities do not miss out on essential infrastructure and services that would otherwise be funded by their council. Our submission notes the multiple barriers to accessing health services, such as a lack of viable transport options and long waiting periods. A lack of in-person and culturally appropriate care can also jeopardise those early intervention efforts. We are seeking better coordination of funding arrangements to ensure people can suitably access the health services they need. Further, rural and remote communities wish to see better resourcing of preventative practices—for example, regular annual screening checks.

Councils in rural and regional New South Wales are also concerned about the acute mental health difficulties facing rural and regional communities. Young people, in particular, experience a higher level of suicide in rural and regional communities, worsened by a lack of psychology, youth counselling services, programs and centres. Councils across New South Wales operate youth centre services but often cannot afford these for full-time staff or hours of operation. This funding needs to be provided over a period of years to improve the community's wellbeing and resilience post-disasters.

Finally, a key concern of councils relates to the reforms to in-home aged care. The existing Commonwealth home support programs provide Australian overnment funding directly to providers, including around half of all councils, through grant agreements. These providers then deliver subsidised services to older people. The new Support at Home program arrangement means that providers will primarily be paid on a fee-for-service basis after the service has been delivered. This will result in less certainty for providers. If funding is not sufficient under the proposed Support at Home funding model, councils will likely have to transition out of the market, potentially leaving communities without in-home aged-care services, particularly in rural and regional services. Local Government NSW thanks the parliamentary Committee for your continued efforts in ensuring that the state of health care in rural and regional New South Wales is improved.

The CHAIR: Thanks, Councillor Turley. I'll start the questions. I'm going to start on a positive note. Local government is often involved in providing health services or supporting their provision—for example,

aged-care, drug and alcohol and mental health services and some allied health services. You obviously have concern in other areas that this Committee is looking at, such as cancer and maternity services. I'm wondering if you could reflect back to us on strengths or improvements you've seen since the original inquiry and the recommendations.

DARRIEA TURLEY: Mr Chair, I think the strength is that there is a commitment by the Government for the 44 recommendations and that this Committee exists to monitor the improvement of that. It cannot be understated that it reinforces to our members and to our rural and regional communities that this Government wants to invest in rural and regional health. My concern is what is happening on the ground. My concern is often around the infrastructure to support those motions. I would have to say, in my experience, I'm not seeing the messaging to the community as strongly as it should be. I say this with much respect: I think Health needs to be an employer of choice. We shouldn't say, "You have passion for health, so you should come." We should make it attractive, to attract people to be in our rural and regional communities. I don't see that in that area. I will hand over to Mr Reynolds for comment.

DAVID REYNOLDS: Thank you, everyone, for your time today. I'd echo Darriea's comments, but without her firsthand experience of being in that community for that time. On behalf of our members as an association, we appreciate the commitment to following through on the first inquiry's process. We think that's very important. There were key issues identified in those 44 recommendations, and for them to be prosecuted properly is valuable not just for our councils but for the people that they serve—the communities that they're out there to represent. Councils at the moment feel unique funding pressures. Their communities feel the pressure that goes with that. Councils are being asked to effectively play the role of the last person standing in many service areas, health being one of them. Councils are often the last person standing providing housing. They're the last person standing in trying to attract workforce to communities, including trying to attract international workforce to these communities to provide services.

Some councils are funding housing; some councils are funding visa applications. They're providing transport for at-risk community members. They're providing property on shared arrangements to allow the provision of service in safe environments. But they're also then not doing the other things that their communities would expect them to do with the money that's being spent on providing these services that perhaps other levels of government are more directly responsible for. Darriea referred to 21 of the smallest councils in the state spending approximately $2 million. That's $2 million of ratepayers' money that could be going to sports fields, community issues, potholes or disaster recovery. We see that as a key issue that could be thought about very well. I'll maybe leave some comments there.

The CHAIR: Councillor Turley, you said Health should be an employer of choice. I presume you're referring to New South Wales local health districts?

DARRIEA TURLEY: Yes.

The CHAIR: Clearly you don't think they are an employer of choice at the moment.

DARRIEA TURLEY: No. I think if they were, we would see recruitment. I've left Health recently because of this role, but my colleagues are still working in Health. My observation is that we still have high levels of vacancies. Of extremely high levels of concern are vacancies across the area. I see financial incentives but the reality is, if we want people to come into a rural or remote community, we have to think a bit more out of the box. We have to think about what it is that makes us a community to attract people to stay and be employed with us. One of the parts of that is child care. That is one of the issues for anybody coming to a community. They ring up and say, "What's education like? What's the school systems like? What is child care like? If I come back into the workforce, how quickly can I get into the workforce?"

If we don't have a model around these things, how can we attract people? The corporate world is looking at it. The corporate world gets it that they need to bend and they need to sometimes break. But they also need to think outside the box about how they attract and retain workers. For some reason, we see ourselves as government agencies and we say there are rules. The reality is it's a new generation. We've had COVID. We've gone through crises. We've got competition. We had the Great Resignation. If we want to look at attracting and retaining people, Health internally needs to look at how they do that.

Ms JANELLE SAFFIN: My question is to either or both. Thank you for your submission. It's about recommendation 43 of the report. It said that LHDs should work with local communities and health providers, in particular, to develop place-based health needs assessment and local health plans. Have you seen that happen? Have you noticed any progress in that area, either where you live or across the state? And do regional LHDs consult with local councils, effectively or at all?

DARRIEA TURLEY: My experience is that there is a conversation happening with local councils at different levels. I can't say it is across all the local health districts. But when you're looking at those local plans, I'm not sure how they're engaging with their local health councils around that, to make sure their health councils are endorsing their plans. One of the models that NSW Health developed many years ago, which has been in situ, is around local health councils representing the community. I'm not sure if those plans go for endorsement or if staff go to the health councils and ask, "Is this information being shared with the community?" If you did a screen across the board, I wonder how many media stories you would see of councils standing with a CEO, sharing a health plan. I just don't know if it's being implemented. I'm happy to take that as a question on notice and ask our general managers and mayors.

Ms JANELLE SAFFIN: Thank you. That would be good for you to take it on notice.

Ms TRISH DOYLE: Thank you both for being here today, for your submission and for your work for your communities and representing all of our councils. Can you speak a little more about the need for a local government rural and regional health reimbursement scheme and perhaps provide some examples about how much local councils would spend on providing or supporting health services?

DARRIEA TURLEY: Before I handed over to our CEO, I would say that while we gave the example of $2 million for those 21 councils, we've also collectively been working with a few councils that are responsible for aged-care centres. They have done great partnerships and deals with their local health service. One example is Cobar council, which did a very good partnership with their local health service to build an aged-care centre joining onto their hospital with an adjoining door. They've discovered that, since council donated that land to the health service, that door is locked. For the aged-care person to access the health service, they have to get an ambulance to pick them up and take them to the hospital, which is through the door. I know, probably, we all would say that they should have had a stronger agreement, but the reality is that you think you're doing a service for your community. We are really struggling with aged care for some of our health services because of that—not because the doors are locked by Health, but because of the fact that there's a lot of funds spent on aged care. I think one of our councils recently has worked very closely in getting a workforce external to Australia to keep their doors open for their community. In terms of the reimbursement fund, I'll ask our CEO to comment on that.

DAVID REYNOLDS: Thank you, Darriea. The purpose of the fund is to try to give back to councils some of the money that they're spending on those services that would otherwise go to infrastructure and community costs. So when we talk about the cost of providing housing, the cost of attracting and retaining a workforce—in, maybe, subsidised housing, immigration, foods or expenses, or the other costs of trying to make sure that these core community elements still exist in a place where people can access them—it takes money away from the other core services that a council provides, whether that's lawnmowing, pothole repair, community building restoration or asset management generally or other softer programs communities need and deserve to be delivered by their council. It's really a call-out to government to say that we're spending millions in our communities on behalf of other levels of government, and we would like some acknowledgement of that by way of a reimbursement. We think that's a critical piece. It's a bit of an unusual submission in that we ask to be subsidised to pay the costs of another level of government, but we feel there is no alternative on behalf of our members but to call for something like that because our communities are doing without, because there's a greater need that's been assessed.

Mrs TANYA THOMPSON: The PC2 report made recommendations that NSW Health, local health districts and Transport for NSW work together for more frequent and affordable transport services for people to attend medical appointments. Have any regional councils reported progress in relation to this recommendation, to your knowledge?

DARRIEA TURLEY: We'll take that on notice.

Ms LIZA BUTLER: My question is to Councillor Turley. You spoke about supported home-based services. Could you expand on that and maybe give an example so I can fully understand that scenario?

DARRIEA TURLEY: Can we take that on notice?

Ms LIZA BUTLER: Sure.

DARRIEA TURLEY: I will ask the CEO.

DAVID REYNOLDS: I'm happy to provide an initial response to that and also to provide some more details as we will for other questions today. Supported in-home programs are effectively aged-care services or in-home support that councils will provide on a contract basis. The point that we're making is that they're a highly regulated form of service. They're a service where the funding becomes more and more at risk, and so you get a couple of key things happening there. One is that the contracts become less commercially viable for councils to

run because there is less certainty of the contract in terms of the rates that a council may receive for the service. You'll note, in Councillor Turley's opening remarks, that's swapping more and more now to a fee-for-service basis as opposed to a certainty-of-funding basis. That's an acute issue for councils where labour is tight, because the ability to scale up and scale down is that much harder when your workforce is smaller and demographically you have a growing number of aged people that you need to start to provide for.

The other key community impact is that the people you're providing the service to really value continuity of care. They really value seeing the same person, they really value the same driver, they value the same person delivering Meals on Wheels and they value that contact with the outside world. That's a community service that a council is providing, hopefully with some commercial sustainability behind us, but the more precarious that funding becomes, the harder it is for councils to commit to that service. So there's a bit of a vacation of some of that field.

Ms LIZA BUTLER: So you previously got block funding and it's transitioning to user-pays funding. Is that the nuts and bolts of that?

DAVID REYNOLDS: I'll be cautious about the term "block funding". I understand there were longer term contracts that gave more certainty to councils before.

DARRIEA TURLEY: Can I add to that? It is actually that you are paid after the service has been delivered. Already you're paying service delivery outside your scope that council is responsible for. If you're actually paying after the service is delivered but you're already paying all your staff and all your goods and services now and you may not be paid until three months down the track, then where does the cash flow go?

Ms LIZA BUTLER: Whereas it used to be the other way around.

DARRIEA TURLEY: You're talking about 21 one of the smallest rural and regional councils that run very small budgets.

Ms LIZA BUTLER: So it changed after the Department of Aging, Disability and Home Care disbanded when the NDIS—because you used to get paid up-front on a quarterly basis.

DARRIEA TURLEY: Yes, there were great changes that affected councils at that time. A lot of councils made huge decisions on whether they should exit the market and let it go into an open marketplace, which we had different views on.

Ms JANELLE SAFFIN: Have you seen Hospital in the Home work in some of the smaller, particularly rural, settings? Have you got any comment about that?

DARRIEA TURLEY: I would say that, again, it will always depend on the staffing levels. I know that you've got Dr Sarah Wenham presenting this afternoon, who runs an excellent program in Broken Hill for palliative and cancer care. I think for that, Broken Hill are a much bigger hospital service. I wonder—and we can take it on notice—what it's like in places like Bourke, Central Darling and those rural and remote councils where, culturally, it may be better to do Hospital in the Home. I'm wondering about that. Often, my CEO hears me talk about rural and remote health and the challenges. In some ways there are smaller towns and smaller communities that really struggle to access those services. If you haven't got the staff then you cannot deliver.

The CHAIR: One final question from me. We've received evidence about the state of primary healthcare services, and in particular general practice services, throughout the state to the point where people are saying they've never seen it as bad or with as few practitioners. Would that be the experience of your councils generally, that there's been a decline in general practice services and access to those services in rural and regional communities?

DARRIEA TURLEY: I think for any general practice at the moment in those rural and regional communities, it's hard to attract doctors, and even for their nursing staff, to deliver that primary health care. I think it'd be interesting, the demands on those general practices as well. To be quite frank, they're a business. There's a balance between my old GP, who I loved and adored, to what I'm seeing as a new business model of delivery of 15-minute sessions and move onto the next. It's a challenge to see that. I can reflect on the care that we once had to the reality of the cost of opening up a business. I think that were seeing changes, and I don't believe that they're for the good.

The CHAIR: Thank you, that's very helpful. I'd like to thank you for appearing before the Committee today. 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?

DARRIEA TURLEY: Yes, we would.

The CHAIR: Thank you. You've indicated that you would take a couple of our questions on notice, so if you don't mind we'll follow up with you. That information has been very helpful today and I very much appreciate you taking the time to appear before the Committee.

(The witnesses withdrew.)

Ms MARGARET DEERAIN, Director, Policy and Strategy Development, National Rural Health Alliance, sworn and examined

Ms SUSANNE TEGEN, Chief Executive Officer, National Rural Health Alliance, sworn and examined

Dr ROD MARTIN, College Councillor, New South Wales, Australian College of Rural and Remote Medicine, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome our witnesses from the National Rural Health Alliance and the Australian College of Rural and Remote Medicine. Please be aware that staff will be taking photos throughout the hearing. If you've got any concerns, please let us know. Can the witnesses 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?

SUSANNE TEGEN: Yes.

MARGARET DEERAIN: Yes.

ROD MARTIN: Yes, we have.

The CHAIR: Would each organisation like to make a brief statement of no more than two minutes in length?

SUSANNE TEGEN: Good morning, Committee, Chair and members. The National Rural Health Alliance welcomes the opportunity to present at this public hearing in a matter that is very close to 30 per cent of the population's hearts. The National Rural Health Alliance is the peak body for rural health in Australia. We have 52 members—however, we work with many others as well—and develop policy programs and, above all, advocate for rural health and the wellbeing of seven million people. That is about 30 per cent of the population living in rural, remote and regional Australia. Importantly, our membership covers the multidisciplinary health workforce team working in rural Australia, but we also cover the researchers and those entities that train the medical and health workforce. In our previous submissions and appearances before the Committee in October '23, December '23 and April '24, we referred to the report commissioned by the alliance to look at the national rural health funding deficit, which Nous Group undertook for us, and the analysis. We found that the underspend was $6.55 billion annually, which is the equivalent of $848 per person in rural and remote Australia compared to those people that live in the city.

This Committee will have become all too familiar with the reduced access to high-quality healthcare services in many rural locations. This is unacceptable. The alliance believes that the New South Wales Government—and, indeed, all jurisdictions around Australia, together with the Australian Government—should be committing to a national rural health strategy. Such a strategy would be underpinned by a Commonwealth-State agreement through which rural, remote and regional Australia has a schedule to the 2025-30 National Health Reform Agreement. This is a recommendation of the mid-term review report of the current *National Rural Health Reform Agreement – Addendum 2020-25*. An agreed definition of what constitutes a reasonable level of care for rural Australians will guide the investment and policies most needed for those considered rural locations.

The distance to the nearest tertiary hospitals, demographics and population health status needs to be included, as well as workforce availability and cultural considerations. A commitment needs to be made to community-led design and implementation of health solutions. This sits with Portfolio Committee No. 2's recommendations relating to the delivery of specific health services and specialist care in remote, regional and rural New South Wales. It specifically corresponds to recommendation 10, which relates to the Primary care Rural Integrated Multidisciplinary Health Services—or PRIM-HS—model advocated for by the Alliance, which was previously termed Rural Area Community Controlled Health Organisation, or RACCHO. The mid-term review of the National Rural Health Reform Agreement addendum report includes the PRIM-HS as a case study. This case study was developed with rural, remote and regional communities around Australia. While the report suggests this type of model could be undertaken within the next National Health Reform Agreement, there is no reason for State governments to delay an investment in these models that would make a tangible difference to the health outcomes of rural people.

Rural Australia and its people have suffered significantly through lower life expectancies. Some communities have people dying 12 to 16 years earlier than those in the urban centres. Just imagine your aunt or your mother or your grandmother or grandfather dying 12 years earlier, purely because they live in rural Australia. Rural Australians have suffered enough. We can no longer justify this difference; we can no longer say that they're out of mind and out of sight. We can no longer say that it is okay for two-thirds of Australia's export income to be so great because of rural, remote and regional Australia; for that 30 per cent of the population to put 90 per cent

of Australia's food on the table; and for that same 30 per cent of the population to bring in 50 per cent of our tourism income and then not provide the same funding—or more, because of their population health outcomes—to the percentage of the population that live outside of the urban centre.

I can tell you, if you're looking at Bondi Junction or Randwick or any other suburban centre, they would not be willing to go out there and raise more funds to receive the same access that others get, because they have also paid the Medicare levy, they've paid their taxes and they've contributed to the economy. They would not be willing to raise more funds to get the same access to services, and yet we're finding that those communities are having to go out there to raise funds or go through local government, where they've paid their rates, which should be used for other things.

ROD MARTIN: Thank you to the Committee for the opportunity to present our observations of progress so far. New South Wales' regional, rural and remote residents have poorer health outcomes, as previously mentioned, inferior access to health and hospital services, and face significant financial challenges in accessing services compared to their metropolitan counterparts. This was a key finding of this Committee in the initial report. Despite this, it's still difficult for us to discern whether there has been much progress on the basis of the report's many initial recommendations. Australian College of Rural and Remote Medicine's (ACRRM) submission and testimony to the parliamentary inquiry were quoted extensively throughout the Portfolio Committee No. 2 report. Our submission included detailed discussion of the role and potential contribution of rural generalists across rural and remote New South Wales and support for the rural generalist model of care.

Rural generalist doctors are trained to meet the healthcare needs of their communities throughout a broad—probably the broadest—scope of practice, which includes comprehensive primary care, public health, and advanced skills, as appropriate to community need. These are developed within the unique circumstances and contexts of rural and remote medical practice. They are in a unique position to provide holistic care crossing healthcare silos, and also to provide care across the illness spectrum and the life span, typically working with an extended scope of practice wherever the community needs it. ACRRM contends that the RG model is the most effective way that rural and remote communities can attain sustainable, cost-effective, high-quality health services. We believe that the provision of a network of RGs would ensure rural and remote communities across New South Wales can receive high-quality, locally based, sustainable health services.

Our workforce, including our Rural Generalist (RG) registrars, could be much better utilised in rural, regional and remote areas of the State. Where properly funded and intelligently designed using rural-centric models, rural health services can provide excellent health care which meets the needs of the community and provides substantial longer term return on investment. A strong RG workforce, as has been seen in other states, is a key solution to restoring sustainable healthcare services to rural, remote and regional areas of New South Wales. The New South Wales Government has either supported or supported in principle the majority of recommendations from the inquiry. ACRRM recommends the introduction of a regular report card to monitor the implementation progress and ensure that all stakeholders remain informed regarding the entire process.

We also recommend that the New South Wales Government consult with the College to address barriers to rural generalist training in New South Wales and better integration, support and recognition for rural generalist practice at the health service district and state level. Given the importance of and urgent need to address a range of inquiry recommendations, ACRRM would also strongly support the appointment of a Minister for regional health who would be able to focus solely on this important component of the broader health portfolio. As one of my Fellowship of ACRRM (FACRRM) colleagues often states, "It's now time that we had more locals, not just locums."

Ms JANELLE SAFFIN: They were two very powerful presentations, apart from your submissions, so thank you. Recommendation 30 of the Portfolio Committee No. 2 inquiry supported the expansion of telehealth services as a supplement to face-to-face services and a means to boost clinical trial participation, particularly for cancer patients in rural, regional and remote areas. Can you elaborate on that or on any models you have seen, particularly the Queensland remote chemotherapy supervision one?

SUSANNE TEGEN: Who are you asking?

Ms JANELLE SAFFIN: Both of you.

SUSANNE TEGEN: The first thing is that telehealth is a wonderful service provision vehicle. It is not the answer to all workforce issues. We have raised that when we have worked on committees developing these item numbers over the years. COVID has basically shown that it works well. The only thing is that there is nothing like a doctor or clinician seeing the person, seeing their body, and seeing the way they act. You often miss much of that. I think it's often seen as the panacea for all; it is not the solution for all. It definitely has a really fantastic place. I would err on the side of caution when you start having urban-based deliverers of care picking all the easy

parts out and leaving all the difficult bits for the local doctor or the local psychologist or other service provider without any communication. It has been a real problem because there is no continuation of care for the patient. Secondly, there is no communication and there is often no follow-up. It is seen as an easy way of coming in. It needs to be an extension of the existing service provision and service delivery model.

Ms JANELLE SAFFIN: Dr Martin?

ROD MARTIN: I was originally in Queensland before I came to New South Wales, in a wee town of 400 people, 700 kilometres from the nearest oncologist. We used to administer the chemotherapy to our patients in those remote settings. It is entirely feasible, but there was a fair amount of work involved with making sure that we could keep those patients safe, not just during their chemotherapy administration but also in the seven to 10 risk days after their chemotherapy had been completed. It's entirely feasible that a rural generalist—I was doing that as a registrar, but it took a reasonably substantial bit of planning to be able to do it. As long as we are all appropriately trained for it—certainly our college has end points that deliberately prepare people for that type of end point. It means that our rural patients shouldn't only have access to a clinical trial pathway only if they have an oncology unit in their regional city, for example.

The CHAIR: Dr Martin, it seems to me that that's a situation where telehealth is used to actually augment a service.

ROD MARTIN: Yes. I have a favourite pet phrase: The camera cannot cannulate and it can't resuscitate. It's great to have an oncologist that can look into the room and have the discussion with the patient because it makes it real for the patient but, as Ms Susanne Tegen intimated, it can't be the sole thing that helps enable those sorts of services. Sure, there are some very senior Clinical Nurse Consultants (CNCs) that manage oncology and chemotherapy administration entirely appropriately, for example, but it is having that good continuity there that is supplemented by telehealth support.

The CHAIR: I guess the point is that virtual care, telehealth and now artificial intelligence represent opportunities to sustain and improve regional health services, but they obviously need to be done in conjunction and with the support of the workforce that is there, and a key component of that is clearly the rural generalist workforce. Dr Martin, you referred earlier to barriers to rural generalist training. This Committee has had evidence and observed, frankly, an ongoing decline in primary care services in rural New South Wales. A key component of reversing that will be rural generalist training, as well as models of care. I will come to models of practice later. On the issue of training, I wonder if you could give us an indication of the current barriers to training, what you think is being done to address those and what needs to be done in New South Wales.

ROD MARTIN: With the caveat that I've sat on the rural generalist steering committee for HETI and NSW Health for probably six or seven years, I think when we look at how other states have successfully achieved this, one of the key things is that there's a higher degree of independence available to someone wanting to train as a rural generalist in Queensland, certainly; Victoria to a reasonable extent. They feel that it's an easily apparent pathway for someone to tread. That's a training pathway, as well as a place where they're going to be able to go and know that they can work. There's no point training as a rural generalist. In these statistics, they only add two or three places that you could possibly train. One of the other challenges—and certainly one locally—we've got a bevy of rural generalists wanting to come to our town, for example.

One of the challenges that we have is we need some responsive and quite dynamic approaches to be able to construct the positions that best suit the training needs that they have. Some of that is human resources flexibility and a bit more dynamism, I guess, in terms of saying, "Okay, we've got this opportunity. We need to be able to exploit it," so to speak. The other component is having it that we can, to an extent, leave behind us some of the older ways of doing things, whether that means that the VMO model in New South Wales—which is a fairly contentious thing—may not be what our future rural generalists are looking towards. That proper integration of the Single Employer Model, where rural generalists are working in primary care as well as deliberately knowing that they're going to have a role not just in primary care but secondary and transient tertiary care, as I like to call it, is built in and embedded in the rural areas where it's probably the only thing that's going to keep people in those towns and get people to those towns in the first place.

Ms TRISH DOYLE: Thank you for being here and speaking with us today about these significant issues. My question is to both the alliance and the college. Recommendation 29 of the previous committee's report was that NSW Health and NSW Ambulance ensure that paramedics are distributed equally across New South Wales, as well as a review of the current call triaging system and referral services. I'm wondering what you might have noticed in terms of any improvements in that area since 2022, where particularly telehealth is being relied upon but it should be paramedics and patient transport services more appropriately. Have you noticed any improvements in that recommendation in the last couple of years?

SUSANNE TEGEN: The patient transport scheme?

Ms TRISH DOYLE: More particularly where paramedics should actually be working with NSW Health in regional, rural and remote communities and be distributed across the State.

The CHAIR: In some instances, for non-urgent transport to be replaced by other services, their own scope of practice expanded, numbers increased and so on.

Ms TRISH DOYLE: Can we maybe go to you first, Dr Martin?

ROD MARTIN: Certainly one of the challenges at the moment, because of hospitals that are on bypass in lots of areas of the state, is the opportunity for services like that to be implemented—where very experienced, very sensible and well-protocolised paramedics have to spend lots of their time transferring patients to a different facility. There's not even necessarily the opportunity for some of that expanded role to even be trialled. The challenge continuously is that there's patchy hospital service, and that breach has been filled, unfortunately, by paramedics doing lots of transfers between locations. But you're quite right—there are plenty of opportunities with experienced paramedics, who know their towns and know their doctors and the clinical staff, to be able to make on-site assessments for patients. Five, seven years ago, our paramedics here in town in the big metropolis of Armidale would, depending on the patient and which paramedic it was, jump on the phone to you at 11 o'clock at night and say, "Does this person need transferring?" rather than landing them in hospital, having it that they then have no choice but to fill up a hospital bed for a number of days or a week or so. That local knowledge and making good use of paramedic experience and town experience is certainly an option, but they've got to have the flexibility to be able to have the time to trial that out.

Ms TRISH DOYLE: Okay. Ms Tegen?

SUSANNE TEGEN: Was that question about the 50 additional trainees? After they finished the New South Wales Government took on the 50 paramedics? Is that the question about that?

Ms TRISH DOYLE: There's that, and then there are particular paramedics set aside for regional, rural and remote areas as well.

SUSANNE TEGEN: How many of those have already gone out? Because I'm not sure if there has been a big difference as yet.

Ms TRISH DOYLE: Well, I suppose—

The CHAIR: I think the number is 500, actually.

Ms TRISH DOYLE: Yes, the number is 500, but that has happened more recently, rather than in the last whole two years. I'm more interested in your view about where telehealth has been relied upon and, as Dr Martin just said, local paramedics and local communities would be more appropriate, and whether you've seen any difference in the last couple of years.

SUSANNE TEGEN: Not yet.

Ms TRISH DOYLE: Not yet? Okay, that's the short answer.

SUSANNE TEGEN: Just to reinforce what was said before, the thing about rural communities is that they already work really closely together, and they all know each other. If for some reason there isn't capacity on one end, they actually draw each other in just to make sure that they can support each other. We'd need to take that one on notice and see maybe in six months or so, just to see if that change has come through yet. But it hasn't.

Mrs TANYA THOMPSON: Ms Tegen, the NRHA submission noted the possibility that the Royal Australasian College of Physicians might remove its requirement for paediatric trainees to complete a six-month placement in rural New South Wales. Can you outline the potential consequences of this decision? Have you been part of any consultations about this issue?

SUSANNE TEGEN: We've definitely been part—and we'll take this question together. We have provided our feedback to the college. Six months alone is quite small, even for training in general, but the fact that this is a consideration—and it is up to the college to actually decide what the curriculum is. The statement was that it was in reflection to the feedback from trainees. We know from general practice that if you come from rural, remote and regional Australia, and then you train in rural, remote and regional Australia, you're seven times more likely to go back. If we have physician training and there is no training at all in rural, what's the likelihood of you actually going to rural Australia, where there's already a shortage of support for the population of young children? We hear from patient groups—including our Friends of the Alliance, which are grassroots individuals—that there just aren't the services. Those clinicians that currently work out there are at stretched capacity and they can no longer support

that, and those fellows of the college of physicians, in paediatrics in particular, are feeling unsupported by their college but also unsupported by federal and state governments. Margaret, would you like to add more to that?

MARGARET DEERAIN: I will, because I have been contacted by rural New South Wales paediatricians concerned about this change. Those paediatricians are already working in regional hospitals, they already know that there are waitlists there, but they've told me in no uncertain terms they rely on that training placement to get the registrars in. That is the bulk of their—I shouldn't say it's the bulk of their workforce, but it's a large majority of their workforce—what they rely on to have 24/7 care and to have a full roster. The real risk if this rural training placement is taken away is that people will have no reason to choose a rural placement, unless it's something they were going to do anyway. Then, of course, once you take away those training placements, you can risk losing accreditation, which means you're not even able to offer those training placements. So it's the potential for a very vicious circle. Of course, paediatrics are so important and rural children are already behind on a lot of health and education outcomes, so to take another part of the workforce away is a real risk.

Ms LIZA BUTLER: My question is to Dr Martin. The Australian College of Rural and Remote Medicine's submission noted that the college has "established training and support initiatives to increase the number of Aboriginal and Torres Strait Islander registrars and Fellows". Have you observed any progress against recommendation 33 of the previous report, that NSW Health and LHDs prioritise building the Indigenous workforce across all medical disciplines?

ROD MARTIN: Specifically in New South Wales, no. We certainly know as a college that we have more a more First Nations registrars and trainees in our system, but being able to have clear understanding and clear vision on the number of First Nations trainees across all disciplines, we have no sight on that at all.

SUSANNE TEGEN: Could I comment on that too? There are definitely more colleges seeing this as their priority. The Orthopaedic Association is doing quite a bit of work in terms of rural training, but also ensuring Indigenous trainees are supported to go through. The Royal Australasian College of Surgeons is also doing some work. The Royal Australian and New Zealand College of Ophthalmologists is doing some work on it. I think everyone is quite cognisant and supportive of a larger percentage of Indigenous people coming through, in particular because Indigenous patients would like to be able to access care through an Indigenous person. The big issue has been that Indigenous people need support along the value chain of training from the day that they consider it at school all the way to the end of their career, partly because of the anthropological situation, but also because often they are the only person in their family that's even gone to university. Then when they go through the university system and then the training system, that it is culturally appropriate and they are supported within those communities. We do know that two-thirds of the Australian Indigenous population live in rural, remote and regional Australia. We also know that the majority of them actually go back to rural or stay in rural if they can train there. That goes for general practice as well, or ruralist general training.

The CHAIR: Ms Tegen, I want to come back to a comment that you made in your opening statement, and it's in your submission. It relates to Federal Government underfunding of the rural and regional health service. I commend the association on the commissioning of that report, which documented so clearly what I would call an underspend. In other words, because there aren't practitioners available—this is my interpretation—in rural and regional New South Wales, the Commonwealth ends up not spending funds in those regions, because it spends its funds through the services provided by practitioners. So if you don't have a GP in your community or you don't have a particular specialist, then you don't have the service and the Federal Government ends up, if you like, not spending that money. To me, they end up saving it. Of course health outcomes are worse, I would argue, as a result.

The question is how do we address that, given that we don't have services present there? In fact, it seems to me and to this Committee, can I suggest, that there is a declining level, particularly in primary care. How do we go about getting that money spent? Have you any thoughts on that? Dr Martin, you may have a comment on that, but I'll go to Ms Tegen first.

SUSANNE TEGEN: It's a really important question and there are some solutions around that. The first thing is there needs be a national Federal and State government compact. With every State and Federal government, it needs to be a compact to address the rural health issue, because it's an Australia-wide issue. The second thing is there is an opportunity to say that if everyone in the population receives approximately this much for aged-care access, disability access and health access, let's put that funding that's underspent into a separate bucket of money, as we do in Indigenous funding, and say, "We can no longer put up with the discrepancy just because you live somewhere else." When that funding is put aside, under a national rural health plan you can start delivering by utilising grassroots approaches to how to solve that problem. But it has to be population health-based, not on the budget from last year and we'll just add a 2 or 3 per cent increase.

Our primary rural integrated multidisciplinary care model has been developed with those communities that can suffer considerably and are not able to access healthcare services or disability services. We would work at a local level, where you have an independent chair and all the stakeholders sitting around the table—that is, the local health service, the local PHN and workforce agency, local government and local industry. You start looking at: This is our population health need. These are the services that currently exist on the ground. Let's look at the gap and go to that fund that has been put aside, the underspend of $6.55 billion, and go, "What is it that we can deliver?"

We need to make sure there is a flexibility, because at the moment when those communities apply for Federal government funding, they don't fit into the Government funding rounds. They're inflexible and we're told, "Oh, sorry. You don't fit into this area," yet there's this massive underfund in those regions and governments would rather those communities not receive anything. Then they have to raise the funds than to actually apply for what I would call piddly amounts of funding that is not accessible to them because they don't fit in. The funding and the funding streams—we have to get away from funding that is "pilot" or "limited". They deserve the same as every other Australian because they are not a Third World country.

The CHAIR: Dr Martin, did you want to make a comment on those observations that I made?

ROD MARTIN: Briefly. I get in trouble all the time for comparing across the border to Queensland. But if we look at how parlous the state of Queensland was previously when it came to doctors not being present in towns—no services for 300 or 400 kilometres inland—and look at the change factors for those, the key things when I talk to docs from Queensland, when I talk to lifers in rural areas, are the conditions. The fact that a town of 11,000 or 12,000 people—the size of, in New South Wales, say Inverell—has three full-time rural generalist obstetricians to look after that town and district, it doesn't exist in New South Wales in any substantial way at the moment. The shift of that underspend—again, it's a challenge because of the fact that it's a federal pot of money and what is perceived as a very much state-based issue.

The solution for the town—I went back and had a look to see what their doctor numbers are in Queensland—is they built up the state hospital system. They had plenty of rural generalists working in the hospitals. Now those rural generalists are not just spending their time in hospital, they're also having to do half time in primary care. That's how the model seems to have taken its second-tier of evolution. They've got all of these RGs that are very keen to do hospital-based things. They're now told, "But you can only do hospital-based things on the basis that you also provide a primary care service in this town as well," and that's what's happening. How we better distribute that federal pot of money through a state-based silo is still going to be one of the challenges because we won't get good spends in primary care because we won't be attracting people to primary care in a small remote district unless there's some of the rural generalist skill set that new trainees are wishing to deploy.

The CHAIR: Just to go over that again, in Queensland, there was a committed effort over a number of years to actually provide the workforce necessary to sustain and improve services in rural and remote locations. It wasn't left to the market; it was a State-based, active strategy. It combined training along with attractive conditions for people to practise in those communities. The suggestion, I think, from the National Rural Health Alliance is that were the Federal Government to make some funds available—which, morally, it should make available—perhaps in a way that was jointly overseen by the State and Commonwealth and those funds were available, communities could then use those funds to build up services in a way that would attract health professionals and the services would be tailored to those communities.

You almost need the dual approach where you actually create some funds that are available to communities to build on-the-ground services, but, at the same time, you need the State Government to take a role in committing to sustaining and improving rural hospital services. That is at least through training, but it's also through conditions of employment. It's a dual strategy, but the third point is it needs active management. Leaving it to the market, at this point, will simply see a decline in services. We'll take that as a comment from me. If there are no other questions from the panel, I will bring this session to a close. I thank the witnesses for their time today and, as my Deputy Chair said, for your powerful presentations. We may send you some further questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

MARGARET DEERAIN: Yes.

SUSANNE TEGEN: Absolutely.

(The witnesses withdrew.)

(Luncheon adjournment)

Mr LUKE SLOANE, Deputy Secretary, Regional Health, NSW Health, sworn and examined

Mr RICHARD GRIFFITHS, Executive Director, Workforce Planning and Talent Development, Ministry of Health, NSW Health, sworn and examined

Ms GERALDINE WILSON, Executive Director, Centre for Aboriginal Health, NSW Health, affirmed and examined

Dr BRENDAN FLYNN, Executive Director, Mental Health Branch, NSW Health, affirmed and examined

Dr MICHAEL BOWDEN, Senior Clinical Adviser, Child and Youth Mental Health, Senior Child and Adolescent Psychiatrist, NSW Health, affirmed and examined

Professor TRACEY O'BRIEN, Chief Executive, Cancer Institute, NSW Health, before the Committee via videoconference, affirmed and examined

Dr ANDREW WOODS, Senior Clinical Advisor, Obstetrics, NSW Health, before the Committee via videoconference, affirmed and examined

Dr HELEN GOODWIN, Chief Paediatrician, NSW Health, affirmed and examined

Dr PAUL CRAVEN, Executive Director of Children, Young People, and Families, Medical Workforce, and of networks and streams, Hunter New England Local Health District, NSW Health, before the Committee via videoconference, affirmed and examined

Dr SARAH WENHAM, Palliative Care Physician, NSW Health, before the Committee via videoconference, sworn and examined

The CHAIR: Good afternoon. I welcome our next witnesses. Can each of you please confirm that you have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

RICHARD GRIFFITHS: Yes.

LUKE SLOANE: Yes.

BRENDAN FLYNN: Yes.

The CHAIR: Everyone online?

ANDREW WOODS: Yes.

PAUL CRAVEN: Yes.

The CHAIR: Excellent. Good afternoon to all of you. There is an opportunity for you to make opening statements, but I understand, Mr Sloane, that you're happy to proceed directly to questions.

LUKE SLOANE: Yes, I think we can do that.

The CHAIR: There are a number of different areas that each of us want to cover this afternoon. We have until about 2.30 p.m. to do so. There'll be some supplementary questions in other areas that we need to cover. The first couple of areas that I'd like to cover relate to workforce recruitment locums and primary care. I'm going to start with primary care, Mr Sloane. The Committee, in its visits and in evidence and submissions, has become extremely concerned about the situation with primary care in rural and regional New South Wales. It has been described as a crisis. There has been an observation that it has not been this bad in 20 or 30 years.

The Committee is also aware of considerable work that NSW Health has done to mitigate the impacts of a lack of primary healthcare services—extraordinary things such as teams reaching into nursing homes so that patients don't present to emergency departments, the establishment of Urgent Care Centres and other initiatives in relation to virtual care and telehealth to sustain services. NSW Health is also paying a considerable amount for locum services not just in primary care but in other specialty areas. We'll cover the other specialty areas in a moment.

This is clearly an issue of significant impact for NSW Health, yet the fundamental issue of a decline in primary healthcare services seems to remain unaddressed. Arguably, it falls within the remit of the Commonwealth, but the observation from communities is that no-one seems to be addressing the issue. I'm interested in NSW Health's reaction and the actions it may be taking to address that issue. We have been made aware of the considerable investment in telehealth that supports practitioners. We appreciate that. We have also been made aware of models of collaborative care and different approaches to primary care that hold potential.

Given that it's almost an existential threat—let's face it, if disease isn't managed at the primary care level, eventually hospital services will be overwhelmed—I'm interested in NSW Health's response and its plans in the primary care space. After that, I also want to go to a discussion around locums and workforce, which is clearly broader than that. I'll probably involve Mr Griffiths in that. Can I start with a discussion around primary care?

LUKE SLOANE: Thank you for your question, Dr McGirr. I think it's important to start out by understanding the stakeholders with relation to the recommendations from the inquiry that we've been working through and implementing. One of the firm recommendations and themes that kept coming through was the State's collaboration with its Commonwealth counterparts, and then also, in turn, with our primary health network counterparts within New South Wales. Within regional, rural and remote New South Wales, it's very important to understand that, unlike tertiary facilities that rely on the normal medical officer training pathways and then progression to specialist medical officers, in many regional towns, small or otherwise, we're reliant on general practice. Those general practitioners are, nine times out of 10, the private general practice person supplying primary care. It's probably good to differentiate primary care because it's not just medical primary care or access to a general practitioner. It's access to general practitioners, community nursing and midwifery, and many other forms of allied health and primary care to prevent people coming into acute care and the acute hospital setting.

Going back, for many towns—I'm focusing on general practice for the moment—the general practitioner is also then tasked with the general practitioner Visiting Medical Officer role within the small hospital or health setting, whether it be a multipurpose service or hospital, within those regional towns. For NSW Health, our main collaboration points have been, to date, noticing this continues to be not only a shortening workforce but also a workforce that's spread very thin. We know through previous hearings, both within the select committee and outside, that the workforce has fundamentally changed. Where one singular doctor might be looking after many, many communities, they are becoming very tired and worn out and have been doing a lot of hard work. Perhaps that one full-time equivalent general practitioner might need to be replaced with two, or two and a half, to undertake the workload at the moment.

We heard through the inquiry that one of the major barriers to people selecting training as general practitioners was not only financial incentives on the end of completing their specialist training but also that workload for many people in the community, and also some of the barriers of swapping between the normal medical training pathways into general practice, and leaving the public service and transferring over to private. The main barrier there is the transfer or the mobility of entitlements—leave, maternity leave, access to sick leave—and being able to transfer those over to continue their training as a general practitioner. It may have been talked about already within this tranche. It's hard to tell what the exact cause of that is, but through the inquiry we saw that as one of the big causes of drop-offs in people seeking to become general practitioners.

I say all that to talk about the first thing, and that will be the Single Employer Model. NSW Health, off the back of that being raised as a pretty big barrier to people going through to that training, have worked with Murrumbidgee Local Health District. They were the first district to pilot the Single Employer Model within their local health district, to be able to employ those doctors in training and provide them secure training pathways and employment throughout that training, for them to then move seamlessly between the public, or hospital, setting—and that training side of things—and the private GP practice setting.

A year and a half ago we started working very closely with the Commonwealth, as did a number of jurisdictions across Australia, to look at implementing new, innovative pilots for GP or single-employer workforce within the country. New South Wales was granted three collaborative trials, which effectively allowed us to have up to 80 section 19 (2) exemptions for training general practitioners or rural generalist trainees to be able to be employed within NSW Health but undertake their rural generalist training within New South Wales as well. Those first two collaborative trials cover off both the north of the state and the south of the state—effectively the whole state. We were able to commence the first line of recruitment last year. Whilst it's not going to solve all of our general practitioner workforce problems, we totally appreciate that we do have some responsibility in offering those training places and reducing those barriers. We were able to recruit not only the first five through the Murrumbidgee model, which was enveloped into collaborative trial number two, but then a further number of recruits to take the whole number of Single Employer Model trainees up to 21 for this year, which is quite a positive thing.

Around that, with regard to primary care and training pathways for any of our workforce, we were able to wrap around what we're calling a socialisation program, which is a severely fancy way of saying we're welcoming them to the communities. We're making sure that they're very well connected to not only the community but the health service, and that general practices that are involved or have indicated they want to be involved in this program are well communicated with and recognised for the hard work they put into training and the support they provide for the local health districts and primary care in those communities. We'll continue to do that program.

We're nowhere near the 80 exemptions by any means, but we do have those there ready to take further recruits into rural generalist into the future.

The CHAIR: That program is indeed a very positive program, and NSW Health should be commended for their advocacy. What is going to be the timeline for getting the 80 positions up and running?

LUKE SLOANE: If it was up to me, it would be tomorrow. It's reliant on people choosing general practice or rural generalism as a training pathway. We have had very close contact with colleges in order to promote those training pathways. We have also had contact with our partners from the Health Education and Training Institute, or HETI, which is a pillar of NSW Health, and the workforce team, with regard to being able to communicate that this model is available, work with all the general practices throughout New South Wales rural, regional and remote areas in order to make sure that they know the program is available for anyone looking to either train as an advance trainee or start the pathway for rural generalist training, to boost those numbers. Will we get to 80 within the next five years? That, I couldn't say for sure. We might have a flurry after my testimony today, which puts it out there and makes it appealing for everybody. But it's hard to say when they will come through to the entire number.

The CHAIR: You may want to take this question on notice. I think it's a matter of urgency from the evidence that we've heard around the number of primary care practices that will remain. Are there any barriers that need to be addressed to accelerate that process? I accept that people have to choose that as a career, but are there are any other barriers that need to be addressed and can be addressed to expedite that?

LUKE SLOANE: I think all the rest of the barriers are probably around incentives. We've got workforce incentives in place that Richard can talk to. We're working through prioritising key worker accommodation so that we have places for these trainees to stay when they go out to rural, regional and remote areas. I think the relationships at the moment with both of the general practice training colleges are very firm. I can't see anything other than career choice as being a barrier. We cannot force people to choose to become rural generalists. We'll continue to work with all the stakeholders to promote this as a pathway to a medical career in regional areas. The same thing goes for nurse practitioners—nurses, midwives and all of the allied health specialties. It is a similar thing. The incentives are there. We're working on the accommodation and the key worker housing problem to get them out there from a primary care point of view and having a place for them to live, work and stay and be welcomed to the community.

The CHAIR: Mr Griffiths, do you want to comment on the incentives?

RICHARD GRIFFITHS: I'll speak generally about the incentives and then I am happy to talk about how that applies in terms of medicine. From the incentive perspective, after about a three-year design process, we launched a rural health incentive scheme in 2022. That was utilising an existing government incentives package, but we expanded its reach. We moved it into areas that had been previously restricted by policy. We applied a health methodology across eligibility, so areas that were classified as MM 3 to MM 7 under the Modified Monash (MM) Model became eligible. Obviously there were some other eligibility criteria around being a hard-to-fill role—not all health roles are hard to fill in those areas—or where there were some critical positions. That program has been very successful.

There remain some challenges. There'll be some roles in some areas where you could offer a substantial amount more and it would still be very hard to attract the practitioners into those areas. But on the whole, it is certainly having a positive impact. It has turned around the retention rate challenge, which was its primary purpose. It was designed to do two things: keep the health workers in those areas and attract new health workers. We've been able to attract around about 2,300 health workers on the basis of applying an incentive, and we are paying around 10,000 retention packages to health workers. In terms of medicine, we always knew that, perhaps for the junior medical workforce, that might be an attractor. For the senior medical workforce, a $10,000 or $20,000 payment was never going to really be a sufficient attractor to get them to some of those remote areas when you have to weigh up their potential earning loss from what they could earn in metro areas.

The CHAIR: We'll come back to the incentive scheme in just a moment because we've had some evidence around that. I want to go back to primary care briefly. Recommendation 10 talks about piloting Rural Area Community Controlled Health Organisations. We have had considerable evidence around the need for a new model for primary care in regional and rural areas—one in which there is not a reliance on fee-for-service payments; one in which the Commonwealth and State collaborate; one in which we don't have GPs on call around the clock but have them focused on chronic and complex conditions, managing early intervention; and one in which we have allied health professionals and nurse practitioners working at the top of their scope of practice. There are some models of collaborative care. I'm interested in where you're up to in relation to recommendation 10, which links into that, and the opportunities to begin to pilot and develop alternative models for primary care provision.

LUKE SLOANE: Absolutely. Last year, we commissioned the Sax Institute and worked closely with them. Again, coming back to this notion that primary care falls into the bailiwick of the Commonwealth, which we know that it doesn't in its entirety—that's based on funding, and the community don't actually see the difference between, nor should they have to. We worked with Sax Institute to understand what NSW Health and the local health district role is in the Collaborative Care model. I note that we've got five trial sites that have been set up throughout the state at the moment, including one that I'm sure that you've been privy to with your recent trip to the Far West, the 4Ts Model, and the Snowy Valleys model down in Tumut. Those five models are currently set up—I won't go through them all—and they've had varying ranges of success. The most important part of why—the main successes were that they were the first attempt at doing some form of place-based, bespoke, specific, collaborative model within New South Wales to comply with the intent of recommendation number 10 through the funding we have available.

The decision was made to increase those Collaborative Care sites, led by NSW Health in collaboration with Rural Doctors Network, by five more, allowing us to work with not only with the communities themselves—which is the most important part—all of the private providers, non-government, charity and not-for-profit in the community, but also with the primary health networks and the Commonwealth departments looking at thin or fragile markets and primary care pilots. We've started, and have just had the brief approved, to progress those five sites across New South Wales—not only from the listening tour that we did last year from a regional health division's point of view, but working with the districts and the primary health networks about which communities might be great to trial this from the ground up with NSW Health fully at the front of the leadership of these models. Starting off with Leeton and Wee Waa, we've commenced meeting with both of those communities with regards to what that might look like.

What the Collaborative Care scalability assessment—and I'm happy to furnish the Committee, if I haven't already, with that document—really worked through, from our point of view, is the need for trusted leadership within a community to be meeting with and working with not only the district but also the PHN or the primary health network, to understand what services are coming into the town from a health and wellbeing point of view right now. Anecdotally, Geri and I were out at Wilcannia just a little while ago with the Department of Aboriginal Affairs and quite a few other cross-agency groups. At the end of the day with the community out there, we did a mapping exercise and it showed 30 or 40 different service providers—not just Health but others coming into the community—that could well be arranged or organised in such a way to be more effective and work better for the community.

Our primary motive for these Collaborative Care trials, going forward for the next five, will be to do that with the community, to make sure that we're communicating properly—and I've talked about this with the Select Committee previously—with them about the data that not only NSW Health but the primary health network has on the health profile of those communities and what they need most pointedly from a care provision point of view. It might not just be what happens if you fall off your motorbike or there is a significant car accident or someone breaks their leg or their arm, but also around the chronic and complex problems that a community might be wrestling with at the moment, and to be able to give that information back to the community and have a discussion about what health care looks like.

The CHAIR: So did the work done by the Sax Institute identify those five or was it broader than that?

LUKE SLOANE: No, it was broader than that. It was commissioned to help us understand what NSW Health's leadership role would be in this space.

The CHAIR: It would be great have some information on that and it would also be great to have some information on the five further sites.

LUKE SLOANE: Yes, absolutely.

The CHAIR: What have been your discussions or involvement with the Commonwealth in relation to this initiative?

LUKE SLOANE: I should pre-empt this by saying that that's not the only model that we are trying or looking at with regards to support and wraparound services for primary care in regional areas. When I say "regional", going forward, it's regional, rural and remote. I've been discussing with several departments within the Commonwealth not only around that scalability assessment and the Collaborative Care pilots because they were very pivotal in the first five and working with the local health districts on that and the PHNs and, most importantly, those clinicians involved, but further to that, I've been working and have been invited to the expert advisory committee with Mick Reid and Sabine Walsh around the classification with regards to workforce for sections 19AA and 19AB—Modified Monash, the DSA, the DSP and all the classifications around rural and remote rurality and how they're pinned to different medical workforces.

Then, further to that, with the Department around thin markets, which is probably the most important part to talk about because they are keeping an oversight from a Commonwealth point of view at thin and failing markets across the State—they do that for all jurisdictions. Trying to understand how we can better work some of the exemptions or the funding models to be able to put blanket funding over a thin or failing market to support the GP or the primary care in that area rather than relying on activity and billing services—but that is very early days with regards to those discussions. We have identified a couple of sites and we've gone out to the chief executives early last week around their interest in this. We'll be doing that more formally and meeting with the Commonwealth next week around how we might progress that as an option.

The CHAIR: Just to be clear, those discussions do involve discussion around, as you termed it, thin and failing markets and the opportunity for the Commonwealth and state to look at different funding models to establish those services away from fee-for-service—perhaps pooled funding?

LUKE SLOANE: Yes, that's exactly right. To be fair to the Commonwealth, they've already got some of those initiatives happening within New South Wales. In Glen Innes, they've got the co-op and mutual model which is working off a pooled funding or pro bono support model to be able to organise systems and services in that town. It sounds like corporate speak, but it's involving lawyers, the health services and several other NGOs within Glen Innes—early days, again—to try and look at health and what health might look like from a primary care point of view up there in the near term and then make it sustainable.

The CHAIR: I am going to pursue one more area before I go to Ms Doyle. This concerns an issue that we've previously talked about, and that is locum and agency staff. I'd appreciate either from yourself, Mr Sloane, or Mr Griffiths, an update on the work around reducing locums which are continuing to clearly be an issue for the health services that we hear from and speak to—expensive, the lack of continuity of care and so on and so forth. So, that's the locum workforce and how that is being dealt with. I would appreciate an update on that.

We visited Orange Health Service and learnt that they do not use agency nurses. The Committee was, frankly—not shocked, but delighted in a very surprised way to find a health service that did not use agency nurses. I'm not sure if there's another health service that is in that position, but we were interested to know what the secret there was. Agency nurse use has also been raised with us as a significant issue in terms of continuity of care and impact on staff morale and quality of care. So locums and then agency staff—I don't know if perhaps Mr Griffiths could take this question.

RICHARD GRIFFITHS: Yes, thanks, Dr McGirr. An update on locums—we're addressing that with, really, a three-pronged strategy. The first element is looking at the way that we manage engagement of locums, so how we go to market, how we engage them and their experience. We are in the process of rolling out a vendor management system across the state. We procured one, in around 2022, and we've had five local health districts roll that out. Those local health districts that have rolled out that out have seen some improvement in terms of the way that they engage with the locum agencies and have seen some improvement in their agency fees because of tighter controls. The Ministry of Health has mandated its use across the system, and it'll be a two-year rollout program. But entering into the next financial year, we are rolling out about eight local health districts. They'll be required to use this vendor management system, which will change the way that you engage with the individual locums. All the agencies will be required to.

The CHAIR: Are any of the five rural?

RICHARD GRIFFITHS: Yes, western New South Wales has rolled it out. They've had a very positive experience using it, from what I've been advised. The aim of it is, as I said, to really tighten the controls around the engagement. We also know that there's work we have to do in the health system and to improve the experience of locums, and so we're looking at streamlining some of the engagement processes and the screening processes. At the moment people are screening multiple times. We're putting in a process where you can screen to work for Health once, and that will speed up their engagement. Obviously it's a build, so it takes a little time, but the intent of that is to improve the experience of the locum.

The CHAIR: Is that the second prong of the strategy?

RICHARD GRIFFITHS: Yes, improving the governance, improving the experience, and then there's a third element, which is, from a national perspective, working with other jurisdictions to see how we can address the issue of locums across the country. We're not alone in New South Wales in our experience of locums and the cost. What we are seeing—as you probably heard during your previous Committee meetings—is that because of some of the rates that are on offer in locum shifts, it's becoming very attractive for medical officers to choose what we're terming as a gap year and undertake a locum experience. Really, if we're going to tackle it, we need to do that from a national perspective, and so there's work that we are cooperating with from a Commonwealth perspective where we're looking at how we can, as a country, address the issue of the burgeoning locum rates.

The CHAIR: Do you have any timeline around that strategy at the Commonwealth level?

RICHARD GRIFFITHS: As you can imagine, that's quite a complex piece of work because it requires a lot of due diligence in terms of really getting a snapshot. So I don't have a definite timeline, but perhaps I could take that on notice and come back to you.

The CHAIR: Thank you. Apropos of your comment around the gap year, I understand that almost a fifth of our medical graduates between postgraduate years 3 and 12 are not in a training program or general practice training. I would suggest that the bulk of those people are probably on this gap year, but it sounds like it might be closer to a gap career because the conditions, rates of play and flexibility are so attractive. I just make that comment because I think it's a substantial issue.

RICHARD GRIFFITHS: I don't have the statistics with me, but I could take that on notice, if you like, to try to get it. I think there is still attraction in the specialty training, though. A lot of those people that are electing a gap year are still drawn back into the health system if they can get a training place in specialty training.

Ms TRISH DOYLE: Thank you all for being here today and for your work, and especially the patience of those who are online. I'm going to direct a couple of questions to Ms Wilson. Recommendation 33 of the previous committee's report was that NSW Health prioritise an Indigenous workforce. It included targeted funding for Aboriginal care navigators and Aboriginal peer workers. The Health submission mentions challenges to recruiting and retaining Aboriginal health workers under the current award. Are you able to explain what some of those challenges are, and what NSW Health is doing to address some of those challenges?

GERALDINE WILSON: Thank you for your question, Ms Doyle. I will need to defer that to Mr Griffiths. Aboriginal workforce reports through to Richard's branch. But in saying that, as well, we work closely in partnership with the Aboriginal workforce team and Richard's team more broadly, noting that workforce challenges are right across the system and not unique to any specific area. But there is a lot of work being undertaken looking at the award structures and the career pathways for our Aboriginal workforce. But I might let Richard speak to that in a bit more detail if that's alright.

RICHARD GRIFFITHS: Thanks, Ms Doyle. Over the last couple of years, we've seen a slight reduction in Aboriginal health worker numbers, but we've seen an increase in Aboriginal health practitioner numbers. It's about a requisite increase to the reduction, because we have focused on really looking at the prominence of Aboriginal health practitioners in the NSW Health system. It's pretty important that our workforce branch and the Centre for Aboriginal Health work closely together in terms of really building some of those models of care around Aboriginal health practitioners. I think there's an absolute willingness and appetite across the system to incorporate Aboriginal health practitioners into clinical models, but I think there's a bit of guidance that's needed in terms of embedding them into the clinical models.

We have a couple of projects in place where we are working very closely together—Aboriginal health practitioners in emergency departments, for example—to really showcase what the Aboriginal health practitioner workforce can provide to the NSW Health system. While there has been a slight decline in Aboriginal health workers, the practitioner workforce has increased. In terms of the award, we do recognise that there's work we need to do in terms of the industrial frameworks with Aboriginal health practitioners and Aboriginal health workers. There are some things that we've been able to do locally in the health system; there are others that have really required a broader approach to the award negotiation. We've got some conversations underway around, if we design a new industrial instrument, what that should look like. But in the meantime, we've looked to free up some of the restrictions around movements in and out of the Aboriginal health worker classifications and the other classifications, which I think is helping in terms of encouraging people to move into that classification.

Ms TRISH DOYLE: Excellent. Just further to that, Health's submission mentions formalising partnerships with the Aboriginal community controlled health organisations. Are either of you able to provide an update on which of those organisations you have formalised partnerships with or which regions you're focusing on?

GERALDINE WILSON: I can take that question. Most local health districts do have partnerships in place with the Aboriginal medical services (AMS) within their footprint. They're longstanding partnerships. We've had an overarching partnership at the state level for probably close to 30 years with the Aboriginal Health and Medical Research Council of New South Wales, and that partnership agreement is replicated locally with AMSs and LHDs. There is a process of review that takes place with those partnership agreements. We are moving more towards an outcomes focus within the partnership agreements as well, but they are very much something that, in terms of the work that the centre does, we do very much support the local partnerships and work very closely with our districts and also our Aboriginal medical services in facilitating those relationships where needed and when required. I think the majority of districts do have them or they are at the point of reviewing them at the moment.

Ms TRISH DOYLE: Are there any that stand out? Can you give some examples of what is working well in terms of setting a blueprint?

GERALDINE WILSON: There are probably quite a few examples right across New South Wales, but if I think regionally, Northern New South Wales have quite a good partnership between their district, and there are a couple of Aboriginal medical services within that footprint where the clinicians—primarily driven through the Aboriginal medical services—are coming together to review patient data as well, and looking at more of a CQI process around continuity of care for those patients between the AMS and Local Health District, and looking at how we can improve those shared outcomes between the two. That, for me, I think is where we want to move to more broadly across all of our partnership agreements, but that one in particular is evolving and taking shape, but it's very much I think where we need to head towards.

Partnerships also within the Western New South Wales footprint—I think there would be quite a few there. Luke will have seen some of those examples as you travel around the state. They are not just with our Aboriginal medical services as well; a lot of the Local Health Districts are working with other Aboriginal NGOs within their footprint. That is something that we do want to see more of because if we are going to close the gap in life expectancy, we have to be looking at the social determinants, so working with a really broad range of providers that are working in our communities. Those partnerships are really growing and strengthening through some of the work that's occurring across government with local decision-making groups as well as our AMS colleagues.

The CHAIR: Ms Wilson, the Aboriginal community controlled organisations in the north of New South Wales that were working—what was the name of those?

GERALDINE WILSON: Bulgarr Ngaru AMS.

The CHAIR: That's based in?

GERALDINE WILSON: Casino, Lismore.[4]

The CHAIR: And in Western New South Wales?

GERALDINE WILSON: There are a number. Most of the AMSs are actually in the footprint. There is Orange, Dubbo, Coonamble and Walgett. Some of the partnerships operate at varying degrees in terms of their maturity, but that is something that the centre is working with the districts and the AMSs around, looking at how we can strengthen those partnerships, particularly when it comes to the outcomes that are required locally for those communities that each are working with. But there are quite a number of AMSs that we fund. We fund close to 41 AMSs across New South Wales. There are many more AMSs than that, but those are the ones that we have a funding relationship with and look at how we support those services in their partnership with our local health districts.

The CHAIR: I make the comment that we visited with a service in Grafton and we were very impressed with their approach to population health. In fact, they had led work in terms of rheumatic heart disease. I have to say, their feedback was that they had found it quite difficult to engage on the ground with the local health district, particularly in their efforts around clinical governance and engagement. We were quite impressed with the work they had done, as I say, in rheumatic heart disease in that region, but they did feed back to us some difficulties there and some resistance to the work that they were doing. I will just make that comment.

Ms LIZA BUTLER: My question is to Mr Sloane, Deputy Secretary of Regional Health, around maternity and obstetric services. I'll begin by just telling you what we heard today. We have heard that there are 91,000 births in New South Wales each year, and one-third of these births are in regional, rural and remote areas, yet we are still seeing maternity and obstetric services closing. We heard that local maternity services are vital, that reopening birthing services is essential for small communities, that there are barriers to ongoing training and upskilling for GP obstetricians, that obstetric maternity services need a real focus, and that it is beyond local health services to resolve. In relation to recommendation 27, the NSW Health submission recommends two committees that support the implementation of *A Blueprint for Action – Maternity Care in NSW*. Can you provide an update on the actions taken and outcomes of those actions as a result of these committees?

LUKE SLOANE: I will throw to Dr Woods to outline some of the actions taken. If that doesn't cover your question in its entirety, I can come back to you. But what I will say is we know not only from the local health districts but all across—I'm not sure what those training barriers for GP obstetricians are. We know, absolutely, that there are workforce shortages for midwives, GP obstetricians and obstetricians in general right across

[4] The Committee received correspondence from Ms Wilson providing clarification on these statements, which is published on the Committee's webpage.

New South Wales in regional and remote areas. Where we can, we have been trying all different kinds of alternative models in order to fill rosters for midwives. There has been a slow return to midwives that perhaps decided to take a break during or around COVID—a very slow return to those.

We are continuing to work through the Chief Nurse and Midwifery Office with universities to ensure there is an understanding around the need from a pipeline point of view, which Richard can probably talk to as well. What we are seeing when we are talking about birthing services shut—we need to balance that with safety. I really want to make sure that that's on the table today. The lower the birthrate goes in a certain town—and that's not everywhere and sometimes it is according to staff availability, but sometimes it's just purely related to birthrate in that town—that does impact on the clinical staff's ability to maintain their skills and maintain a healthy and safe environment for people to birth and have their care in. We do not want that; we want to maintain quality and safety throughout all of our services. I think we know that there is a want or a need from a lot of districts to pivot towards a midwifery-led model of care for a lot of mothers. We have heard that throughout the birth trauma inquiry and it's outlined in the blueprint for maternity.

We know that, again, it comes back to those retention and attraction activities across all rural and remote areas to make sure that we can entice workforce, whether it be new career midwives and/or GP obstetricians. We also probably should highlight though that whenever there is a birthing service and we might have a plethora of GP obstetricians—and I really do want to vouch for the amazing care that they deliver throughout regional New South Wales—there is a reliance to have GP anaesthetists in order to offer the most appropriate support, again, coming back to safe care for certain levels of birthing and antenatal and perinatal care in some of these towns. When we don't have those interdependent relationships—or coming back to the thin or failing markets—the general practitioner might like to go and live somewhere else, which we can't really stop, then we do need to assess what services can be provided within the role delineation of that site. I might throw to Dr Woods to comment further.

ANDREW WOODS: To follow on from Mr Sloane, we are committed to strengthening maternity care across New South Wales. Of course, that includes rural, remote and regional centres. There are a number of aspects and initiatives that we are looking at that are supporting that. As you would be aware, *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW* has a strong focus on improving maternity care, and has two specific committees—the Consumer Reference Group and the Expert Advisory Group—which are represented from across the entire state, including the areas that we are discussing today. We have a good opinion on how to improve care across all our maternity services. That's supported by the work that the Clinical Excellence Commission (CEC) and the Agency for Clinical Innovation (ACI) are doing in this space, as well as the Ministry itself, with maternity and neonatal service capabilities, which focuses on ensuring that each service can provide the care that's appropriate for its workforce location and linked in with a tiered perinatal network to provide strong support, from a safety and quality care perspective, with every service linked within its LHD and within its tiered perinatal network to higher level services should women require transfer for higher level care.

To monitor service capability, every LHD is required to submit maternity and neonatal service capability assessments annually and, should there be any identified gaps, undertake appropriate risk assessments to flag those with the LHD and work to fill those gaps and reduce those risks. We have an initiative called Pregnancy Connect, which you may be aware of. This is the evolution of the very successful maternal transfer redesign, which supported women to have care close to home and transfer for higher level care to birth in the right place at the right time. The next part of Pregnancy Connect is to extend the scope to connect women with care close to home to reduce the need for travel, and part of that is to support local clinicians in rural, regional and remote areas to provide the care even for high-risk women, with support from their tertiary centre and higher level care through the tiered perinatal network. Part of that is looking at how we expand outreach, and that's not just face-to-face outreach care but also virtual care for both planned and unplanned activity.

I think it's also important to recognise that we involve all stakeholders in supporting maternity care. So NSW Ambulance—all our paramedics have training to provide unplanned maternity care in the community when required. There's a lot of work done with non-birthing facilities to ensure, should a woman present with a maternity or a pregnancy-related complication, that non-birthing facilities have the skills to be able to provide that care. Again, they are linked in through the tiered perinatal network for advice and support as needed.

Ms LIZA BUTLER: All the area health services are doing those things individually. Is there a process for it to be looked at as a whole across the whole of New South Wales to find the best practice? For example, Glen Innes has just had birthing services returned. Are you looking at that and working how that could be rolled out across rural, regional and remote areas across New South Wales?

LUKE SLOANE: I will just re-emphasise that the work that Dr Woods is talking about is completely statewide. It's not by exception for LHD or otherwise; it's all of the obstetrics teams brought together—their

leadership groups with midwives and otherwise—to look at how that tiered perinatal network looks as a net across all of New South Wales, including rural, regional and remote areas. I cannot stress enough that when we talk about returning birthing services, in a lot of the areas it's about recruiting, and recruiting midwives to come back into a town, whether it be Glen Innes or otherwise.

Dr McGirr, you asked a question earlier why Orange does not use any agency nurses. I mean, this is the magic question, right? I've been to 190 facilities of the 220 now. As I think I've said to the Committee previously, you can go to a place like—we'll say Broken Hill, for example, where they've got a really great, well-structured and well-staffed maternity unit, with a consultant who is very dedicated to that area, and their maternity and full perinatal service is working great; or somewhere like Glen Innes, where they've got a great midwifery group that has been re-established and recruited back together. You then might travel, I don't know, an hour down the road and they will be X number of full-time equivalent short and be unable to provide that wraparound service like they would like to.

To really emphasise, where there are perinatal and obstetric services in place, we still need to be able to recruit, retain and attract people to come and work in those areas. We've got good pipelines for midwives and good relationships with the university with regard to—so we've got the MidStart training pathway. We've got direct-entry B mid student entry pathways, and then we've got overseas recruitment for midwives happening at any given time of the year. It's a case of then being able to influence them to distribute them to a place where we need them the most. At the moment that's as far as we can go with regard to gently encouraging people to go and work in a certain area that will be safe for their level of experience as well, but also to entice them to that area to work.

Ms LIZA BUTLER: Orange hospital calls it its Grow Our Own staffing model to encourage people to undertake training. Are we doing that in other health districts, looking at what Orange has done, to implement that elsewhere to grow a local, regional—as we've all said, if you train regionally, you will stay regionally.

LUKE SLOANE: Richard might want to make a comment on that—no pressure. This is this tension between doing very bespoke, place-based work for each one of the districts, towns or otherwise. Some towns, right down to the town, have a strategy around this. Again, coming back to Glen Innes, they've got a very good strategy and have had for some years around connecting, attracting and recruiting workforce to the town across various different areas. But, yes, each one of the districts will have their own "grow and retain" plan that's done in conjunction with the universities that they're connected to and/or other things that they can optimise, like country university centres for campus, those Commonwealth-supported places for degree training into different—look at Kempsey—for medical engineering, town planning, nursing, midwifery, and their connection with the university. I think each one of the districts has it. There's an overarching strategy from the workforce from a system point of view, but each one of those needs to be nuanced a little bit for the district or the communities that they're serving as well.

The CHAIR: Can I follow up on that? Dr Woods, you mentioned the neonatal maternity care capability assessments that are done yearly by health services. I would imagine that there would be situations where particular facilities, in the course of those assessments, revealed that they had low numbers of either obstetricians, GP obstetricians or midwives, and their capability therefore had dropped. We've certainly been to and heard from a number of services where there's a shortage of obstetricians and a shortage of midwives. We heard this morning, in fact, of considerable shortages.

It seems to me that, if you got that assessment—I am not sure who reviews them—there would be two ways of approaching it. One would be to say, "This service really has got to the point where the service can't continue because the staffing is not sufficient." You've emphasised the issue around safety, Mr Sloane, and we certainly are not going to advocate for any unsafe practices. The other alternative strategy would be to say, "That service has reached a certain level of capability. We need to build that up." I am not sure what approach is taken. I guess the Committee's view would be that we would like to see services built up and not, by default, reduced. But I understand the pressures in the system.

I am wondering what approach is taken. Mr Sloane, encouragingly, I think you indicated an acceptance for the need to sustain and build services, so I would like to hear from you or from Dr Woods what steps are taken. For example, particularly, say, with obstetricians in some of our regional centres, there seems to be a real shortage and a heavy reliance on locums. Frankly, I am not sure how the local health districts are going to recruit specialists to continue to live and practise in those areas and what support is being provided by NSW Health for those health districts to, if you like, build back up those services. Either you or Dr Woods. What is the response to a capability assessment that says, "We're losing staff here. We don't have enough staff"? Do we go in and look for ways to build it up? What support is provided to the local health district to do that?

ANDREW WOODS: I can't really speak to the workforce issues. I'll ask that back. But in terms of undertaking a service capability assessment, they're performed across the districts annually, as I mentioned. The medical and midwifery maternity co-leaders are responsible, supported by the neonatal leaders, to provide those assessments and, should a service volunteer, identify a gap. Whatever that gap might be, the necessary risk assessments are done and escalated through to the district's executive leadership team for consideration and action. Of course, all service capability is underpinned by appropriate steps and plans and business continuity plans to ensure, as far as possible, that the maternity service is sustainable, kept functioning. We've already talked about the reliance on locum and agency staff that many areas have. The service capability assessments are reported through to the Ministry on an annual basis and they form part of the NSW Health mothers and babies report. I think the service capabilities give us an idea of where to prioritise action from a district perspective, but also they help to inform things such as the expert advisory group to look at how we can support services moving forward and prioritise aspects of improving maternity care across New South Wales.

The CHAIR: Can you give me an example of the actions taken to support, restore and build up those services where they are suffering significant workforce shortages?

ANDREW WOODS: If it's okay, I can speak from experience within my local health district.

The CHAIR: Yes.

ANDREW WOODS: My substantive role is within Hunter New England. We have 14 maternity services within Hunter New England: a level 6, four level 4 services and the rest are level 3, many of which are struggling with various workforce challenges related to obstetrics, midwifery, anaesthetic and perioperative services—all of the necessary services required to support safe birthing. We look at each of our services not in isolation but as part of the network and ensure that, as far as possible, we are providing continuous services across the various sectors. Services have supported one another, particularly when they're isolated services, to provide backup for staff. Services that are close together will work together to ensure that women are birthing as close to home as possible. The executive leadership team are prioritising recruitment strategies to ensure that we attract the staff that we need—both midwifery, medical and others—to keep those services sustainable. It's challenging.

Ms LIZA BUTLER: At every public hearing we've had when we talk about maternity and obstetric services and losing those services in regional, rural and remote areas, there have been suggestions from people that, instead of building that workforce up when you're struggling, it's easier to close the service and then blame that on workforce. It's around budgeting for an area health service and that's a great excuse. What is your comment on that?

LUKE SLOANE: I don't think any LHDs or the system from a frontline perspective would be looking to do that. Even last week we were talking about the amount of effort to go through to recruit one RN at a certain place within northern New South Wales. We're talking about 30 applicants applying, 15 applicants not completing their application, that person then having to ring every single one of those 15 applicants to say, "Do you need help completing your application? Because we need more than just you on the ground here," going through all of the 30 applicants to that one registered nurse position and trying to entice them to come through for an interview, with half of them then pulling out or otherwise. And that's just for one site. Multiply that by 185 or 200 sites. I think the districts are absolutely recruiting or have rolling recruiting happening. I've had multiple representations even down to the south-west of us around what's happening with regards to recruiting.

You only have to log on to "I work for NSW" or otherwise to see the amount of rolling ads or recruitment with the top line being incentives offered to be able to bolster and fill the FTE that are vacant or being covered off. Some of the districts have tried a different tact around some of their casualisation of their workforce, where they know it's probably even less expensive to fly people out to do midwifery sections in short stints as a bit of an attractor rather than going out for months on end. They might say, "Look, will you come out? We'll fly you out and put you up for a week," to fill the roster for a midwifery service within the state, because we know that's also cheaper than some of the agency rates or locum rates that are going around for those positions.

They have had some success of recurrent staff that will take them up on that offer and come out and then fill the roster back up. But, again, it's not a permanent solution; it's more of a stopgap at the moment. I don't think that any of the districts, hand on heart, would be doing what would look like a bank spiral to close a service or reduce services that might be in a certain area. But there might be some rationalisation in certain circumstances where there are two places that are 20 minutes apart, and one is fully staffed and the other one is not, to then devote all of the attention to one of the places to build up the capability and to develop what is a good thing. If you talk to any of the clinicians around the table, I think that what they would tell you is you need really great leadership in some of these specialty areas—a couple of people around to support so that they're not doing every night on call. That creates another social or clinical incentive to go and work in a safe and well-supported environment that's well networked across the districts.

The CHAIR: I'd agree with your comments there and I generally think local health districts have been able to recruit staff in a number of areas. They all have challenges, we know. We've talked about locums and agencies. It's probably our perception as a Committee that maternity and obstetric services are a special case, that the local health districts—it's well beyond their capacity now. I accept what you've just said around what's required to recruit and build up those teams. But so many services now are on the brink of or are facing persistent locum challenges. Our concern is that this is becoming an emergency situation because it will take a while to fix it. If we don't start acting at state level, there may be an issue. On that issue, I want to come back to Dr Woods. When was the last time a graduate of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists in New South Wales filled a rural vacancy in a rural and regional hospital?

ANDREW WOODS: I'm going to go back to my own district, if that's okay. We have had recruitments to Tamworth within the last three months—specialist recruitment.

The CHAIR: And is that a common thing? Is that an Australian-trained graduate of the college?

ANDREW WOODS: Yes, it was.

The CHAIR: It would be my impression that that's unusual, judging by the workforce that currently provides obstetric services in regional New South Wales.

ANDREW WOODS: I'm not aware of the recruitment across the entire state or the challenges. If you'd like specific information around that, I'm happy to take that question on notice.

The CHAIR: That would be good, because it's my concern that goes to the heart of the issue here. We perhaps aren't producing graduates suitable for rural practice and that's a challenge for NSW Health. That's why I think there needs to be a statewide look at that issue. It would be good to get some information from you on that to check what is happening in that area. Thank you, Dr Woods.

Mrs TANYA THOMPSON: I'd like to move to mental health. Recommendation 11 of the Portfolio Committee (PC) No. 2 report aimed to address workforce shortfalls in the mental health sector such as mental health nurses, psychologists, psychiatrists and counsellors. We've had many conversations on the ground with staff that work in that space. We're finding through those conversations that they are still highly fatigued—the on-call component, the rostering. They feel very unsupported and there are some problems there with management not recognising those issues in some LHDs. We've heard today that one-fifth of the state's psychologist positions are not filled, so there are still huge gaps within that sector within mental health. We have also heard of the pressure on paramedics that patients can't be treated and moved where they need to be and they're stuck in a kind of a limbo there. That places more pressure on paramedic staff as well as the patients. I'm interested to know what action has been done in relation to recommendation 11. Also, has the Rural Health Workforce Incentive Scheme really played a huge role in the recruiting and retention of staff across the state?

BRENDAN FLYNN: I'm happy to start. I would point out that we are conscious of the concerns that staff have raised with the Committee, with districts and networks and their directors through to the mental health branch. There are specific workforce initiatives that are related to that recommendation for each discipline that I will ask Mr Griffiths to expand on because it sits with workforce. I would say that the challenge—and it is often successfully addressed—is trying to make sure that the staff that we've got feel supported and that is done in concrete ways. So, for example, trying to pay attention to case loads, education and professional development. A big part of that—and it's something that we often talk about from the branch's point of view—is retention of the staff that we've got in regional and rural New South Wales. There's obviously a workforce challenge across Health but particularly in mental health. I think that's true to say that it is certainly our sector's greatest challenge. I don't know if you want to expand on the initiatives or if that was something you wanted more information around.

RICHARD GRIFFITHS: I'm happy to keep going. Before I move on to the incentives, Mrs Thompson, I think you mentioned psychologists. I don't think that would be—

Mrs TANYA THOMPSON: Psychiatrists.

RICHARD GRIFFITHS: Psychiatry is a particularly challenging discipline at the moment, not just here but internationally. So much so that—and I'm sure you probably heard from our industrial partners this morning that we have come together as a group to look at how we can address and refresh our psychiatry workforce plan. Our psychiatry workforce plan takes us through to 2025. Obviously the industrial associations have been talking about remuneration, and we're cognisant of some remuneration challenges, but we think there are also things we can do as a collective to come up with improving the experience of psychiatrists, both from an employment perspective but also a training perspective. We've only had two meetings but we're working through a range of strategies to help with improving the attractiveness of psychiatry.

There's a range of disciplines experiencing similar challenges and, again, we're not alone in Australia. There has been some international experiences of specialties that are experiencing some recruitment challenges. There's a range of strategy work underway in partnership with the Commonwealth. We are looking at ways of improving or improving the attractiveness of medical specialty careers. It's challenged at the moment, as I mentioned before, with the locum scenario. The locum scenario is probably moving people out of the health system employment for a period that was previously their training trajectory. What we are experiencing with medical is, by the time you move through your specialty training, as an individual you're an older graduate. We're looking at how we can encourage people to enter their training as soon as they are able and to not be drawn out into the locum work.

You asked about the rural health incentive scheme. I will always caveat this to say there are going to be ongoing challenges that we'll never be able to resolve with this scheme. But to your question around whether it is really helping yet, we think it is really helping. We are very grateful to the government, both previous and current, for approving and continuing the incentivisation of health workers. We think that's really critical. We know that there is some challenge with other states and the attractiveness of remuneration arrangements in other states. This is certainly helping to compete in that market. I think I mentioned 2,300—that was FTE, but it's about 2,700 people that we've recruited because of the incentive package, the recruitment package. That package is up to $20,000 for the first year and then would drop to $10,000 for the subsequent years. That I think is helping to make rural health careers a little more attractive. That's really probably encouraging people—certainly assisting, anyway—with things like relocation into the country.

The $10,000 or so retention packages, that was our significant challenge coming out of COVID. We were losing health workers in the regions and it has stopped that flow. Now whether you might say, "Was that going to happen anyway?" Perhaps, but it was getting to the point that it was approaching a crisis—if not a crisis—and we needed to act fairly quickly. What we have seen is that turnaround. We're almost at pre-COVID levels. Pre-COVID retention levels were pretty high, probably a little too high in some cases that closed off promotion opportunities. We are seeing a return to near pre-COVID retention levels. It does seem to be working. We know there'll always be rollout and teething issues, and I'm sure you're hearing some of those—this person gets it and this person doesn't. We're working through that as a group with our industrial partners. We will get to the point of some sort of happy continuum fairly soon, hopefully. But we always knew there would be some teething issues with it.

The CHAIR: Recommendation 25, which was not supported by the previous Government but has been supported by the current Government, suggests an inquiry into mental health, including mental health services in rural, regional and remote areas. Are you able to update us in regards to what is happening in regard to that recommendation? I'm happy for you to take it on notice, but you might be able to provide us with some information.

LUKE SLOANE: I'm very happy to take it on notice, but I was of the understanding that the recent inquiry into community mental health was going to take the lead on that, then following recommendations and further outcome from that, there will be further discussions with regard to proceeding to a whole of—given the numerous and very recent in history inquiries into mental health within New South Wales.

The CHAIR: We might get that confirmed and then add that into the actions from the recommendations.

LUKE SLOANE: Yes, happy to do so.

Ms TRISH DOYLE: My next question is to Professor O'Brien from the Cancer Institute. Recommendation 21 of the last committee's report was that NSW Health work alongside the Commonwealth and service providers to find strategies to help with those out-of-pocket costs for cancer treatment. The Health submission includes information on the updated Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) to address this recommendation. Are you able to provide an update on the uptake of the scheme by rural and regional communities who are receiving cancer treatment? How have you been ensuring that these communities receive cancer treatment, that they're being considered in the future IPTAAS reviews?

TRACEY O'BRIEN: Thank you, Ms Doyle, for the question. I'll come to the answer in one moment. I just make two brief points. As the Chief Cancer Officer, I've had the privilege of visiting all of the local health districts—the nine regional local health districts—in the last couple of years. I just want to make the comment that as a cancer specialist myself, it's a great privilege to see the excellent, hardworking multidisciplinary staff right across the regions and the rural areas. I've witnessed exceptional care. There is some care that is actually better than in the metropolitan areas, which I've shared with the metro areas; I'm happy to give some examples of that. I think there is a lot to be proud of. That said, there is definitely always room for continuous improvement. I think that's fundamental to health care. That's why there is a focus on people living in regional and remote areas in the NSW Cancer Plan 2022-2027. There are 14 action items that feed up into the New South Wales regional health plan.

A second quick point to make is that the significant impact of cancer on our communities can't be overstated. I know the Committee is concerned about that and has heard from a number of community members. In New South Wales, someone is diagnosed with cancer every 10 minutes and someone dies every 30 minutes. Although we have got the best outcomes in the world, we recognise not just the devastating physical and medical impacts but the emotional and financial impacts on families. For those in regional, remote and rural areas, the necessity of travel and the isolation really does extend a heavy burden on them during an already difficult time.

Our role as the Cancer Institute, as the pillar for New South Wales, is being responsible for coordinating what is a complex task of cancer control. We often talk about cancer as one disease, but it's hundreds of diseases. It requires care across multiple partners—primary, community and tertiary care, as well as quaternary care. It requires a strategic, coordinated approach, as you've suggested, and working with many partners. It's across the whole of the cancer continuum. That means prevention, awareness, cancer screening and early diagnosis, not just the care component. Research is also very important. We are very committed to working with partners. Over 800 were involved in the cancer plan, and there are 80 active partners in the delivery.

With regard to recommendation 21 specifically, the Committee will be aware that work was done to expand IPTAAS for the use of clinical trials. That's a fantastic thing for rural and regional patients. An audit has been done between January and December 2023, and we know that there have been over 9,100 claims for IPTAAS for cancer. Furthermore, we've broken down those claims. We know that 49 per cent, so just around half of that, is for radiation oncology. With that, we've undertaken a second piece of work to look at radiation oncology. There is a movement within the radio oncology world where the use of hyperfractionation is being used more commonly. That means giving less fractions but more intense therapy. What that means for a patient, say, with early stage breast cancer, is that instead of having 30 fractions, which can take five weeks if you have to travel, they can have that done in 15 fractions, or three weeks of travel. We've undertaken, at a statewide level, to ensure that's in every radiotherapy facility.

There are now 10 comprehensive facilities that offer radiation therapy. In all of the private providers as well, there is rapid uptake of hyperfractionation, so patients have to travel less. As of the audit done last year, we know that around 96 per cent of providers are providing hyperfractionation. We're also now looking at prostate and bladder radiotherapy. This is a way to reduce the amount of travel. With regard specifically to recommendation 21, it's more the financial cost, the out-of-pocket costs beyond the travel and accommodation—things like reduced employment and additional medical costs. One thing we hear commonly is the strain on grandparents being diagnosed and they are carers for their grandchildren. That has a knock-on effect for family members in terms of cost in these really challenging times for everybody.

We work with a number of not-for-profits in the cancer sector because of its major impact in the community. It has many, many providers. At a national level, there are a number of tumour-specific providers that help and coordinate some of the out-of-pocket costs and coordinated care—Lung Foundation, Movember, McGrath and the Ovarian Cancer Research Foundation, to name just a few. There are also tumour-agnostic charities that we work with, like Tour de Cure, and culturally specific charities, like Pink Sari, CanRevive and for the Chinese community, as well. And then, of course, NSW Cancer Council takes a really important role. I know they gave evidence to you on Friday. They provide a wonderful service through the 1300 number, and we work closely with them in their ability. Hundreds of millions of dollars are donated through public funds to many of these cancer charities.

Working as a coordinated, whole-of-system approach in order to deliver as much information to patients and to support patients as much as possible is important. I can say that one of the other things we do at the institute is ensure that there is a connection to the available information, particularly for costs, travel and IPTAAS assistance, and linking to all of these charities through the Cancer Institute NSW website. That's a website that is used by millions. In particular, there have been 125,000 users that have specifically been looking at the out-of-pocket costs, and we've been able to link them to some of the many state-based and national charities that I've mentioned.

The CHAIR: Did you mention Can Assist in that list?

TRACEY O'BRIEN: As you would be aware, Dr McGirr, Can Assist are phenomenally important across our state, particularly in transport. Absolutely.

The CHAIR: Recommendation 21 talks about working with the Commonwealth to reduce these out-of-pocket costs. I know there are out-of-pocket costs that people and families sustain because of time taken off work and so on, but in respect of charges from private providers for public patients—there's an example of that in Wagga, and there are other private centres—what work is being done in relation to working with the Commonwealth to try to reduce those out-of-pocket costs?

TRACEY O'BRIEN: I might need to defer back to Luke for some of those. As you're aware, Dr McGirr, Wagga should be sorted very shortly. As I understand it, in terms of public patients being seen in some of the private radiology providers—which is where the scenario is the most common—across the state, there are not the out-of-pocket costs for the service fee of the radiotherapy delivery. That has been pretty much taken care of. It doesn't take care of the other out-of-pocket costs to travel to see the provider et cetera. We are then reliant on other schemes for that. There's a lot of work being done at a Commonwealth level to address the out-of-pocket costs through the Australian Cancer Plan. It is a targeted initiative through the Australian Cancer Plan. New South Wales has representation on that plan and is actively involved in that plan. I sit on the national implementation committee for the Australian Cancer Plan as well on behalf of—

The CHAIR: Thanks, Professor O'Brien. That's good to know. We might get you to come back to us and confirm that those issues don't exist for the situation where the Commonwealth sets up radiotherapy units and makes it a requirement of their operation that there are no out-of-pocket costs, but then NSW Health ends up paying the out-of-pocket costs because there hasn't been a discussion between NSW Health and the Commonwealth. That's the specific issue there. I know the Commonwealth funds some radiotherapy services and provides grants in different parts of the state, but the issue is do they talk to NSW Health before setting them up and make sure that there aren't out-of-pocket costs? My impression was that they don't.

It would be great to have some clarification that there's now an arrangement in place whereby the Commonwealth is talking to NSW Health so that we don't have that situation arising again, such as what occurred in Wagga. I'll take that as a question for you on notice. That is encouraging. I'd like to ask Dr Wenham a question around palliative care. Dr Wenham, in recommendation of 23 of the PC No. 2 report, there was reference to establishing a palliative care taskforce to address a number of issues. Are you able to update us on the work of that taskforce and any challenges it is currently facing?

SARAH WENHAM: I'm here today as both a specialist palliative care physician for Far West Local Health District and as the co-chair of the Agency for Clinical Innovation (ACI) End of Life and Palliative Care Network. As far as I am aware, we haven't got a taskforce that's set up. There is an end-of-life and palliative care committee that has been established by the Ministry, and we do have the ACI End of Life and Palliative Care Network. But as far as I'm aware, there isn't a taskforce at present.

LUKE SLOANE: Dr McGirr, I should clarify, that committee was set up with the intent of satisfying the intent of the taskforce recommendation. There is the semantics of the name, but the end-of-life and palliative care committee is set up and terms of reference are being reviewed with the remit to satisfy the intent of that recommendation.

The CHAIR: Which is the committee, then?

LUKE SLOANE: The end-of-life and palliative care committee.

The CHAIR: Are you or Dr Wenham able to update us on the work it's doing to address the recommendations in the report?

LUKE SLOANE: I don't know if Dr Wenham wants to talk about the committee, but what I can say at the moment is that they've commenced a review and the actions arising from said review will be finalised in the context of a wider governance framework for palliative care across New South Wales. This will be undertaken as part of the review and evaluation of the End of Life and Palliative Care Framework dated from 2019 to 2024 under NSW Health. Again, it comes back to the recommendation around Far West palliative care being a great model—and Sarah can talk to that a little bit—and understanding how that fits across all the different communities in New South Wales and all the different people, including Aboriginal people. There has been a review with regard to palliative care for Aboriginal people conducted by the Ministry. The review was completed in December 2023, and actions arising from that review will be finalised and intertwined with that governance committee and the implementation of the actions, once the review is complete.

The other thing is that we've also established an Aboriginal palliative care network as a forum for our Aboriginal palliative care workforce, coming back to the workforce discussions. What that does is it enables all of the districts and networks from the system point of view to share information around the really successful initiatives and the great work that's happening in Aboriginal health workforce training, with specific reference to palliative care, not only at a state level but also on a wider interjurisdictional level, with regard to improvement initiatives and the exchange of information where the models of care are working really well. Sorry, Sarah, to interrupt you. I'll throw back to Dr Wenham.

The CHAIR: Thanks, Mr Sloane. Have you got anything to add to that, Dr Wenham?

SARAH WENHAM: In terms of the ACI End of Life and Palliative Care Network, it isn't just a NSW Health committee. It is a broad network of over 1,000 members from all palliative care members, clinicians and consumer representatives from all of the healthcare systems. It does include general practitioner, aged care and community representatives from outside Health as well. Certainly, the work that the ACI End of Life and Palliative Care Network does is much broader than just looking at within NSW Health. The other thing I would say is that there have been representatives from the ACI network in the work that has been happening, in partnership with the pain network, to map the palliative care services that are available across the state. And there has been representation in terms of working with our partners around looking at platforms and data collection for clinical benchmarking.

The CHAIR: I have one final area to ask about. This is to Dr Goodwin. Dr Goodwin, thank you for joining us today and thank you for being so patient. We have heard of a number of issues around the availability of specialist paediatricians in rural and regional areas. Some centres have a reasonable number but we have heard of some centres that are struggling. We've certainly heard feedback from the community about accessing paediatric services for the purposes of assessing developmental delay amongst children in regional and rural areas. Each of us has had stories of constituents who cannot get in to see paediatric services locally for up to a year or longer and who either seek them in the city, go privately or don't access those services. It does seem to be a significant and emerging issue, and I'm wondering if you have any comments on it.

HELEN GOODWIN: It's a complex issue, and it's not a new issue. For those of you who don't know, I was a regional paediatrician for 16 years in Tamworth. Certainly, something that we faced is that recruitment and retention in general paediatrics is a problem. Similar to psychiatry, it's not just in New South Wales, unfortunately. We're seeing it in New Zealand, across the country. Regional areas are probably worse off, but even metropolitan places, including some areas in Sydney, are struggling to recruit to general paediatric positions. It's a complex issue. It's a mixture of skill mix and critical mass. As part of the challenges faced in regional areas, if you have a lot of people, it makes it an attractive place to work. You can back each other up. In smaller areas or areas of smaller workforces, one vacancy will have a significant impact on the work-life balance and on-call arrangements et cetera of paediatricians.

There's no doubt that paediatricians working in regional areas have a fulfilling career, but it does come with a lot of challenges, including the broad skill mix that's required to be an effective general paediatrician. Paediatrics is still an area where specialists are mainly in general medicine, more so than subspecialty care. Therefore, a general paediatrician in a regional area will have to cover such things as preterm births, attending deliveries, emergency departments, acute inpatient units and special care nurseries, and then have fully booked outpatient clinics managing children with chronic and complex conditions—end-of-life care, cancer follow-up and all the things that you're trying to do to keep people as close to home as possible.

Everyone is working very hard and doing a great job, but there's no doubt that there is significant and unmet need in the community for children, particularly with developmental and behavioural problems. That's multifactorial. Part of it is the medicalisation of disability and learning difficulties. Potentially, diagnosis-based entry into services to provide help is part of a problem that creates its own issue. There's definitely an increase in diagnosis in ADHD and autism spectrum disorders. Most of those require a paediatric review for diagnosis and some require treatment paediatricians to be involved in treatment, particularly if its medication related. Having said that, we're making progress. Twenty years ago, most regional centres had a couple of paediatricians who worked ridiculous hours to maintain the service. Now we have many more positions in regional areas than we did. There's no doubt. There's double the number of general paediatricians in Tamworth compared to what there was when I was there. Wagga has 10 people. Admittedly, only half of those are publicly funded. But that's making massive progress and that's the way forward—to have a critical mass to make it a good place to work and live.

There are things that we are doing, though, to try to improve that. The acute services need the backup of tertiary advice on-call after hours— Newborn & paediatric Emergency Transport Service (NETS) retrievals. VirtualKIDS is definitely a way forward, particularly for places that are poorer, where there is a higher number of children attending emergency departments for triage category four or five, or what we consider potentially more minor illnesses. Hopefully, VirtualKIDS will have a big impact on that. I think that's particularly the case in regional areas where access to GPs is that much more difficult. Changes in the prescribing rules for stimulant medication, where GPs can co-prescribe with paediatricians and psychiatrists, we're hopeful will have an impact, but that's only just been rolled out. Part of the access block into developmental and behavioural checks for paediatrics has been with ongoing prescription requirements for children already on stimulant medications, and the hope is that, through partnerships with primary healthcare networks and GPs, the more stable children can be prescribed medication by a non-paediatric specialist or a GP specialist, then that hopefully will free up some of that access block.

But I think the other thing is that developmental and behavioural issues in children are a whole-of-community problem; it's not just Health's problem. We need to work more strongly with the Department of Education, Department of Communities and Justice (DCJ), NSW Police and have more facilities in regional areas for children to have things to do. It's a whole-of-community response, not just Health and specialty paediatrics. I think we can probably move towards and we are working towards more networked care—trying to utilise people to their full scope of practice. Nurse practitioners, that's kind of the way—nurse specialists and allied health people working together to provide connected care and working with education and early childhood centres. The first 2,000 days initiative—they will all have an impact. But you're right; there are definitely children waiting a long time for developmental and behavioural assessments.

Also, assessments that can potentially be done still require ongoing care, so even just popping in to do the assessment is not the long-term solution. The aim would be to have a more robust service where those kids who really need to see a paediatrician could see a paediatrician. But those who could be assessed by other people or packaged up—like the Wellbeing and Health In-reach Nurse (WHIN) nurses, for example, is one initiative that is having an impact, particularly for young people, which is where health and wellbeing nurses in schools are able to do a lot of the assessments, so that when they get to a more specialist review then the information is there. All of those things, I think, will have an impact. But, yes, there's no doubt that children who need those assessments are taking a long time to get them. I don't think that's in question. Recruitment and retention in regional paediatrics has been a long-term problem. As I said, we've made a lot of progress, but they're still difficult positions to fill.

The CHAIR: And there are some centres that have been successful, and it's about getting the critical mass and the local leadership, as we've heard, in a number of areas. Finding out how you do that is critical. Mr Sloane?

LUKE SLOANE: Sorry, Dr McGirr, I just wanted to add—thanks, Helen for outlining that—also, there are some good things happening. There's an absolute willingness from the paediatric networks within Sydney Children's Hospitals Network and, of course, Dr Craven's backyard there in John Hunter Health to reach out and connect in a networked fashion and a collaborative fashion across all the regional, remote and rural areas. We've got Kids GPS, done by the Sydney Children's Hospitals Network, which is coordinated care for very high-end and very specialty care required in quite a few—I think we've got five local health districts currently signed off with regard to a partnership arrangement for coordinated care with workers based in the districts in order to liaise between high-end specialist care with the Sydney Children's Hospitals Network. We've got some great stories of people not having to travel at all and being connected to that care, having it coordinated so that then, if they do have to travel, everything is wrapped around them when they have that visit, rather than going seven times. Down at South East Regional Hospital—I'm not sure if Corin, the GP, still works down there.

HELEN GOODWIN: She does.

LUKE SLOANE: But on my last visit down there, they've been able to attract—a very beautiful part of the world, of course, as well—several paediatricians now, who work very closely and link with the GPs to do the entire workup, so that that pointy end of prescribing and specialist care can then be provided by the paediatrician in that pointed assessment, and thus taking a real chunk out of their waitlist. That's not to say it's gone away completely, but they are making inroads there. Just coming back to some data from a workforce point of view, for GP advanced traineeship for paediatrics, there was no uptake—zero uptake—for paediatric GPs in the year 2024. The numbers are very low, so getting a GP who has then specialised in paediatrics is one of those things that's like trying to find dinosaur bones. They're just not available at the moment, so we're seeing more of these collaborative networked partnerships with GPs and paediatricians throughout the system. Some of the paediatric-led partnerships are very expensive, as well, and so we need to somehow work out how we're going to get that dollar to work for all of the communities across New South Wales.

As Helen rightly said, it's one thing to have a paediatrician come in and do that specialty assessment, but then the continuum of care falls back to the GP or the allied health team or the multidisciplinary team that will take care of that child going forward, and their family as well. So it's not as straightforward as getting a whole bunch of paediatricians out into the districts, which would be my dream come true, of course. It's about marrying that up with the primary care workforce that we talked about earlier on.

The only other thing I was going to say—there are other discussions happening at the Ministry at the moment around just mapping some of these services out. Looking at the data, which I got my team to pull just recently—the PHN data for paediatricians visiting, staying or working in regional areas—it's not that it's not accurate, but it's not representative of people actually living and working in regional areas. It shows quite an equal distribution of paediatricians, but we know, for example, Helen is still listed as Tamworth. That's not necessarily accurate at the moment, and we know that that data needs to be updated to give us a really clear and visible oversight of the distribution of paediatricians, first and foremost. But we know that the districts themselves are offering paediatric support. But, like many places, a lot of people don't know that you can just go to the hospital

for paediatric support; you don't need to go to a specialty children's hospital for paediatric support. We're trying to re-communicate that.

The CHAIR: Can I just reiterate the importance of building capacity in rural and regional areas, and I'm encouraged if there's an approach from the Sydney-based children's networks that recognises that. I think a model in which those networks are responsible for building capacity and providing services on the ground, and building that capacity in the primary care workforce by supporting paediatricians there, is absolutely critical. I know in some areas that's done, and it's encouraging to hear it's being done. I don't think services that are handed out from city-based services without that on-the-ground support and capacity building are the best model. I think you've got to recognise that rural and regional areas need to have those services as best they can on the ground, and the role of tertiary networks is often to support the development of those services. I just make that comment, and I'm encouraged. You've just described some good examples; it would be great if we could have those documented back to us.

I do have another question, and I realise we've gone over time. You might want to take this on notice, but we have had some pretty significant evidence around urgent patient transport services from rural and regional areas not being available from the current provider. The contract was with Royal Flying Doctor Service (RFDS) some years ago. Recently, I think the last two or three years, that contract was with another provider. I understand that, in fact, that provider currently isn't providing that service frequently and RFDS are having to pick that up. Perhaps you could take that on notice.

LUKE SLOANE: I'm happy to talk to it. I won't comment on anyone's private business functions or tenders that may be in existence in the system at the moment, but we are undertaking a review of air transport funding in line with the recommendation from the inquiry. That's just in the final stages of being worked through at the moment with regard to where we take that in the future. There are some recommendations around that. Again, it's achieving the balance of what can be serviced by air transport providers. Shortage of pilots is yet another thing that's a little bit outside the sphere of influence that I have, with regard to pilot provision and being able to put aeroplanes up in the air, but we do need to work on some of the efficiencies and making sure that those transport providers are working for the best intentions of the community in the regional areas.

The CHAIR: Is that review about to be finished?

LUKE SLOANE: Yes. It doesn't mean that—the review is about to be finished, but we will be looking to then action it. Those actions may take some time because I don't think they're going to be very straightforward.

The CHAIR: Are you able to share any of that with the Committee?

LUKE SLOANE: At the moment I'd be loath to do so because we've got to talk it through with the responsible entities, from a NSW Health point of view, and then talk about a way forward with respect to not only the people that we're working through but all of the stakeholders involved and the entire systems of transport.

The CHAIR: I was going to ask Dr Bowden or Dr Craven whether they wish to make a comment because they have been very patient. We appreciate you being here. Do you want to make a comment?

MICHAEL BOWDEN: I think everything has been covered. Mental health is really struggling with the same issues that every other part of the health workforce is. We are very aware of the issues around rural and regional health provision. That really is across specialties. We have mentioned psychiatry but it really is nursing and allied health positions as well. There are a number of initiatives that we are taking—virtual care models and so on. While they may not be the perfect solution, they do go some way to supporting the workforce and developing some of those core capacities that we are talking about. Some of the hub-type approaches that we've been pursuing—one would be mental health and intellectual disability comorbidities—are specialty hubs which are metropolitan located. Part of their remit is to develop and build capacity through teaching as well as consultation. There are a number of initiatives there, but I think that the pipeline for training is long and also very complex. It has been quite encouraging to work with workforce services to start to deal with some of those issues.

The CHAIR: Dr Craven?

PAUL CRAVEN: I'm based up in Newcastle. The only thing I'll add at the moment is that—because I work with Helen in the paediatric space—having gone around the majority of the north of the State, understanding what makes people want to live in our rural and regional sector has been very valuable for us. Therefore, when we are advertising positions in this region, we are really ensuring that we are attracting people who want to live in this area and selling the area for what it really does offer at that stage. That has made a big difference for us. I think also—this has been said now—ensuring the equity of the number of staff that work in those individual areas: We have worked very hard in the paediatric space to ensure the FTE balance is right across the district because I think what people want is lifestyle when they are working in all of our centres at the moment,

and certainly that has worked in our favour. We are really looking at what is the need in every single centre in this district as well. We do obviously need those specialists provided in our regional hospitals to train our GPs as proceduralists as well. One of the issues you mentioned before was about training GPs as proceduralists. We do need them in our regional hospitals to provide that support as well. That is all I have for now.

The CHAIR: I'd like to thank everyone for appearing today. We might bring the hearing to a close now. We have already flagged questions that you have taken on notice. We may send 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?

MICHAEL BOWDEN: Yes.

LUKE SLOANE: Yes.

The CHAIR: That concludes our public hearing for today. I thank all of the witnesses who appeared before the Committee. I also thank Committee members, Committee staff and Hansard for their assistance in the conduct of today's hearing.

(The witnesses withdrew.)

The Committee adjourned at 14:45.