REPORT ON PROCEEDINGS BEFORE

LEGISLATIVE ASSEMBLY COMMITTEE ON COMMUNITY SERVICES

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

At Narrabri Shire Council Chambers, Narrabri, on Tuesday 12 August 2025

The Committee met at 9:25.

PRESENT

Mr Clayton Barr (Chair)

Ms Liza Butler
Mrs Helen Dalton
Ms Donna Davis
Ms Trish Doyle (Deputy Chair)
Ms Felicity Wilson

The CHAIR: I welcome everyone to the first hearing for the Legislative Assembly Committee on Community Services inquiry into the Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025. My name is Clayton Barr and I'm the Committee Chair. I am joined by my colleagues Ms Trish Doyle, the member for Blue Mountains and Deputy Chair of the Committee; Ms Liza Butler, the member for South Coast; Mrs Helen Dalton, the member for Murray; Ms Donna Davis, the member for Parramatta; and Ms Felicity Wilson, the member for North Shore.

I welcome everyone attending the hearing in the public gallery and online. I thank you all for your interest in this inquiry. Please remember that today's hearing is a formal proceeding of Parliament. We respectfully ask everyone in the gallery to keep mobile phones on silent and to refrain from talking during the hearing, as this can interrupt the proceedings and be a distraction to the witnesses. Members of the public are not permitted to film or photograph proceedings. We thank the witnesses who are appearing before us today and the many stakeholders who have made written submissions. We appreciate your input into this inquiry.

Mrs ROBYN KEEFE, Chief Executive Officer, Wee Waa Aboriginal Land Council, sworn and examined

Mr CLIFFORD TOOMEY, Chair, Wee Waa Aboriginal Land Council, sworn and examined

The CHAIR: I welcome our first witnesses. Thank you for appearing before the Committee today to give evidence. As previously mentioned, members of the public are not permitted to film or photograph during the hearing. Committee staff will be taking photos and videos during the hearing, and the photos and videos may be used for social media and public engagement purposes on the Legislative Assembly social media pages and websites. Please let Committee staff know if you object to having photos and videos taken or if you would like a copy of the photos and videos taken. Mrs Keefe or Mr Toomey, before we start, do you have any questions about the hearing process?

CLIFFORD TOOMEY: I'd just like to apologise for Roy. He's out west doing what he does, so I'm here today.

The CHAIR: Would you like to make a short two-minute opening statement before we begin with our questions?

ROBYN KEEFE: We don't have a long statement. But my statement is the fact that Hunter New England Health covers such a wide area that they made a decision to close our hospital, which has a very dramatic effect on our people. We don't have transport, so our people have a barrier now to seeking medical help, because the alternative now is to go to Narrabri. If they think that that is going to happen, they won't go and seek help. The decision made by Hunter New England Health without consultation or communication with our people was just not on. I would say that was given the wide area they cover. We are on the end of that area so we don't get to have any input into their decisions, and that that's not the way it should go.

CLIFFORD TOOMEY: Just from an Aboriginal perspective, like Robyn just stated, we don't have any public transport at all. We feel isolated. We definitely absolutely need our hospital open.

The CHAIR: When you say "our hospital", you're talking about Wee Waa hospital, just to be clear.

CLIFFORD TOOMEY: Yes.

The CHAIR: Robyn, you used a term or a phrase that "the decision was made to close our hospital". Could you just completely identify what you mean by that term or phrase when you used it in your opening statement?

ROBYN KEEFE: There was no consultation. They just said, "We're going to close the hospital," and it was for a short period of time. But they didn't consult or didn't communicate with anyone that they were going to do that, prior to that. I just feel that communication with Hunter New England Health is very, very limited, and in our area it's nil. When I say they just closed the Wee Waa hospital, that's what they did: They just closed it. They didn't communicate. They didn't put it out there that this is going to happen and why this is going to happen. They've used stats that aren't relevant to the time frame of when they closed it. They used the fact that it was hard to get staff. Well, their recruitment process was flawed. I know of people that applied for jobs there and by the time Hunter New England Health would get back to them, like two or three months, they would take up another position. I believe it was a staged process of what they wanted to do.

The CHAIR: So are you saying that today, right now as we sit here, that the Wee Waa hospital is completely closed—it offers no services at all and the doors are just permanently shut?

ROBYN KEEFE: Not completely shut. We have emergency services from 8.30 to 5.00, so you can only go to the hospital at that time. If you want to go to the hospital after that, it's too bad, so sad; you go to Narrabri. That's just not on with our people. We don't have the transport. They don't want to go to Narrabri because they can't get back. They're released late at night. There have been incidents where grandparents have had to go and pick up grandchildren late at night, because everyone doesn't have transport.

The CHAIR: Staying on Wee Waa for a second, there is an emergency department from 8.30 to 5.30?

ROBYN KEEFE: Yes, there is.

The CHAIR: Are there wards? Are there beds? Are people staying in overnight? Are there surgeries that take place there?

ROBYN KEEFE: No. You're not allowed to use the beds. That's all there is. We've got a functional hospital there, a beautiful hospital, that Aboriginal people had input into, and they've closed it. We don't have access to it. We have access to—

The CHAIR: So no X-rays?

ROBYN KEEFE: We have access to emergency from 8.30 to 5.30, and that's it. The VMO is not there, so you don't get to see a doctor, and they decide, "Well, you need to go to Narrabri because you need to be assessed." So they put you in an ambulance and away to Narrabri you go.

The CHAIR: I want to come back to that question about, if you go in an ambulance, getting home and transport. I will come to that in a little bit. I'm not ignoring that. I'm just trying to clarify, at the start, the nature of what is happening inside Wee Waa hospital today as we sit here, and for you as a community.

ROBYN KEEFE: Today, 8.30 to 5.30, if you feel ill, you can go to the Wee Waa hospital and they will assess whether you need to be assessed by a doctor. You are sent to Narrabri and you are assessed there. If you're assessed and they say you're fine, you've got to find your way back to Wee Waa.

Ms TRISH DOYLE: Thank you both for being here, representing your community and informing us directly of your views. In your view, and on behalf of your community, would the splitting of the Hunter New England Local Health District be beneficial for Aboriginal people in your local community?

ROBYN KEEFE: Definitely.

CLIFFORD TOOMEY: Yes.

ROBYN KEEFE: I think our voice would be heard if it was Tamworth or Armidale. They'd have more understanding about the outlying areas and what's needed. And where we're situated, to compare us to hospitals in other areas that have another hospital half an hour away that they've closed or where they've reduced services, we don't have that. We don't have the transport like other people have. We're rural and remote. Our hospital is a feeder hospital, because it covers a wide area of the agricultural area. I just believe that we pay our taxes, we contribute to the economy and we are entitled to have a health service that meets our needs.

CLIFFORD TOOMEY: From an Aboriginal perspective, we really need our hospital open because it also services other Aboriginal communities, smaller Aboriginal communities, within distance of Wee Waa. For them to be able to get to Wee Waa is okay, but if they're out west a little bit further and they need to get to Narrabri and it's an emergency situation then, I guess, it's not going to look real good. If they're assessed and get sent through to Tamworth and on to Newcastle, there's the displacement of being off Country, away from family.

Mrs HELEN DALTON: The issue of getting to Narrabri, you've talked about transport for a lot of people. When you do get there, you stay there and when you're discharged, there's no transport to come back either?

CLIFFORD TOOMEY: No. You have to find your own way back to Wee Waa.

Mrs HELEN DALTON: You could be discharged at 10 o'clock at night and try and find your own way home?

CLIFFORD TOOMEY: 10 o'clock at night. Yes.

Mrs HELEN DALTON: The motels in Narrabri, there wouldn't be too many receptions open at 10 o'clock at night, would there?

CLIFFORD TOOMEY: No.

Mrs HELEN DALTON: You've got to rely on your friends or family in Narrabri, if you've got them?

CLIFFORD TOOMEY: If you've got them, yes.

Mrs HELEN DALTON: Do you know of any cases where people have been out on the street and not had any support?

ROBYN KEEFE: I had a grandmother woken up at 12 o'clock at night to go and pick up a granddaughter in Narrabri who'd been transported there and assessed, that could go back home. She had to go and get the truck, get the granddaughter. For elderly people, that's putting them at risk. Everything that we look at to do and to support our community, they're at risk. Anyone who has got to drive at night, we have kangaroos, all that sort of stuff, and I don't see that that's a good thing when we have a hospital that's functional and has everything there. All it needs is to be opened to service the community. I don't get why Hunter New England Health thinks it's okay to close that hospital. I'm amazed that it was allowed to be done like that.

Mrs HELEN DALTON: What about maternity? If you're going into labour, there are no timelines with babies; they do what they want. Do you know any cases where women have birthed on the side of the road because they've had to bypass—

ROBYN KEEFE: There probably are cases, but we don't know of those. We have heard of them. There are cases. The maternity section has been closed in both hospitals, really, even at Narrabri. There are times where you can't have babies at Narrabri; you've got to go to Tamworth. When they say that you can access Narrabri Hospital, it doesn't always have all the facilities either. You're shipped to Tamworth, and now the latest is if Narrabri is full, you go to Moree. No-one wants to go to Moree, I can tell you now.

Mrs HELEN DALTON: Do you think that because Wee Waa hospital doesn't open 24/7 that our life expectancy has been reduced?

ROBYN KEEFE: Aboriginal life expectancy is reduced anyway, and this is dramatically reduced. They're not going to access medical care for the simple reason they don't want to go to Narrabri, so they will at all costs— there have always been barriers to that anyway, and this is another huge barrier. So, yes, it has put them at risk.

Ms FELICITY WILSON: Thank you very much, Robyn and Clifford, and thank you for welcoming us here to your country. You mentioned Moree. I was in Moree yesterday. I met with Pius. I had some really interesting conversations with them about what I would call primary health care and the service provision that they deliver to the community of Moree. We were talking about Wee Waa as well and some of the demands from Wee Waa. To what extent are you finding that people in your community that are trying to access hospital care are doing so because of a lack of access to primary health care, so GPs or—

ROBYN KEEFE: They access a GP. Again, I know the follow-up probably leaves a lot to be desired. But, in saying that, they do access the GPs. We have three GPs in Wee Waa. We have four residing there but we have three that are functional. They do access the GPs in the time frame and they will wait. They won't go to the hospital. They will wait until the next day. That puts them at risk.

Ms FELICITY WILSON: So you can access a GP the next day in Wee Waa?

ROBYN KEEFE: They will fit you in if it's really an urgent case, yes. Having three doctors is probably a good thing out there.

Ms FELICITY WILSON: I understand you don't have a specific Aboriginal medical service, so these are town GPs?

ROBYN KEEFE: We don't have one at this stage, no. We do have eye clinics. Walgett Aboriginal Medical Service does an outreach and conducts eye clinics at the land council, so we do have an outreach service from there. That's probably four or five times a year.

Ms FELICITY WILSON: This is not a reflection on any specific GP. Are the GP services offered seen, by your community, to be culturally safe and respectful of Aboriginal people?

CLIFFORD TOOMEY: I would say, to a certain degree, yes. The people that I've spoken to are fairly happy to, and feel safe to, go in and see the local GP. Others don't like to go and see doctors at all. They would rather, I guess, if they're sick, be able to go in and access a hospital instead of sitting in a waiting room and waiting for a GP to call them in and then assess them in there. It's what it is.

Ms FELICITY WILSON: Robyn, you mentioned the eye clinic that travels to Wee Waa. What about other specialist services? Do travelling specialist services come into town or do you have to go to hospital for those?

ROBYN KEEFE: Over the past probably six months HealthWISE has had a paediatrician, a psychologist and, I think, a dietician coming to Wee Waa, to the medical centre there. And I think Hunter New England Health had a diabetes bus. Again, I have to say, that bus has been in the works for about 12 months. We heard about it probably about two weeks before it was to come. The lack of communication is not good. I did bring that up to say had we known earlier, probably more people would have been able to access it.

Ms FELICITY WILSON: Do you know, not all the details but off the top of your head, how frequently a paediatrician comes?

ROBYN KEEFE: I did ask HealthWISE for a schedule, which they did supply. We have a Facebook page. We put it up so that people are aware of when they're coming. But, no, Hunter New England Health hasn't given us any schedule for that bus, whatever it is.

Ms FELICITY WILSON: Does your community feel that the waiting times are acceptable for seeing specialists within your own community or do you find they're more likely to try to travel to some of the regional centres to do that?

ROBYN KEEFE: They would rather have it in Wee Waa, because of the transport. We've had incidents—I'm just trying to think. Am I allowed to talk for [redacted by resolution of the Committee] about what happened with her?

The CHAIR: Probably not, because she's not here to give permission.

ROBYN KEEFE: She has given me permission. I'll just do it in a general sense. There was an incident where a young person—he has disabilities, mobility and physical. He was unwell. It was out of hours, so she had to bring him into Narrabri to the emergency service there. They had what they call a teleservice. He had pain and was feeling really unwell. Anyway, the tele-doctor asked him to jump, this child. He didn't know the child. The child has disabilities, so his jump was sort of—well, you wouldn't be able to tell, anyway. He determined that he'd eaten something and that was why he was unwell. The mother went back to Wee Waa. That was one day. The next day he was no better and she was very concerned about him. She had made an appointment with the doctor for a couple of days after that, and she thought, "No, he's not really well", so she went into the doctor's surgery and they fitted her in. The doctor sent her straight to the hospital at Wee Waa—the emergency was open—for a blood test.

On the way to the hospital, his appendix burst. The blood test at the hospital revealed that it was the appendix. They got him to Tamworth and they operated. They had to take part of his bowel because it was too late. That's an incidence of tele-doctors and what they can do. The thing that has been put out there at the moment as this tele-doctor, it is no good. It just isn't good, and that's an example of a child that could have died because the tele-doctor was looking through a computer at a child. They're the incidences that we really get concerned about. If we had a functional hospital—well, it's a functional hospital; it's just closed—and a VMO at our hospital, and when we have three doctors that we could have there, we wouldn't have to go through those sorts of things.

Ms DONNA DAVIS: Thanks very much for giving your time today. I've just got a couple of questions regarding the transport. I appreciate that there's no public transport. Is there any access to community buses? Does the council operate anything at all, or NSW Health?

ROBYN KEEFE: No, the council doesn't. I believe there's a community bus. I have to say that I don't know if it's just for aged care—aged people. It goes once a fortnight to come in and do the shopping. I believe they do some transport for specialist appointments but, again, I don't know the limit that they have there. Whenever that sort of transport is available in the regions, there's a limit to it. It may be available for a certain period of time and then it's not available, because the funding is set.

Ms DONNA DAVIS: Being specific in terms of cancer care, I know in some regional areas there is access to cancer buses—well, not a bus, but a car that has been fundraised and people can use that for transport to chemo appointments. Is there any access to anything like that?

ROBYN KEEFE: We have Closing the Gap, but that's for chronically ill people. But they do help where they can, so that's available. Cancer patients have to find their own way, mostly. When there is support, there's limited support. It's not available all the time. It's the same with dialysis. We've got people who go to Moree three and four times a week for dialysis.

Ms DONNA DAVIS: And that's all through private travel—through friends and family?

ROBYN KEEFE: Yes.

Ms DONNA DAVIS: No Red Cross car where volunteers drive?

ROBYN KEEFE: No.

Ms DONNA DAVIS: Sorry, but it's really good for us to be that specific. In terms of the services that are available now at Wee Waa, you mentioned that you can get a blood test. Is the blood test at the hospital or is that at the GP?

ROBYN KEEFE: I don't know who did that; I have to be honest. I would say that the nurse did that.

Ms DONNA DAVIS: Yes, but there are no pathology labs in Wee Waa—you'd have to send them to Narrabri?

ROBYN KEEFE: There must be something, because they knew straightaway it was the appendix. I'm not medical, so I'm not really—

Ms DONNA DAVIS: No, that's okay.

ROBYN KEEFE: But they knew that it was the appendix, and the mum knew it was the appendix, but they wouldn't listen. She kept saying, "It's not something he's eaten."

Ms DONNA DAVIS: That's fine. I'm just asking more generally in terms of getting an idea of what services, but we can find that out somewhere else. Prior to the cut in services and reducing it down to 8.00 till 5.30, was it 24 hours with a VMO or a doctor onsite, or was Wee Waa reliant on telehealth?

ROBYN KEEFE: They were relying on telehealth. That was because the VMO was still in negotiations with Hunter New England Health. There were, again, a lot of barriers there but, yes, that was in the process. We've been without a VMO for a while. But the hospital was really functional. In another area like palliative care, people don't want to go to Narrabri to die where there are no people around them.

Ms DONNA DAVIS: There is palliative care in Narrabri?

ROBYN KEEFE: There is palliative care, yes.

Ms DONNA DAVIS: But it is limited.

CLIFFORD TOOMEY: There was a room set up in Wee Waa hospital for palliative care. We did have a local lady that had cancer. She was a single mum of three kids. For her to be able to be in that room and have her children be able to come and go as they please was easier than them trying to find public transport—or not even public but private transport—for somebody to transport them over to Narrabri or even Tamworth to visit their mum. I have a personal attachment to that lady and her kids. It was so much easier and less stressful on their behalf for them to be able to access Wee Waa hospital to visit their mum.

Ms DONNA DAVIS: That's understandable.

Ms LIZA BUTLER: Thank you for joining us today and welcoming us to your Country. I want to get a bit of a picture about what was at Wee Waa before. What services did you have? You obviously had beds and you had palliative care. Were babies being delivered there, or was that quite some time ago?

ROBYN KEEFE: We haven't had maternity. Like any hospital, they've cut a lot of the maternity.

CLIFFORD TOOMEY: I think the last baby that was born in Wee Waa hospital was in 2004.

Ms LIZA BUTLER: Do people have to come to Narrabri or Tamworth to give birth?

CLIFFORD TOOMEY: Narrabri, but in most cases they ship them off to Tamworth. From an Aboriginal perspective, that's a bit of a disconnection for them not being able to have their babies on Country. Tamworth is still a Kamilaroi area, but it's a different area of Kamilaroi. If you grew up here in Narrabri or you grew up in Wee Waa, then that's your home; that's your Country. It's usually that the mum just gets shipped off to have the bub. She may have other little ones at her home, so then she's got to rely on other family members to look after them for a few days, depending on if everything goes okay, for her to be able to come back home. Then when she gets over there, she has to find her own way home with the bub.

Ms LIZA BUTLER: Prior to the services being reduced, was the emergency department open 24 hours?

ROBYN KEEFE: Yes.

CLIFFORD TOOMEY: Yes.

Ms LIZA BUTLER: And there were beds in the hospital?

CLIFFORD TOOMEY: Yes.

ROBYN KEEFE: Yes.

Ms LIZA BUTLER: What other services were provided? There was the case you provided of the child with appendicitis. Would that have been dealt with?

ROBYN KEEFE: That probably would have been operated on in Narrabri or Tamworth. It probably would have been Tamworth because that's where the operations mainly happen now. They would have been shipped back to Wee Waa to recover. It would have been a recovery process at Wee Waa too, or rehab. I think physio was visiting there. I had my mum in there for about three weeks before she was put into care. It was an area where they were happy to do that, which was really good, because she was from Narrabri. They shipped her to Wee Waa because they were quite happy to look after her until they had a spot at Weeronga.

That's another thing, too. Weeronga is our aged-care area. For people with dementia to be able to go 50 metres across to be assessed and go back if they're okay; they can usually push them across—rather than get in an ambulance, go to Narrabri, be assessed, get back in an ambulance and come back to Wee Waa. That's a huge thing for people with dementia. That's another area that is not available now for our aged-care people. It has taken away a lot of normality for people. They would normally just go to Wee Waa, but that's not there anymore.

Ms LIZA BUTLER: For the record, I want to clarify that outside the emergency department, from 8.30 until 5.00, all the wards and all the beds are now closed and shut down?

ROBYN KEEFE: Yes.

Ms LIZA BUTLER: So if I was to turn up to the hospital now, today, would I see a nurse practitioner, or would it be straight to telehealth?

ROBYN KEEFE: I don't go there, so I would say a nurse practitioner and then, I would say, they would transport you to Narrabri.

Ms LIZA BUTLER: Do they have X-ray facilities at Wee Waa, or would I have to come to Narrabri?

CLIFFORD TOOMEY: No. You'd have to come to Narrabri.

Ms LIZA BUTLER: Did they used to have it?

CLIFFORD TOOMEY: They used to have it.

Ms LIZA BUTLER: Just back to the community transport, I just want to clarify that you actually do have a community transport service, but it's one that you have to book in advance. Is that correct?

ROBYN KEEFE: That's correct, yes.

The CHAIR: I want to go to the macro level because the concept of splitting a health district is a massive question. It's not just a Wee Waa-Narrabri question. Much of the conversation at the moment has been in terms of Wee Waa hospital and the travel between Wee Waa and Narrabri. What do you think would be the benefits of splitting the entire district? If you can think of it at a local level, obviously that's where you live and that's where you know and understand, but if you can try and think of it more broadly as well, across the entire New England—what do you think the benefits would be?

ROBYN KEEFE: I think they'd reintroduce services that have been taken away—maternity. There would be more. They'd be able to meet the needs more of the people in the regions rather than in the Hunter, and I think they would look at the fact that we are remote and have more of an understanding of the distances that have to be travelled. When you look at a map, that far is not very far, as far as Sydney and Newcastle are concerned. It's a long way out here; so that understanding, okay? I know people do do that. I lived in Sydney so I know that, okay. They think that it's just over there. It's not. It's a long way. Sometimes it's a dirt road and it's difficult to travel. If you're coming into Wee Waa and you're 45, 50 minutes coming into Wee Waa on a dirt road, you don't want to have to go to Narrabri for another 20, 30 minutes. I believe that if they split it, there would be more understanding about what's needed within our regions and beyond to accommodate the needs of the people.

The CHAIR: So there's a strong sense that you believe that there's not enough understanding at the current board-executive level, the decision-makers who are based down in Newcastle primarily.

ROBYN KEEFE: Yes.

The CHAIR: One of the executives is based in Tamworth. What if I said to you the size of the bucket or the size of the pie in terms of funding for the Hunter New England health district is whatever size it is. It's a bucket of money. If you just split it on a population basis, probably about two-thirds or three-quarters of that money would have to stay in the Hunter and about one-quarter or one-third would go into the New England. That's just based on population. If the money was just cut like that, and your bucket just became about a third of the entire bucket, as it currently is now, how would a new health district increase and expand health services, given

that the amount of dollars they've got to spend is the amount of dollars they've got to spend? What would you see as a solution to the fact that the money's not limitless and endless in terms of providing services to the community in that regard?

ROBYN KEEFE: So you're asking, okay, given the fact that there would be less money available to service our area—

The CHAIR: A portion of the money, yes.

ROBYN KEEFE: Yes, but that's what it would mean, okay? So we would not be able to get the services, anyway. That's what you're saying.

The CHAIR: That's the concern, yes.

ROBYN KEEFE: Yes. So what's the alternative?

The CHAIR: The model as it is, trying to be improved in terms of better listening and hearing and stuff like that, I guess. We have a submission, obviously, from Hunter New England Health as well as a lot of submissions from the communities of Wee Waa and Narrabri. Hunter New England Health is essentially saying that there's the opportunity for some of the specialist services to reach into the New England area, co-funded by the Hunter area, so it's a shared fund at the moment. If you put a line or a border somewhere there, then those services wouldn't move in and out of the New England area, so New England might be stuck with less services, if you separate it. Do you think that's a possibility? And would that concern you if it was a possibility?

ROBYN KEEFE: Of course it would concern me. Yes, definitely. But all of a sudden Hunter New England Health are supplying these things? Is that because they could be split? So they're actually—I won't use that word—they're actually doing something that they should've been doing before?

The CHAIR: The diabetes bus that you spoke of earlier was an example. I think you said that'd been in the works for 12 months.

ROBYN KEEFE: It was in the works for 12 months, yes.

The CHAIR: But what was the other part of that? It'd just turned up in the last couple of weeks or something?

ROBYN KEEFE: Yes. We were given about, probably, two, maybe three weeks notice. And that's just not enough, out our way. The communication is nil. That's an example of closing a hospital. No communication. Had they come out and spoke about it, there could've been an alternative to that, but no. And then they decided we will have Emergency 8.30 to 5.30. So that's the only time you can have an emergency. That's not just realistic.

The CHAIR: Do you have a local health committee? Are you aware of a local health committee across the Narrabri/Wee Waa area? No. A local health committee is meant to be a voice between the district and the local community. And, given what you've described in terms of not having the communication, not being aware, not having any input, I assumed that it probably didn't exist. So it doesn't exist, to the best of your knowledge, at the moment.

ROBYN KEEFE: No.

The CHAIR: All right. Can I just mention some Aboriginal-specific programs that Hunter New England Health believe they are rolling out, that they told us they are rolling out? Could you tell me if you're familiar with any of these? One is called an integrated chronic care plan for Aboriginal people, which is a team including Newcastle-based physicians which provide chronic disease management directly into the communities. Are you familiar with that one? No? Little Ears, Deadly Care, which is ear, nose and throat specialists for Aboriginal children?

ROBYN KEEFE: We only wish; no.

The CHAIR: No. Healthy Deadly Feet, which apparently was established in 2019, which helps address foot-related complications among our Aboriginal people, which has significantly reduced the number of amputations that are required?

CLIFFORD TOOMEY: No.

The CHAIR: Not familiar with that one either?

ROBYN KEEFE: Are these all Hunter ones, are they?

The CHAIR: The position from Hunter New England Health is that they're providing these services that reach into the regions, into the New England district.

CLIFFORD TOOMEY: My personal opinion is that, when these programs get filtered out to us, they pull up at the bigger places in New England, such as Tamworth, such as Armidale, and not a lot of them come out this way.

ROBYN KEEFE: And they term that as putting the service out. So they've ticked the box.

The CHAIR: Is the Moree hospital health facility a bigger facility than Narrabri?

ROBYN KEEFE: They're building big new hospital there, so that's probably been the plan. But I wouldn't go to Moree. People won't stay there. It's too dangerous.

CLIFFORD TOOMEY: They have more facilities for Aboriginal people in Moree than we do here in Wee Waa and outreaching into Narrabri—but yes.

The CHAIR: That was a better way of answering the question that I failed to ask. How would Health—I'm talking about NSW Health now, every district. How would we better meet the needs of our Aboriginal communities, in terms of connection to Country, being close to family and community when you're born and at the end of life, when you die, and for all the injuries and stuff? We obviously can't have a hospital everywhere. So what advice would you give to NSW Health about trying to make sure that health is delivered in a more culturally sensitive way, to keep people close to family and close to Country?

CLIFFORD TOOMEY: Wow. Open our hospital up.

The CHAIR: Okay. Start with Wee Waa.

CLIFFORD TOOMEY: Because it's local. For Aboriginal people—we don't go far from home. If we're sick—and we know we're sick—and we need to go away, then that is a disconnection straightaway. That is why Aboriginal people don't like going into hospitals. It's because of the disconnection. It doesn't matter what hospital in New South Wales it is. If they have to go to a hospital, even if it's just down the road from Wee Waa to Narrabri—which is 35 to 42 kays—that is a disconnection for that person from that community, let alone being shipped from Wee Waa to Tamworth and then onward again from Tamworth to Newcastle. It is a massive disconnection from family and from community, which is the base of their support system. To make it culturally safe and aware for Aboriginal people to access medical help when needed, the best solution would be to have their local hospital so they can access it there and then, and so they're not being transported away from family.

Ms TRISH DOYLE: Robyn and Clifford, I hear loudly and clearly your point around having no input in decisions that the local health district have made and your comments on the poor communication by the local health district with your community, particularly around the hospital—what they call "reduced services" or "reduced hours"—and the community talk about closing the hospital. I wanted to ask you what your communication was like with the health expert panel. There were four individual, independent health experts that came out in mid-April to Wee Waa. I understand they met with the Aboriginal land council. I don't know if that was with the two of you.

CLIFFORD TOOMEY: No. It was with our board.

Ms TRISH DOYLE: There may have been some discussion or suggestions—I'm not sure who it came from—about having an Aboriginal health practitioner working with the community. Can I ask you to elaborate on that? Did that suggestion come from you, or was it a suggestion that came from that expert panel? What are your thoughts around having an Aboriginal-specific health practitioner in the community?

ROBYN KEEFE: That would be really good if that is attached to the hospital. We've had health workers in Hunter New England Health. Only recently, we had a health worker that would come and do the eye clinics. It was about April, and I thought, "We should have had a clinic." I rang, and the lady said, "I can't do them anymore," and I said, "What?" She said, "My job has changed, and I can't do them anymore. I'm not allowed to come out and do the eye clinics." I got onto the Minister about it, and it was put back in place. There is an example of take a worker that people in Wee Waa know, and have known for a long time, and put her somewhere else and not allow her to come to the community.

That's what it is about when you're dealing with Aboriginal people. They like you to come to their community and be a part of that and communicate with them on their ground. That is an example of the non-communication. That had a huge impact on us. We had children waiting to be checked. They were at school and having trouble with their eyes. When you say "Aboriginal health practitioner", that would be great as long as they don't change it all the time. When people get used to someone, they're happy to go there. But they're not going to go to a strange person. That would be good. But, again, attached to the hospital—that would be great.

Mrs HELEN DALTON: The lack of communication has been the point made again and again by yourself and Clifford. Obviously that's a huge issue. You've got no LHG—which is local health group—by the sound of it?

ROBYN KEEFE: No.

Mrs HELEN DALTON: They're just the go-between, I guess, from the Government to the community. Often I know a lot of the LHGs don't exist where they should. That's actually a big problem. The Wee Waa community has really been cut out of the conversation about health, for sure, from what you've said.

ROBYN KEEFE: Yes. I have to say, too, when I talk about lack of communication, I had two health workers come from community health from Wee Waa. I've been there nine years. This was the first time I had seen them. That was about a month ago. I didn't know who they were, and they said, "We're working with community health." I said, "Are you? So where are you?" "Over at the Wee Waa hospital." I think they've cut back in allowing the people to come out to the community, and I don't think that's a good thing.

Mrs HELEN DALTON: I guess the elephant in the room—and this is not just for Wee Waa, too; it's across the State—is what changes are needed where we are included back into the conversation?

ROBYN KEEFE: I think they need to really come out into the community and communicate and to see what the needs are and how they can address those needs, not make decisions and think, "Well, that's okay," because it's not. We are entitled to a service and a really good medical service.

Mrs HELEN DALTON: Your taxes are worth just as much as the taxes in the city, do you think?

ROBYN KEEFE: Say that again?

Mrs HELEN DALTON: Your taxes are worth just as much as the taxes in the city?

ROBYN KEEFE: Oh God, yes. We put heaps into the economy out this way. We're a rich farming area.

Mrs HELEN DALTON: Thank you both for attending the inquiry.

Ms DONNA DAVIS: One of the suggestions or recommendations to improve services in Wee Waa is to improve incentives. One of those is accommodation and recruitment. Was there any accommodation available when Wee Waa hospital was fully functional for visiting—

ROBYN KEEFE: There is accommodation at the hospital, and two houses were built by the Wee Waa medical service. So they had that. Again, there is accommodation you can access, but no-one—I don't think anyone went outside the square to look for it. I found some accommodation where you could access the police and the education area, in the short term, because they hate having the houses vacant.

Ms DONNA DAVIS: Are those properties vacant now?

ROBYN KEEFE: Yes. I spoke to the lessee.

The CHAIR: Thank you for appearing before us today. You will be provided with a copy of the transcript of the evidence for corrections. Committee staff will email to you any questions taken on notice—but there weren't any questions taken on notice—and any supplementary questions from the Committee that we may develop following these hearings. We will send them to you as well. Thank you so much.

ROBYN KEEFE: Thank you for listening.

(The witnesses withdrew.)

Mr CHRISTIAN PETERSEN, Founder and Program Manager, RiverBank Youth Works Ltd, sworn and examined

Mr ANDREW BOWEN, Secretary and Treasurer, Wee Waa Chamber of Commerce, sworn and examined

The CHAIR: I welcome our next witnesses. Thank you for appearing before the Committee today to give evidence. Members of the public are not permitted to film or take photographs of the hearing. Please note that Committee staff will be taking photos and videos during the hearing. The photos and videos may be used for social media and public engagement purposes on the Legislative Assembly social media pages. Please let Committee staff know if you object to having your photos taken and used in that way. Before we start, do either of you have any questions about the process that we're about to undertake?

CHRISTIAN PETERSEN: No.

ANDREW BOWEN: No.

The CHAIR: Would either of you or each of you like to make a very short opening statement of up to two minutes?

ANDREW BOWEN: I know Chippy wants to as well, but I'll start. Being a chartered accountant but also a history buff, I went deep into this and did the timeline thing. In 2002 the Rural Health Plan was released, which outlined three key directions for the future of rural health. They were recruitment, retention of health workers, and providing more services closer to home. In 2004 the Minister for Health launched the Planning Better Health reforms. These reforms aimed to deliver a more efficient health system. Seventeen health areas were then merged into eight large health services, expecting to get $100 million out of admin for frontline services. In addition, they introduced these health advisory councils to ensure clinicians, health consumers and other community members are consulted. The whole idea was to make it more local and have the front line more local.

That went through. We had eight areas. In 2011 the Federal Government put their hand in and introduced the National Health Reform Agreement signed by all the States. That goes into a lot of detail but, in relation to that, we ended up going back to 15 areas. At that point in time they really should have split Hunter and New England at the same time, but that never happened. The takeaways from all of this are mainly that all of these agreements and plans had an emphasis on local. Up until recently, there has been little engagement by health administrators with the Wee Waa local community, as required.

I could find no evidence of parliamentary oversight, either at State or Federal level, to ensure local hospital networks were delivering the appropriate outcomes for the communities under the National Health Reform Agreement, and there has been a reduction in hospital facilities over this 20-odd-year period the further away from Newcastle that you are. I also noticed, reading the submissions, that there is a schism between the opinions of the medical fraternity and those they seek to service. It points to an underinvestment in rural and remote hospitals, especially in our local health district, in favour of a larger hospital in the Hunter. It needs to change. The split of the district is not a panacea but will force greater focus on those who need equal local access to their city cousins because the administration would live in the rural region that it is servicing.

Another thing is the population of local health districts. Hunter New England Health is approximately 984,000. Western district, which is Dubbo and Orange and everything, is 287,000. They don't seem to have a problem. They've got problems, but they don't seem to have a problem with this issue. The Central Coast is 357,000. I see absolutely no problem with carving out the Newcastle greater region of approximately 540,000, and that would still leave you with 454,000 people in the greater rural region that is the New England. It's quite viable. As a matter of fact, it was viable before they got merged together in 2004.

CHRISTIAN PETERSEN: If we had have had the hearing on the first date, I wouldn't have had anything to say, but in the last week I've had a personal experience that impacts the way that we'll work in RiverBank. My son had a brain biopsy last week. We're still waiting for the Hunter New England Health specialist to get back to us on whether they're going to see him. We had to go outside the district into Sydney to get that to happen. We were able to do that because of our health insurance. We had to go privately to make that happen.

For the kids I work with, most of them don't have that option. You can't look into the past and the future and see what would've happened if we didn't have health insurance. A biopsy on a growing tumour seems like something that's kind of important. This discussion around the idea that we won't have access to specialists is null and void, because we already don't have access to specialists. Like I say, if the hearing had happened on the first date, I wouldn't have had anything to share. The last week has really shown me that there's this complete disconnect between what we think is happening and what is actually happening in the regions.

The CHAIR: Andrew, I wanted to go to the numbers you used about the potential split. My base understanding is that the Hunter Valley—so all the way up to Muswellbrook, Singleton and Cessnock et cetera—has a population of about 700,000 to 750,000.

ANDREW BOWEN: Yes. But we're talking about the Newcastle greater region being about 540,000. That, in size, is still greater than the Central Coast region, which is 357,000. The Hunter probably needs to be looked at as part of the rural sector as much as anything else. I've got friends that live in the Pokolbin region, and they are saying that even the Cessnock and Maitland hospitals are suffering.

The CHAIR: I'm the member for Cessnock, so I can tell you we've got a population in excess of 60,000 people. We don't have maternity at our hospital. We don't have emergency surgeries at our hospital. We don't have dialysis at our hospital.

Mrs HELEN DALTON: That's disgraceful.

The CHAIR: We're expected to travel across to either Maitland, which is about 45 minutes, or into Newcastle, which is one hour. It's similar to the expectation of the people of Wee Waa needing to go to Narrabri or further on. I was asking the question about the numbers because my base understanding, again, is that the old New England district or area was from Tamworth up.

ANDREW BOWEN: And out.

The CHAIR: And out, yes. So somewhere between Murrurundi and Tamworth, there would be a line potentially drawn under this proposal. The up and out would be the New England, and down towards Newcastle would become the Hunter, as it was prior to 2005. I ask you both—and I asked this question at the very end of our previous witnesses. If the bucket of money for the current Hunter New England Local Health District was to be split—and it would be about a two-third to one-third split, with the one-third that would go into the New England health district—how do you think you could better utilise that money in a more clever or creative way to improve the health services given that the amount of money is the amount of money and that's it? What would be the advantages of having control of your own bucket of money instead of waiting for decisions to be made down at Newcastle as to how your money is spent?

ANDREW BOWEN: At the moment, all funds go to the big bucket. I have found no oversight by either State or Federal to ensure that it's evenly distributed amongst rural or city, or the major regions. By isolating it, you at least ensure that that one-third will get to the rural health, which is not happening at the moment. I live opposite the Wee Waa hospital. I have watched the degradation of services over the past 30 years, especially in the past 10 to 15 years. It's just got less and less. We used to have visiting specialists turn up there. Once a week at least, they're still using the X-ray machines there. I've been able to walk over there at 9.30 on a Sunday night after slicing my hand open with a very sharp chisel and be looked at.

The CHAIR: In the past?

ANDREW BOWEN: In the past, yes. None of that is available now. We used to have doctors there that had visiting rights who were surgeons. They could do surgical procedures in the hospital. They've got an operating theatre there. It's nothing that we haven't had, it's just slowly—it's sort of like a frog in water—getting everybody comfortable with less and less. But I would say we would be better off in the New England being merged with Western and having completely this side of the Great Dividing Range as an internal health district than we are—

The CHAIR: Why do you say that?

ANDREW BOWEN: Why do I say that? Because if you're talking about having a larger population to fund, between us we've got enough regional hospitals of a decent size to actually service the community, rurally. Western is also a rural district and they understand rural. Once you sit east of the divide, you don't come west. Less comes west. Most goes east. So if you actually have it all here—we all move up and down the Newell Highway—it's sort of like the lifeblood of the inland. If you had all of your systems along this side of the divide attached via the Newell, you would actually be far better off doing that than having us still attached to the Hunter.

Ms TRISH DOYLE: Thank you both for coming along today and speaking for your community. I would just like to acknowledge Chippy, for sharing that personal story, and the anxiety that would be causing you and your family at the moment. I just want to acknowledge you're still turning up to speak on behalf of the community. We appreciate that, and wish him well. There has been some commentary around the potential impacts of splitting the local health district, with some people believing there would be duplication and others saying that there are no services anyway in communities that are desperately crying out for them, and that the local health district and NSW Health doesn't understand how to service communities such as this one. I'm interested in your thoughts on this. If this bill were to pass, will there be a duplication? Is there a possibility of duplicating services when what we are hearing is there are next to no services, anyway? What are your thoughts on that, both of you?

CHRISTIAN PETERSEN: Having more jobs in regional Australia isn't a problem for me. I think that's a great idea, actually. As far as duplicating services, as I alluded to with my story a few minutes ago, the services just aren't there. The Hunter New England health district had a three-week head start and we still haven't got an appointment to see a specialist, whereas my son has had his biopsy and we're waiting for results by stepping outside of the district, anyway. Driving from Wee Waa to Newcastle, you may as well go the extra little bit and just head into Sydney. There's far more services there available and far quicker, if you're able to do that. Obviously some of the young people I work with don't have that option. So duplicating services would be brilliant. That gives us access to things that they don't have access to. Obviously you've got that costing thing, but that's someone else's problem to sort out. I am too busy trying to keep my thing funded.

ANDREW BOWEN: When we did have our own local area health service, we still had access to John Hunter. That was never a problem. We had specialists coming up from Sydney, and we would have rooms in Wee

Waa hospital and all the way around, so they came on a regular basis. But it also gets down more to the point of ensuring that every rural hospital has their EDs open as a starting point, because that's where you get triage. We've always had the helicopters coming in either to Tamworth or, in the worst case, to John Hunter. That has never been a problem. The problem is that, because they are not open at night anymore, we are not getting the helicopters in. What is happening is there is higher pressure on our ambulance forces. They are taken out of the region to take somebody to either Tamworth or John Hunter and then, because of that, if another issue happens the same night, somebody from another region has to bring an ambulance in, which is more travel. It's just this, "We won't supply the hospital. We will palm it off to the ambulance services." They don't have the facilities.

Ms TRISH DOYLE: Interestingly on that, a young fella I know did some work as a paramedic out in this area and was talking to me about the huge stressors on the ambulance force, with a lack of hospital services and that tyranny of distance with travel being used as a patient transport system but also, as you pointed out, Andrew, being taken out of one area and leaving another without any ambulance services. Do you have any further comments on the availability of ambulance and patient transport services in your community?

ANDREW BOWEN: Yes. We've got a lovely group of ambos in Wee Waa. They go above and beyond.

Ms TRISH DOYLE: That's what I hear.

ANDREW BOWEN: Their stories are horrific. They talk about having to go and collect people further west than Wee Waa and not being able to come to the Wee Waa hospital because it's shut and then having to drive the extra 30 minutes. At night you have to be wary of mainly kangaroos, so you can't speed, otherwise you end up hitting those and you don't get anywhere. That adds an extra hour to them doing a job to get somebody to a hospital, just to get to Narrabri, after having come from, say, Burren Junction or further out west to get closer. It's taking people away just to do the travel—that is unnecessary—to get somebody to a hospital, which then frees them up to do another job. This is what I was alluding to, the fact that they are out of area and somebody else gets tagged that is even further out of area and you just have this shuffle of people hoping that one of the areas that has an ambulance isn't going to get two call-outs.

CHRISTIAN PETERSEN: Or a trip to Tamworth or Newcastle to take someone that next step.

Ms TRISH DOYLE: Sorry, Chippy, did you want to comment on the availability of ambulance and patient transport services as well?

CHRISTIAN PETERSEN: Just jumping on the back of what Andrew is saying, you've got a theoretical trip from Burren to Narrabri, and then that's assuming that you've got the services in Narrabri that you need. It's then another hour and a half at least into Tamworth, depending on how quick your ambulance is allowed to go. That makes it a three-hour trip for that ambulance to come back into Narrabri, let alone back to Wee Waa or out to Burren if there happens to be another accident that night. That is quick maths. It's about four or 4½ hours. That's about half a shift that your ambo isn't onsite.

Ms TRISH DOYLE: Yes. It's crazy, isn't it? I think it's a good point to actually make for the purposes of the information we are collecting in this inquiry. Within health, there are obviously those issues with lack of services at particular times and the huge amount of stress that that shifts onto another element of health, and that is our ambulance services and those workers. I appreciate that.

Ms LIZA BUTLER: Thank you for joining us today. I want to explore a couple of things you have said. We have a set bucket of money, which is roughly a third. If we could ensure that one-third of that bucket of money was coming here, would that be preferable to splitting the health district? Because you would have extra costs with executives, CEOs et cetera, so you might cut out some of your third. Would that be a preferrable option if we could guarantee that one-third of the funds was coming to this side of the great divide?

CHRISTIAN PETERSEN: Funding is one thing; understanding how communities operate out this way is a different thing completely. I imagine you see it across every profession. People who have spent their lives in a city environment come out to regional and rural areas and they just don't know how it functions. That is okay because if you put me in the city, I'd be lost too, as I experienced last week. It's just a completely different culture. That is without looking at—Wee Waa has quite a high Indigenous population as well, so that adds that extra step. The funding thing is one question, but having someone in charge of the area who understands how the area operates is the other side of it. If you could guarantee one-third of the funding, that would be awesome. I don't think that's what we're getting at the moment. But having the people who are making those decisions be people who understand the differences between rural and regional areas and city areas is the other question you need to ask.

Ms LIZA BUTLER: Did you have anything to add to that?

ANDREW BOWEN: Given the lack of oversight by governments in the last 20 years over the plans that they've put in place, I find it difficult to believe that they would ever ensure that one-third gets to us anyway. Again, there would be efficiencies in the Hunter region. They wouldn't need the same level of administration because they would be administering a smaller area. You would actually get cost benefits there, which could be offset by what it is being utilised elsewhere.

Ms LIZA BUTLER: My next question feeds into that. It's about your suggestion of splitting from the great divide into the western district with a third of that money. Would that be preferable to creating a whole new health district?

ANDREW BOWEN: It would be preferable to having to stay with Hunter, because they've got the same understanding of what is required.

Ms LIZA BUTLER: Of country living?

ANDREW BOWEN: Yes.

Ms LIZA BUTLER: Did you have anything to add to that?

CHRISTIAN PETERSEN: No. Andrew just said it. I imagine they would be more likely to have a better understanding of how rural communities work, to have a rural health district.

Ms DONNA DAVIS: Thank you for attending today. Chippy, thank you for sharing your personal story. Extending that and talking about youth and your experience, we know that wherever youth live, there are very common issues with their health. Mental health is a big issue for youth, as well as suicide ideation, self-harm, drug overdoses and relationship issues. At the moment, where do youth go to access services if they are experiencing any of those severe health concerns? Where do they turn?

CHRISTIAN PETERSEN: For most of them, it's probably a bottle. It is interesting. We are in Wee Waa. If you go about an hour further west and call a mental health hotline, you will speak to someone much quicker because they're in the Far West Local Health District, which has a better understanding of mental health issues in rural communities. You could be on the phone for as long as an hour before you talk to someone in Wee Waa. The kids I hang out with, we talk about that sort of stuff a bit, looking out each other, where do we go. I had a bit of time doing some training. I've done a mental health first aid certificate and some youth work training, so I do what I can to alleviate that.

Then we've got to make phone calls if we need to. As far as seeing someone face to face, unless you've been in the system long enough, you don't know someone to talk to face to face. A couple of kids I work with have psychologists and counsellors they meet with regularly, but most of them, if they're having an issue, they've got maybe mum and dad, their mates, teachers at school. The ones that I see will chat with me and a handful of trusted adults in the community who, chances are, don't have any training at all except for being able to listen. The fact that I'm not going to more funerals as a result of suicide and things like that is nothing short of miraculous with the access to resources we have.

Ms DONNA DAVIS: The closest mental health facility, is it a specialised hospital in Newcastle, or is there anything closer?

ANDREW BOWEN: Banksia in Tamworth.

Ms DONNA DAVIS: I'm going to play devil's advocate. As the member for Parramatta, I've got Westmead in my electorate. We actually, believe it or not, have struggles to get specialists at Westmead in particular fields. How would a split in the area health service actually ensure that you had the specialist services that you're lacking now, if we are experiencing those issues in all of our health districts?

ANDREW BOWEN: It's a problem across the board. It's not just New South Wales; the whole of Australia has that problem. But we didn't have a lot of the specialists in the old New England. We had a better baseline of service than we have now, which covers the majority of what's needed. We then had visiting specialists who, as part of their practice out of Sydney, would fly up and consult, use consulting rooms at the hospitals or elsewhere to see patients and assess them and, if needed, schedule them down through the hospitals or even they would come up as a specialist and do operations locally as part of their practice. So we shared them. We didn't say that we'd have them but that level of care, they are specialist, it's a smaller set of people.

We're not even really getting that anymore. That needs to come back, and that's the way you handle it. I don't think it's asking too much to have those sort of facilities. It's rare, except for real trauma patients, but these sorts of things are something that can't be scheduled. When it comes to a big trauma thing, it doesn't matter where you are, it will be a case of onto a helicopter as fast as you can, get you to at least Tamworth Base as a starting point to stabilise and, from there on, further through the system. That's always been the case. It is still a very

expensive way of doing things, but you'll understand how much this region relies on helicopter services by the amount of donations we make to the Westpac helicopter up here. It is seen by the community to be so vital to us that we fund it. We don't worry about getting the funds from the State Government to get our air ambulance to come up and look after us.

CHRISTIAN PETERSEN: If I may add to that, if you don't have access to the specialist in your area, then you look at ways to have access to a specialist outside of your area. Districts are only lines on a map. The roads still go past them and the helicopter flies over them. You just have to work out the best way to get access to those. Like I said, with my story, it's only that we had private health cover that we could access that. Most of the kids I work with don't have that opportunity. They're sitting waiting for specialists already. We need to find a better way to get access for people who are a bit further away. If a specialist wants to live in Sydney, who am I to stop them, but we need to have access to them somehow—that is available to people who don't currently have it.

Ms FELICITY WILSON: Thank you very much, Andrew and Chippy. We appreciate you joining us here today. Speaking about specialists, and getting specialists flown in, the conversations I've had with mayors across New England is that the changes to flights have been incredibly detrimental to a range of communities out here. For instance, you used to able to fly in and fly out of Moree on the same day, and provide specialist services on that day, whereas now it might be a two-day trip, for instance, which may not work with those specialists, with their family obligations, for instance. If you're bringing in specialists to service the community of Wee Waa, where are they flying into and out of, and what are the flight options that they have?

ANDREW BOWEN: Back in the past they used to fly into Wee Waa Airport, with various small airlines direct out of Sydney. That no longer happens because the Wee Waa Airport is no longer open. Narrabri is where you fly into, but I believe Link Airways used to fly out of Sydney, but they don't anymore. They fly still to Brisbane. So we could still get specialists out of Brisbane, if needed, to service this area. Again, most of these are a one trip a day sort of thing. Moree is the same, even though they've got QantasLink, because Qantas has got no competition. Again, there's sufficient flights into Tamworth on a daily basis, and that's a two-and-a-half hour trip. Most people go shopping in Tamworth. If they had the specialists turning up in Tamworth base, they can get the community bus organised, which is a $35 trip last time I took it, to get you into Tamworth or back out again. You could have your specialists doing their stuff there. It's not as close as it used to be, but it is still in the region. It's sort of like a halfway point, rather than us having to travel all the way down.

Ms FELICITY WILSON: You've got a Wee Waa community bus. It operates every day, does it?

ANDREW BOWEN: No. It's a voluntary service and you book it, except for the trip they do to Narrabri to go shopping once a fortnight. That's scheduled. But, yes, we have a community bus. I can't remember what they are, but, yes, you can go and book a trip.

Ms FELICITY WILSON: So you could do a round trip into Tamworth using that community transport, if it's available on that day.

ANDREW BOWEN: Yes.

Ms FELICITY WILSON: If you can book it in advance and pay for it.

ANDREW BOWEN: But if we had a scheduled time frame where you had two or three different specialists turning up on the same day, or whatever, and you knew it was happening, then they would be coordinating that sort of thing to get across. Especially for people that don't have transport.

Ms FELICITY WILSON: Chippy, you were speaking about your own personal circumstances, and I hope that your little boy is okay.

CHRISTIAN PETERSEN: Yes, he's at school today.

Ms FELICITY WILSON: Good job. Even better.

CHRISTIAN PETERSEN: He wasn't very happy about it.

Ms FELICITY WILSON: Then you know he's on the mend, don't you. Your own personal circumstances, thank you for sharing that with us. You've made the decision to go to Sydney, and Andrew you also mentioned specialist services in Brisbane. When it comes to the difference between trying to access Brisbane or Sydney for specialist services, or even hospital care, we hear from different people across the different communities that some of them would prefer, for instance, to go to Brisbane or the Gold Coast because it's a much quicker and easier drive for family members to access, if you're going to be in hospital for a period of time, or to Sydney.

But one of those challenges is that if you're in the Hunter New England health district, that's not your pathway. Your pathway would be by chopper predominantly to Tamworth, then either to John Hunter Hospital or Royal North Shore Hospital. Something like that. And in any of those circumstances, on discharge you have to find your own way home. Are there people that, rather than going through private means, went through public means? Do you find that, within Wee Waa, people would also prefer to be able to access Brisbane or the Gold Coast for hospital care?

ANDREW BOWEN: Gold Coast is a little difficult in terms of direction. Brisbane's not bad. It's about half an hour to an hour longer than going into the centre of Sydney. But you have a more direct road into the centre of Brisbane than you do into Sydney. You hit Hornsby. I mean, yes, you have the bypass around—I can hold my breath now and go all the way across Sydney without having to go into it now. But once you get to the Pacific Highway and go down through—I used to live in your electorate, by the way, 30-odd years ago. But once you get there, you're then either trying to get through to Pennant Hills and go in on the Lane Cove freeway or on the motorway just to get to one of the hospitals and then turn off to Royal North Shore, if you're on this side. If you're sent further in, then you've got to go that much further and then you've got to find accommodation, especially if you have family members, and that gets very expensive, which is why Brisbane's a better option, because accommodation's a bit cheaper.

Ms FELICITY WILSON: I've been told that people will drive to Goondiwindi to then get airlifted to Brisbane for emergencies rather than having to try and wait to get to Tamworth or John Hunter or Royal North Shore.

ANDREW BOWEN: If you look at Tenterfield, they go over the border, which isn't very far, and they'd be at Stanthorpe and then they'd get into the system that way. If you're at Moree, that's still an hour and 20, an hour and a half, but that's still faster to go that route to Goondiwindi. The border commissioner—I think we have a border commissioner here—would be far more in tune with what happens in that border region where it's literally that we've got a bigger town in Goondiwindi than anywhere else, so anything north of Moree you may rush there. There may be a difference once Moree gets a decent hospital rebuilt. You're always going to have that ebb and flow. Even from Wee Waa, we've had people I know that have gone and gotten their surgery in Dubbo because that was a quicker path than trying to go through John Hunter.

Ms FELICITY WILSON: That's very troubling. My question for Chippy was about the kids and the young people that you work with at RiverBank Youth Works. I just want to get a better understanding of the needs of those kids. You talk about kids with a lot of disadvantage. Often we hear that that might be kids with ADHD, maybe undiagnosed, it might be FASD, it might be the need for grommets or tonsils or ENTs et cetera. Your kids, are you finding that their pathway into your organisation could actually have been reduced with earlier medical intervention? Is there a need for those early interventions for kids in Wee Waa?

CHRISTIAN PETERSEN: Yes, absolutely. There's one young bloke I work with in particular who has no diagnoses at all. I'm not trained but I reckon I could give him a few. The challenges he faces even just to get out of bed and into whatever in the morning are just phenomenal, which could have been alleviated by having access to those services as a kid, and that's a complex situation. It's not necessarily just the health service there. He has a ridiculous family life that just makes those things beyond his ability to do anything about. Obviously as a small child—even now he's a teenager—having access to those things is beyond his means as the system sits at the moment.

The CHAIR: Mrs Dalton, we're pretty much out of time. Is there anything pressing or urgent that you want to ask?

Mrs HELEN DALTON: Yes. Thanks for your attendance today. We were talking about basically population and all of that, where the need is, and perhaps we need to target resources for each community, which may help. But do you think that the Government is cost-shifting with the extra burden on local communities? Andrew, you spoke about 30 years ago we had this or that. Now, obviously, we're going to have to put our hands in our pockets and do more. Is that what you're thinking?

ANDREW BOWEN: I think that there is a larger burden in terms of cost to rural people to not only get to hospital but staying in hospital. It is to a certain extent recoverable through transport subsidies.

Mrs HELEN DALTON: Not fully, though, is it?

ANDREW BOWEN: That's a bureaucracy and a half to get that to start with. You've got to have this piece of paper and that piece of paper. If you haven't got it to start with, then you've got to go back to the people who have sent you there to get that information. Then you put a claim in and hope that it gets passed on. It's one of the burdens of living in such a lovely environment that we have here, rurally, but also in terms of demographics, you've got a large portion of the population that doesn't have the income streams that people in cities get.

Mrs HELEN DALTON: Wee Waa has been identified as a fairly wealthy community, really, isn't it? It produces a lot of cotton and everything.

ANDREW BOWEN: Yes. The farms around do. Wee Waa itself has got a few professionals, but it's actually seen as an area of need.

Mrs HELEN DALTON: I'm sorry, I'm speeding you up, because I know the Chair's anxious that we're running out of time. As a past accountant, or a background in accountancy, we're always looking at the numbers. You talked about the population here and the population there, and stuff like that. Should we be looking at what we contribute or what our area contributes to State revenue, rather than looking at the numbers of people? If you're a wealthy community and you're generating a lot of money for the State Government, wouldn't you think that a proportion of that money should come back to your community?

ANDREW BOWEN: It's almost like the thing about having a mine in your area and you should get royalties back off that. Yes, it could be helpful, but then you've also got to look more at the case of if you don't have towns like Wee Waa that run all these things and earn all this money, not just for State Governments but for exports and income into Australia, if you don't support those to a certain extent, then they're going to disappear and those industries will be very difficult to maintain, because they need those support services. Money itself—yes, I'm an accountant—is only one of the leaders. You've also got to look at the social impacts of where you can best spend. Sometimes you have to spend more than the perceived amount that you're delivering per population to get other things achieved for the overall good of the nation.

CHRISTIAN PETERSEN: It's very tempting to go, yes, absolutely we should spend more money where more money is coming from. But we need to look at equitable rather than equal. If everyone needs to see over the fence, some people need a bigger box. The kids I work with are never going to be huge wage earners, unless something miraculous happens in their life. I don't think it's fair on them to have to sit just because they're not very rich. That's a dangerous path to go down.

The CHAIR: Thank you all for appearing before us today. You will all be provided with a copy of the transcript of the evidence to do corrections. Committee staff will also email any questions taken on notice—there weren't any—and any supplementary questions that the Committee may develop over the coming days will also be emailed to you. We ask that you turn those around for us as soon as possible. Thank you so much.

(The witnesses withdrew.)

Ms CARMEL SCHWAGER, Member, Save Wee Waa Hospital Committee, sworn and examined

Ms KATE KAHL, Member, Save Wee Waa Hospital Committee, sworn and examined

Ms ANNE WEEKES, President, Wee Waa Hospital Auxiliary, sworn and examined

The CHAIR: I welcome our next witnesses. Thank you for appearing before the Committee today to give evidence. Members of the public are not permitted to take photos or film proceedings. However, members of our Committee staff will be taking photos and footage and using them on social media for public engagement purposes. If you would like a copy of the images taken, please talk to us. If you would like to not be represented in our social media, please talk to us. Before we start, do you have any questions about the hearing process?

ANNE WEEKES: No.

KATE KAHL: No.

CARMEL SCHWAGER: No.

The CHAIR: Would anyone like to make a short opening statement of up to two minutes?

ANNE WEEKES: I come before you today on behalf of Wee Waa Hospital Auxiliary, an organisation that I have had the honour of chairing for the past 15 years. I've lived and worked in Wee Waa for 53 years, so I will often refer to Wee Waa in my remarks. We, the auxiliary, feel that the services we now have at Wee Waa are frighteningly inadequate and bandaid measures are in place. The staff at Wee Waa hospital deserve honourable mention for persevering, especially during two recent floods in the last five months. Wee Waa is the most western health service in the Hunter New England District. Urban-centred health administration is 5.5 hours away and is failing us. Significant barriers to accessing health care are very real.

In Wee Waa the lack of public transport is a stark reality. Without a taxi or mini bus services, many of our community members struggle to attend necessary medical appointments. This extreme disadvantage

highlights health disparities. It's imperative that we have a health administration that recognises and acts on these challenges, because every New South Wales resident deserves equal access to good hospital care close to home. Therefore, we strongly advocate for restructuring of the Hunter New England health district.

It's also essential that we work together to Close the Gap, which will be mentioned later by other representatives, ensuring that every voice in our community is heard. The needs of our unique Indigenous population must be acknowledged and understood. Sadly, the gap is not closing; in fact, it's widening. This gap shows a failure to adequately engage with Indigenous people to help understand their culture, especially in light of medical issues they face. The input of community members has been largely ignored and has not been encouraged. Thank you for your support as we pursue a healthier future for rural and regional New South Wales.

KATE KAHL: Thank you for your time today. Under the mismanagement of Hunter New England Health, rural communities like ours aren't being restructured; they're being dismantled. The depleted bandaid solution that is now Wee Waa hospital proves it. That's why the Save Wee Waa Hospital Committee supports splitting Hunter New England Health into separate Hunter and New England North-West districts. Hunter New England Health is trying to run an area almost half the size of New Zealand from Newcastle. It's too big, too remote and too slow to respond. The further you live from management's beating heart, the less care you receive, and Wee Waa is proof of that. It's easy to cut services in a town you don't live in or understand.

In May 2023, our hospital hours were temporarily reduced. Nearly two years later, 24/7 care has never returned. An automatic fence now closes at 5.30 p.m. each night, physically barring our community from our own hospital. We're told, "We can't get the nurses." But without a doctor with VMO rights, nurses won't return. Wee Waa has local doctors ready to work. The only barrier is poor management, failed negotiation and a refusal to act. Hunter New England Health claims splitting the district would duplicate services. But if duplication means communities like ours get the same 24/7 care as Boggabri, Baradine and Collarenebri, then it's not wasteful, it's lifesaving.

Hunter New England Health runs health care like a business, using manipulated low admissions data collected after May 2023, when hours and staff were cut, to justify further cuts. Look at the data before 2018, when we still had a doctor. Our population hasn't changed—only Hunter New England Health's decisions. Ambulances have become glorified taxis, racing patients along dangerous highways, with one paramedic trying to save a life in the back. Emergency care is now a nurse wheeling in a computer to connect you to a telehealth doctor, when the hospital is even open. Maternity care is a lottery and palliative patients die far from home while local beds sit empty. If this is Hunter New England Health's idea of the future of rural health care in New South Wales, we're heading towards developing world standards.

Hunter New England Health is failing us in service delivery, management, securing doctors and even basic communication. Our hospital advisory committee hasn't met in years. Splitting Hunter New England Health and moving management to Armidale or Tamworth would put decisions back in the hands of those who live here and understand that rural hospitals must remain fully operational to keep their community safe.

Ms TRISH DOYLE: Firstly, thank you all for coming here today to represent your community, to speak with us and articulate your concerns, suggestions and demands. I'm going to focus on birthing and maternity care, which each group has made reference to in its submission. Ms Kahl, you just referred to maternity services as "a bit of a lottery". How accessible is birthing and maternity care for mothers and families in your community? How would splitting the local health district improve that access, noting that there are already maternity staff shortages in many areas across the State?

CARMEL SCHWAGER: I think Kate's the most recent to have had a baby. It's a generation ago for me.

Ms TRISH DOYLE: Would you like to speak to that first, Kate?

KATE KAHL: Sure. I've got a lot of friends—like, we're definitely in the age where we're having babies at the moment. A lot of my friends don't know where they're going to end up giving birth. It really is a matter of, when you are going into labour, what hospitals are open and which ones are on bypass. A lot of the time now they're getting bypassed to Moree, to Tamworth, to Armidale, I heard just the other day. To get the specialised care, too, you do need to travel quite large distances. I myself had to go to Moree once a month every month through both pregnancies and then had to give birth at John Hunter as well. Even just the disconnection with the paperwork side of things, as well—I turned up to John Hunter and they had no idea why I was there or why I needed to be induced. I had to basically prove to them why I even needed to be there in the first place.

Ms TRISH DOYLE: So there wasn't sharing of information within the same district?

KATE KAHL: No, correct. It really let me down in that moment, personally, and I know a lot of my friends feel the same. They just feel like no-one cares. There have been newspaper articles on it, but the dangers of going into labour and then having to try to get to Tamworth quick enough—when you're in labour, you don't want to be on the highway. So there's a big disconnect there between who's giving birth in what areas, and then where you can actually give birth.

Ms TRISH DOYLE: If we did see the splitting of the health district, how do you think that would actually improve access, given the point I made? Playing the devil's advocate, we do hear that there are maternity staff shortages across the State. It's not just in this area; other rural, remote and regional areas are struggling with very similar issues. How do you think splitting the district would improve that access?

KATE KAHL: I think if we managed the hospitals in our area better, so that people that don't need to be in Tamworth can be in places like Wee Waa, it opens up bedspace in places like Tamworth where you do need maternity services, for example. You don't get people having to then get shipped off to John Hunter or Narrabri—although we did hear that there might be a few changes even to maternity in Narrabri. We're still waiting on some confirmation on that. But actually giving the capabilities back to places like Wee Waa hospital will enable things to flow better when you actually need that support. You don't have to travel as far.

Ms TRISH DOYLE: Anne, did you want to make a contribution to that response?

ANNE WEEKES: I don't think so. I think that's adequate, thank you.

Mrs HELEN DALTON: Can you provide a brief overview of the key challenges faced by the Wee Waa community and the engagement with the Hunter New England Local Health District on these matters?

CARMEL SCHWAGER: I was a member of a working party that was established after the reduced hours in 2018, and local community members joined that in good faith because we were meant to be working towards the hospital opening again. But we started talking about things that weren't related to getting the hospital open again, like getting OT services. All that kind of stuff is important, and getting physios and all that kind of stuff back to the hospital.

Mrs HELEN DALTON: Specialists.

Ms DONNA DAVIS: Ancillary services.

CARMEL SCHWAGER: Yes, but that wasn't the crux of the problem with us, and nothing was happening within that. I find the fact that we have got doctors in Wee Waa and they aren't contracted to the hospital a failure of management. I know there are negotiations involved and they don't always work out. But there are four doctors in there, and one of them is actually working away now. I actually think if there was goodwill, it would have happened by this time, and doctors would attract the nurses back. People are not going to Wee Waa hospital, on the whole, if something is serious. They'll just go straight to Narrabri. A couple of years ago—we're on a farm. Someone had a stroke on our farm. My son had to drive them to meet the ambulance so they could go to Moree, because Narrabri didn't even have the stroke medication that you've got to have.

Our health outcomes have decreased since 2018, when we last had acute care beds at Wee Waa hospital and our local doctors were visiting. It's just easy sometimes to make those decisions when we are a long way from the beating heart of what's going on. I think Tamworth understands us better. If you look at the areas to the west of us, they're managed by Dubbo and they've all got better hospital services than we've got, because Dubbo probably understands what Baradine is like or understands what Collarenebri is like. Newcastle does not understand what it's like living in Wee Waa. With the farming industries and farming-related industries that we've got round there, we need a hospital open all the time.

If you're not sure if the hospital is open or if you can see a doctor, then you just bypass it if you can. But there are examples of people not getting help. I met a young fellow when we were doing submissions for this, and he had hurt his hand badly during the last flood in April. He went to Wee Waa hospital and they said he needed to get to Narrabri. He is one of the kids who has probably worked with Chippy at some stage. He didn't have transport to get to Narrabri, so he's just got a bung hand now—it just didn't happen. If those services were available in Wee Waa, it would have been a lot better.

KATE KAHL: There seems to be a big disconnect between the communication with them as well. There was no consultation before the hours were cut at the hospital. We've had rallies as a community. We found that we've had to really be loud about it for them to actually listen. For them to listen, it only happens when it's through the media. They don't care unless it looks like bad press for them. Then they start to actually do something about it. There was one point where they wouldn't even let us go into our own hospital. It was only when the media turned up that they allowed us in. There have been instances like that. Even with the floods, like the one in

March, we had to literally beg. We had to get the mayor involved and beg every day for them to stay open overnight while Wee Waa was cut off.

CARMEL SCHWAGER: During that flood, my sister-in-law collapsed. She was brought to Narrabri in the ambulance because they didn't know at that stage whether Wee Waa hospital would be open at night during the floods. She was discharged at night and my husband and I had to come up and get her and try to get her back to Wee Waa and into her home before the flood closed off our roads. It puts a whole lot of cost, emotionally and in dollars, back on the community.

ANNE WEEKES: I just feel that the anxiety caused due to the uncertainty of the whole thing, if you have an emergency, is a key issue that we will need to address moving forward.

Mrs HELEN DALTON: Have you got the stats that say that our health care has declined since the closure? Is it really stark?

CARMEL SCHWAGER: We've got the stats that actually say that the health outcomes—or it might be when you die. The death things between our shire and Moree and Gunnedah is less—like, we've got lower health outcomes than our surroundings.[1]

Mrs HELEN DALTON: Are your lives worth anything less than anyone else's?

CARMEL SCHWAGER: No.

Ms FELICITY WILSON: Thank you very much for joining us today and for the work you're doing in your community as well. Listening to you all and listening to the other witnesses who have been appearing before us so far today, there seems to be quite a common theme about a real fracturing of the relationship with the health district—a lack of communication, a feeling of a lack of respect and value, and I think you said poor management as well. To what extent is that an issue with the actual running of the local health district rather than the structure of the local health district? Do you think that if new practices, processes and culture were put in place, a large health district like this could meet your needs, demonstrate respect, communicate and provide good health services? Do you think it's all about the structure, or do you think it's about the way in which it's being run?

CARMEL SCHWAGER: I think it's about the head of the health district's understanding of what living in a rural place is like. I just think the fact that it's a metropolitan area that's running it, with a vast rural area, I don't know if they can do that, unless you centre it in Tamworth. Maybe if Tamworth ran everything, maybe they've got a better understanding of metropolitan and rural, partly. But I think in Newcastle it's just too far away. We wouldn't see the people from Newcastle very often up here. We see the local managers from Moree and Tamworth occasionally, but not often.

KATE KAHL: I think it's also just the fact that we have doctors in Wee Waa willing to look after the hospital and it's not happening. There's something very wrong there, and that is on them to come up with a plan, come up with a way, to find a solution. We know we have people on the committee who have sat in these private meetings. We know that they're not asking for too much. They're not being unreasonable. They're asking for what other doctors in the region get, so why is that not occurring? The fact that just recently someone had to travel from Wee Waa to Tamworth just to get stitches—that's a 4½- or 5 five-hour round trip, just to get stitches. That is a mismanagement. How can that occur? How can that happen, where they allow their own hospitals to go on bypass to the fact that we can't even get a doctor to do stitches?

CARMEL SCHWAGER: Yes. The local doctors could have been called up and the stitches could have happened.

ANNE WEEKES: That lack of transport access is a real problem. It's one of the reasons we're pushing so hard. It's all very well for those of us who can drive, who easily drive to Narrabri and to Tamworth and do it regularly. But so many of the people who live in Wee Waa don't have a car, don't have family who can drive them even. There's quite a degree of low socio-economic problems, where people don't have a car. They will sometimes then—like someone mentioned, the boy who's got a permanent injury to his hand. That shouldn't be happening in modern New South Wales.

Ms FELICITY WILSON: Anne, you spoke in your opening statement about the Aboriginal community within Wee Waa. As you know, we heard from the land council earlier. You mentioned Closing the Gap. We've obviously had the most recent release of the Closing the Gap reports, and there is a range of different concerns

[1] The Committee received correspondence from Ms Carmel Schwager clarifying this statement. The correspondence is published on the Committee's webpage.

with those. What is the extent of your lived experience or observations—rather than just the stats on a piece of paper—of that from within the Wee Waa community?

ANNE WEEKES: The Wee Waa community's Indigenous people feel like they're not heard. Hunter New England Health have admitted recently that they haven't tried to engage with the Indigenous community. That's shameful. Twenty-seven per cent of Wee Waa are Indigenous. That's my observation, and it's sad that they haven't been interested in engaging. Some areas of the gap have closed, but the two that I note that affect us that haven't are suicide rates have increased and there was one other that, of course, at this minute I can't recall.

Ms DONNA DAVIS: Thanks for coming today. You talk about the VMOs and the fact that the health district doesn't seem to be very willing to make that happen in terms of checking or converting the GPs into VMOs. Do you have any correspondence from the health district explaining why? Have you received responses that you can share with us later?

CARMEL SCHWAGER: No, we don't, but a member of our group has been involved at the local doctor's invitation to some of those meetings, but we haven't got access to the documents or the exchange because it was all in private. A member of our committee has been involved in that and has got emails, but we haven't got access to them.

Ms DONNA DAVIS: Did that member have a level of confidentiality that they had to—

CARMEL SCHWAGER: Yes.

Ms DONNA DAVIS: That might be something that we can pursue on our end, then. And very quickly, we asked others earlier about accommodation in the town. Is it the fact that you do have accommodation there, going begging, for medical staff professionals that could live there and work in the hospital?

CARMEL SCHWAGER: We actually had an idea. Education and police, apparently, share housing. If you made it education, police and health, that would actually probably work in a lot of country towns, and we know that there are spare accommodations there.

KATE KAHL: And the community raised funds as well.

CARMEL SCHWAGER: Yes. We built our own.

KATE KAHL: We've got ones that are built across the road from the hospital, ready to go. Just to talk to your question before, I did actually try and do a GIPA request for some of that information of what were the decisions that were being made between the management back then around the VMO rights. I didn't think that we were asking for much. We just wanted to know a bit of a background so we could understand as a community why this was being decided on, and so we're looking at postcodes for who's going to Narrabri Hospital, who in our area is now starting to go there. We wanted email correspondence between David Quirk and Tracey McCosker about any of that and David Quirk and Susan Heyman as well, any business plans that they had or any financial reports for Wee Waa hospital, and we were told that it would cost $5,000 at least for us to receive that information. It was going to take I think it was 126 hours to search for that information.

Ms TRISH DOYLE: Was this back in 2019?

KATE KAHL: No. This was just recently.

CARMEL SCHWAGER: Since Save Wee Waa started.

KATE KAHL: I did it, I think, in November last year. Give me one second. Most of that was for the information retrieval, compilation and review of the information for release. They had already spent 18.5 hours trying to find this information. This is pretty basic information that we're trying to get, so I don't understand why it was that difficult. But obviously that brought us to a halt. Sarah Mitchell, MLC, has actually requested a lot of this information now, last week, through Parliament. She's requested in the next 28 days to be delivered that information. That'll be good.

Ms LIZA BUTLER: Thank you all for taking the time out to come and talk to us today. The last thing you talked about was the lack of communication. We roll back two years, when they made this decision to temporarily close. Your hospital advisory committee, the auxiliary—were you consulted in any way whatsoever?

ANNE WEEKES: Yes, I was, as auxiliary, and also I was on the local health advisory committee. We were called to a meeting with Hunter New England Health, and they told us that they were going to temporarily close it, for six weeks. That was in May 2023. And we were all very shocked and disappointed and said, "Can you guarantee that it will only be for six weeks?" Because obviously it was a huge move to close the hospital back to just 7.30 a.m. till 5.00 p.m.—or is it 8.00 a.m. till 5.30?—every day.

Ms LIZA BUTLER: Can I just stop you there, just to clarify: Was birthing already removed at that point?

ANNE WEEKES: Yes. Birthing's been gone 20 years. So we were very much on high alert when they announced "six weeks", and there's been no communication at all about going forward, and here we are—

Ms LIZA BUTLER: No master plan, no discussion.

ANNE WEEKES: No. Just, "We're going to close it for six weeks," and here we are, two years and three months down the track.

CARMEL SCHWAGER: And establishment of the working party.

ANNE WEEKES: And establishment of a working party to talk about it, which then didn't work. It failed.

Ms LIZA BUTLER: I just want to clarify about the ambulance. It's an ambulance with paramedics, not the ambulance transfer service? So when they're transferring patients, then you don't have anyone in an ambulance for emergencies, because it's not the patient transfer service.

ANNE WEEKES: It does both, and so it does give us a problem in that if they're busy transferring, there's no ambulance.

KATE KAHL: Which has happened.

ANNE WEEKES: That's right.

Ms LIZA BUTLER: That's what I mean. In other areas, there's the green ambulances with the patient transfer. Do you have a patient transfer, or they're relying on the paramedics in an ambulance?

KATE KAHL: For emergencies, they're relying on paramedics. If they leave, and they're going to Moree—

Ms LIZA BUTLER: But for your patient transfers, they're relying on the paramedics as well?

KATE KAHL: It depends if it's an emergency or not.

CARMEL SCHWAGER: I think if it's booked from Narrabri or something. I'm not totally sure.

Ms LIZA BUTLER: Great, thank you. Back to maternity—for your antenatal care, do you have to travel for that, or do you have the midwifery group practice model so that the expectant mums can go to the hospital?

KATE KAHL: We did. We're still waiting for confirmation, because it's all locked down. It's all very hush-hush. This might be something that you guys can look into more. There is talk that they have changed that now. All mothers in this area need to go to Moree for their first appointment so they can come up with their maternity plan.

Ms LIZA BUTLER: Do you have the same midwife all the way through, or do you just chop and change all the way?

KATE KAHL: No. It's just—

Ms LIZA BUTLER: Last question, Chair, because I am mindful of time. This Committee is looking into the benefits of splitting the health district. What do you see as the main benefits? When you think that there is only one bucket of money, and so it is not going to increase any funding, what are the benefits?

KATE KAHL: I think you'll have hospitals that are actually thriving in all areas and looking after their local people. It will reduce a lot of travel time for everybody. It's just a matter of time where someone is going to lose a life because they're on the road between hospitals. If all hospitals are actually given the capability to operate how they're meant to and those beds are full, then only the emergency ones—the actual higher needs patients—are getting transferred out. It takes a lot of pressure off Tamworth. You hear constantly how they are overwhelmed or have to go on bypass. Even John Hunter was on bypass the other day because it's getting too full. It's getting overrun. If you actually build up the capacity back into places like Wee Waa—so we can look after people that just need to stay overnight to be monitored or to have stitches and have a doctor there who can do that—it's going to take an immense amount of pressure off the whole system.

CARMEL SCHWAGER: We want to go back to 20 years ago when we were run from Tamworth and we had a good hospital service.

The CHAIR: Do you think that any of the problems that you've identified can be fixed without additional money?

KATE KAHL: Yes. You just take what you're paying for now with—I'm sure it's costing so much with the helicopters and the paramedics going all over the region. If we had a doctor in Wee Waa operating that hospital, it would take a huge amount of pressure—I would just take the money that you're spending on that and actually pay for the doctor to be there.

CARMEL SCHWAGER: There has actually been money saved from Wee Waa hospital since they closed it. I don't know whether that—

The CHAIR: Presumably that money is being spent somewhere.

KATE KAHL: Yes. It would be interesting to see where.

CARMEL SCHWAGER: I was wondering, if it was a temporary closure, whether it is being held for us until the hospital opens again.

KATE KAHL: Because there is a line in the budget for us.

The CHAIR: I am listening to all the things that you're talking about and the things that you would want restored at the hospital, et cetera. I am sitting here thinking that all of that—everything that you've listed—costs extra money.

CARMEL SCHWAGER: Look at the other hospitals that are a similar size to us. How do other health districts do it? Should we have to pay more for us because we haven't got the health service that Baradine or Collarenebri have? I don't know why Wee Waa has to be the only hospital, probably, in New South Wales facing this situation. We bear the cost of that at the moment.

The CHAIR: Which then, I guess, lends itself to a question about whether or not Hunter New England Health, as a district, has enough money to provide all the services in the way you want them provided. This is a significantly different question from splitting the district up so that you get the services.

CARMEL SCHWAGER: When the district was split before, it worked better. You're embarrassed to hand that on to your children—that your health service is going to be poorer because of where you live.

The CHAIR: Certainly a lot has changed in health over the past 20 years. GPs used to deliver babies at the local hospital. That doesn't happen anymore now with the risk around death to mother and children, the cost of the insurance and all that sort of stuff. That's just one example. We have less doctors going through their training and turning to GP services. We've got more going into specialist services, which means instead of having a GP that can do 50 different things, you've got a specialist who just concentrates on knees. This is right across the workforce of health, across Australia. The delivery of services has changed, I think, significantly. We're concentrating on Wee Waa hospital, and we're talking about a health district. I want to go a bit macro. We're hearing problems about Wee Waa; we're hearing that. But do we throw out the whole district model because of a problem at one hospital? That's where the conversation is at a lot today. I understand that—geographically, this is where we are; this is where the submissions came from. I get that.

CARMEL SCHWAGER: This is our speciality.

The CHAIR: This is your speciality; this is your lived experience. But we're talking about a whole health district. We're talking about dozens and dozens of facilities. We're talking about, literally, tens of thousands of services. How do we balance that? How do we, as a committee, balance that question? You're giving us examples of one hospital. We're doing an inquiry into an entire health district that consumes about $2 billion a year and has more than 50 medical facilities.

KATE KAHL: I think the fact that all the hospitals are going on bypass should be having some pretty big red flags, or the fact that John Hunter was on bypass the other day—they were only accepting people if you were losing a limb or your life. How is that not showing that there's a bigger problem than just Wee Waa?

CARMEL SCHWAGER: I get that there's only so much money. If we had a budget—I think it was $5 million for our hospital. If the community actually had more input into—

KATE KAHL: How that is spent.

CARMEL SCHWAGER: —what is important, how that's spent—and I think if we had doctors back there, we would attract nurses. We have always been creative in working out ways to solve problems. I realise that money is a problem everywhere, but there's a budget for Wee Waa hospital that's not being utilised. We're not asking for more than our budget, really.

Ms DONNA DAVIS: Can we ask that question that you just asked in a different way? I just wanted to elaborate on what the Chair asked. If the health district was to remain in place but services returned to Wee Waa hospital, could that be a solution to the issues at your individual hospital? There has been a review of Wee Waa health service and recommendations made. I don't know whether you've read that or are familiar with that document. I know there are probably some things in there that aren't palatable. Is that a potential solution rather than knocking out the whole district?

KATE KAHL: I think that would mean that Hunter New England Health has to see us—like, rural hospitals that have a benefit and not to just turn off the tap to the rural hospitals. If they're willing to say, "Okay, Wee Waa does need emergency services. They do deserve to have a doctor there"—

CARMEL SCHWAGER: And an emergency department.

KATE KAHL: Yes, sorry, an emergency department. That will have a really positive flow-on effect to other rural hospitals like ours, and it will set a standard so they don't turn off the tap to these other areas so it's not just all getting funnelled into Tamworth or John Hunter. If they change that and they looked at that and went, "Okay, let's just try to build up the capacity of all the hospitals in the area. Get doctors in each one," then it would probably work a lot better.

CARMEL SCHWAGER: The other thing, looking long term, if we don't try to engage our doctors that we've got there now, what happens in 10 years time when they leave? Are we going to be able to attract doctors, especially if we've got an urgent care model, which they're recommending in the review?

The CHAIR: I want to acknowledge that Hunter New England Health are acknowledging in their own submission that there are almost 3,000 positions that are empty, unfilled health workforce positions across the district. That's a workforce challenge.

CARMEL SCHWAGER: People are moving to other States too, aren't they?

The CHAIR: Yes, in some instances.

KATE KAHL: Because they're getting paid more elsewhere.

CARMEL SCHWAGER: So that's a problem too.

The CHAIR: Ms Weekes, you mentioned that you used to be on the local health committee.

ANNE WEEKES: Yes.

The CHAIR: When did that cease to operate, to the best of your recollection?

ANNE WEEKES: My recollection would be that meeting we were called to with David Quirk—in May was the last meeting we had.

The CHAIR: May 2023?

ANNE WEEKES: Yes. And we have not had another one.

Ms LIZA BUTLER: Is that when you were told "six weeks"?

ANNE WEEKES: Yes, and there hasn't been another one.

The CHAIR: Thank you all so much for appearing before the Committee today. You will be provided with a copy of the transcript so that you can read through it for any corrections, if you think you've been misheard or misquoted. We will also email to you any questions that we may develop in the coming days that we want to send to seek some additional information from you. Hopefully, you'll be able to turn those around in about seven days. If you can't, please talk to us about that. Thank you again for appearing before the Committee today and sharing your insights.

(The witnesses withdrew.)

Councillor TIFFANY GALVIN, Mayor, Gwydir Shire Council, affirmed and examined

Ms LEAH DALEY, General Manager, Gwydir Shire Council, affirmed and examined

The CHAIR: Thank you very much for joining us today. Members of the public are not permitted to film or video. However, parliamentary staff will be filming and taking videos to use for its social media. If you don't want to be used as part of that social media, please let us know that you do not want to be filmed, photographed et cetera. Before we start, do you have any questions about this hearing process?

TIFFANY GALVIN: No.

LEAH DALEY: No.

The CHAIR: Would one of you like to make a two-minute opening statement?

TIFFANY GALVIN: Thank you, Chair, and members of the Committee. I appear in support of the Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025. I also speak as a nurse with over 24 years of experience in regional care. I've looked after families at their most vulnerable and worked alongside clinicians who carry our system on their shoulders. That experience shapes my remarks today. I started my nursing career in Moree and then came back to work in my home town of Bingara when it was under New England Health. So I've worked in both. Gwydir shire is served by Bingara and Warialda hospitals. They are the backbone of local health. Staff know patients' names and circumstances. Community volunteers and auxiliaries raise funds and step in, yet far too little practical support flows from Hunter New England Health to these facilities.

The day-to-day reality is vacancies that linger, approvals that take too long, limited authority for local managers and inconsistent access to visiting specialists and allied health. The staff are not the problem; the structure is. The Hunter New England health district is simply too large. Its scale creates distance, blunts accountability and encourages a "one size fits most/none" approach. Policies designed for metropolitan or large regional centres often sit uneasily in small rural hospitals. The result is fatigue for our workforce and loss of confidence for residents who should be able to receive safe, timely care close to home.

Splitting the district into at least two, if not smaller, parts is the right step. This is not about building layers of bureaucracy. It is about rightsizing leadership so that decisions are made by people who know the communities they serve. A regionally anchored structure would bring decision-making within reach, speed up responses and allow genuine tailoring of services, while still maintaining statewide standards for safety and quality. Alongside this split, local governance must be restored. Re-establishing local hospital boards with real delegations would make a tangible difference in Bingara and Warialda. Boards should have authority over budget priorities, recruitment, minor capital works and service design, within clear statewide frameworks. With that authority, vacancies could be filled more quickly, essential equipment could be purchased without months of escalation, and rosters could be organised to reflect local demand. Partnerships with primary care, community health and aged care could be strengthened in days and weeks, not quarters and years.

As a nurse, I know that care delivered close to home is often safer, kinder and more effective. Familiar staff reduce risk. Continuity prevents complications. When clinicians and managers are empowered to act locally, patients spend less time travelling and more time recovering. That is what rural people reasonably expect, and it is what a well-governed system can deliver. There is also a matter of trust. Many in our shire feel that the current system is remote and unresponsive. Staff go above and beyond, yet the wider support does not always follow through. By splitting the district and restoring local boards, the Parliament can send a clear message: Rural knowledge counts, responsibility will be shared and communities will have a genuine voice in how services are delivered.

I ask the Committee to support the bill and to pair it with a clear transition plan, timelines that communities can see, transparent reporting and funding formulas that recognise rural realities, including distance, workforce, scarcity and the true costs of small-scale service delivery. Keep the benefits of statewide procurement and specialist support, but devolve authority where it improves outcomes. On behalf of the people of Gwydir shire and the staff who keep Bingara and Warialda hospitals open and caring every day, I commend this reform. Rightsize the district, restore local governance and return decisions to the places where care is delivered. If we do this, we will strengthen rural health not only in Gwydir but across New South Wales.

The CHAIR: Thank you, Madam Mayor. It's a good time to recognise and thank you for your service, as well as all former and current health service workers who make it all tick.

Ms TRISH DOYLE: Thank you, both, very much for being here today and for that articulate statement. You've covered off quite a few of the questions that I had just in your opening statement. I wanted to acknowledge the fact that you made reference, Madam Mayor, to a different system and a different time, and that you have that capacity to evaluate a bit of both and what you would like to see—so what was, what you've got and what you would like to see. Before I put a question to you both, I note that in a different committee, Mr Chair and I have been looking at access to health care for regional, rural and remote areas based on decisions that were made some time ago, and looking at whether particular recommendations have been carried out and whether things have changed. It's great for you to speak directly to what you've experienced. In your experience, Ms Daley and Madam Mayor, how are resources currently distributed across the local health district? How should they be distributed—leaving aside the suggestion that we split the local health district through a piece of legislation? You talked about smaller bites and tailoring services. Would you elaborate on that?

TIFFANY GALVIN: At the moment, the Hunter New England Local Health District is three times the size of the other health districts if you look at most of them. It's more than three times the size of some. We have a lot to cover. Resources are trying to get patients in. We're lucky in Gwydir that we do have physios as well as physios at the hospital. We have private physios and physios at the hospitals. OTs are very hard to get. We don't have a women's health nurse at the moment. That position has been vacant for quite some time. We had a local lady who has sold her farm and moved elsewhere. Since then, the position hasn't been filled, which is quite critical for young mums, especially now that it's so hard—as you spoke about in the last session—when young mothers or any mother is going to give birth. It's the follow-up care. We don't have that. We're very short of OTs. We're very short of GPs. I know that's Australia wide. When we're talking about systems, I think the whole system needs changing.

LEAH DALEY: In preparation for today I contacted a few people who are actually working in the system just to get some facts, because I am local government. I have always been local government. I will park that for a minute and talk about what we're doing as a council, but what was evident to me after talking to the people that are working in our hospitals is that there has been a creep over the years where what was once in place, what was needed—and changes in policy as well, what's possible—there's been a creep in resources to the bigger centres. Your question earlier to the Wee Waa people, it would take a lot of money to reinstall what is needed to cover the current policies and practices and what is acceptable to bring things back.

We are not sure about the resourcing at the moment. I have been on the Warialda LHAC board for probably 20 years. I've just resigned to take on the GM's job, because it was all too much. At every meeting there was concerns around budget, and at every meeting there was frustration because the decision-makers could never make it to our hospital. The understanding from the visiting doctors and the managers, they didn't understand what we were dealing with in a small country council. The decision-makers weren't present, weren't on the ground to understand what is needed, and distances et cetera. I think I've waffled a bit much, but did I answer your question?

Ms TRISH DOYLE: Yes, I think it's important to look at resources.

The CHAIR: Can I just interrupt? The Warialda local health committee? It still exists, does it?

LEAH DALEY: Yes, it does. Absolutely, yes, it does exist. And the Bingara one does as well.

Ms TRISH DOYLE: The two of you have answered, because you're talking about inconsistencies with access, which is the current situation. A preference for how things were organised and how resources were distributed and decisions being made previously, and the fact that you want to actually tailor services. I think that goes to my answer.

LEAH DALEY: Can I just talk to you about what we're trying to do as a council to cover the deficiencies with health in our LGA?

Ms TRISH DOYLE: Sure.

LEAH DALEY: Many years ago, probably 10 years ago, council set up a—what was the name of the committee? A health committee—Gwydir health alliance committee. We reached out to all the services—

TIFFANY GALVIN: PHN and LDN.

LEAH DALEY: We formed a committee that met every month. The focus was getting doctors, because our communities were saying we need GPs to come to our smaller centres. Warialda has a beautiful husband and wife GP service. They're both in their 70s. It'll be short lived soon. I'm sure we will be very much like Wee Waa in the not-too-distant future. Despite all efforts there is still no succession plan for them. Bingara is pretty much run by a locum, but they do have—

TIFFANY GALVIN: We have a different locum every week—three weeks maximum—which is not good for an ageing population. I work in private practice now as a nurse at a medical centre, casually, and it's not good because you have a different doctor seeing someone, some medications are changed.

LEAH DALEY: Back to what I was saying—I went off on a tangent—we decided at a local level that we weren't getting any traction. We had difficulty getting David Quirk and anyone from Health to actually attend the meetings, and I think they felt like we were attacking them all the time, which certainly wasn't the case. We wanted them to be part of the solution that we thought as Gwydir shire; we may be able to lead the charge. What we've done just recently in the past month is we've written to all New South Wales councils and said that we want to have a lobbying group of local councils to lobby.

We know that we can't just wave our flag now and expect GPs to swarm to our area, because they're not out there. The medical professionals aren't out there. What we need as country people is changes in policy, putting structures in where there are rewards or incentives for people to do their GP practice and to move to the country.

We've stopped waving the flag and saying, "Please, GPs, come to our country areas," because every country council in New South Wales and Queensland are doing that. We are looking at developing a lobbying group so we can go to the Government and say, "What do we need to do to change? What needs to happen to change?" That's who we are, and that's how we are addressing it.

Ms LIZA BUTLER: I want to talk about a comment that you have put in your submission, which states:

> … residents tend to feel alienated from the current health system rather than embracing it simply due to the size and remoteness …

Is that because the decision-makers are so far away? We heard earlier today that cities aren't the same as regional areas and you have different needs.

TIFFANY GALVIN: Yes.

Ms LIZA BUTLER: Could you just expand and give us some examples of that?

TIFFANY GALVIN: I was a former community health nurse. What is in policies now is that you are only allowed to go out and see this one to check on this. Whereas in a small country town—and there are more than Bingara and Warialda—as I said in my statement, you know your patients, you know what their needs are. You know that if you go in there to do a blood pressure and you might see they haven't eaten for a week or they are falling over mats they need another service in place. That doesn't happen in bigger centres. You've got someone in the big chair saying, "You don't need to go and do this." It's the whole of the health. Do you get what I'm trying to say?

Ms LIZA BUTLER: We heard from the previous group here—

TIFFANY GALVIN: Wee Waa.

Ms LIZA BUTLER: —about when an area was given, say, money for their hospital. And you're saying a local hospital board then directs how those services would be run and the employment. Is that what you're saying?

TIFFANY GALVIN: Yes.

Ms LIZA BUTLER: Would that be instead of splitting the health district? So it could still be under the Hunter but your board is allocated money and then you get to decide how the services are run from there?

TIFFANY GALVIN: As I said, I worked before under the McIntyre cluster. You had Lynne Chance, I think her name was, who came down and supervised your area and made things—and she was present, and whoever it was after her. When I worked in Moree, that was under a different cluster as well, and you were in New England. I felt you were known back then and you were part of something, whereas now we are three times the size of—I think I read we are 948,000 people in Hunter New England Health. And then you've got others—western, is it 317,000? Something like that. So we are three times the amount of those other health services and we are being looked after by people that have no idea—not no idea, but no idea how small communities run.

I heard you say in the last session to Wee Waa that you've only got so much money to distribute, and that's another problem on its own. The whole health system is bad at the moment, but we need our own bucket of money—not Gwydir but in a smaller cluster. We've got a brand-new hospital in Inverell, there's soon to be a brand-new hospital in Moree and we've got a big hospital in Tamworth. The money's being spent on those, so these smaller places like Wee Waa and Moree and all that can utilise those rather than having to utilise the bigger areas.

LEAH DALEY: The alienation—just to answer your question. I am the mother of a severely disabled young person. An example of alienation is that we have to go now to Newcastle for services. The lack of understanding of how horrendous it is to have to travel the long distances and then to have things cancelled when you get there or people not being able to see you—it's not just the distance. When you are travelling with someone that is not a great traveller, there is stress. That's an example of the alienation. Again, I don't know that it's the size of what we are dealing with more so than the lack of medical professionals that can populate back to the smaller areas. I just don't know what the answer is, and that's obviously why you are here. That's an example of how I feel alienated.

I choose to live where I live and it provides a lovely life for my family. But when it becomes anything medical, it's a horrendous ordeal to have to go through—to travel 5½ hours with someone who screams the whole way, only to get turned around and sent back because of logistics. It's very, very complex. What we didn't say earlier is that—and I think it's unfortunate—a lot of our doctors in Warialda in particular are referring to Queensland now. They are referring to Toowoomba because the services are better. You can get in quicker. What they're doing may be an example there. We know for a fact that if there is anything wrong with anyone in our

family, we can get in to see a specialist in Toowoomba faster. It's just over the border, but there is something wrong with that. It's not quite right.

Ms LIZA BUTLER: There was a suggestion this morning of, instead of making a new health district, to include from the Great Dividing Range west into the Western district. What do you say to that?

LEAH DALEY: How could that make things any better? Did they suggest the reason for that?

Ms LIZA BUTLER: Because the Western district has an understanding of regional, rural and remote communities.

LEAH DALEY: Not working in the industry, I don't know if I can comment on that.

TIFFANY GALVIN: I would have to go away and think about it.

The CHAIR: That's okay. It's a good hypothetical.

Ms DONNA DAVIS: Thank you for coming in. It's great to see women at the top of local government. We like that. It was great to hear that 10 years ago you established that health committee, even though you have had mixed responses from the people at the top. Elaborating on that, in your capacities as mayor and GM and as leaders of your community, could you expand on what your experience has been in seeking meetings and, if not meetings, updates on what is happening between your area and the decision makers in Hunter New England? Have there been any improvements since there has been some movement and the establishment of an executive position in Tamworth?

TIFFANY GALVIN: Not really. What you're saying—that's only just been a few weeks. I had a Zoom two weeks ago with Kylie, who has taken David Quirk's job. We have a quarterly Zoom with Brendan Moylan, our local MP, and the mayors in our electorate to ask questions. That was the first time. That's very new. Nothing has eventuated from that yet.

LEAH DALEY: From a local government perspective, speaking as a manager, the communication is non-existent. I was aware because I was on the hospital board committee. I have close working relationships with our GPs. Everything in our council area seems to fall back to us. The council owns the Bingara and Warialda medical centres. The doctors operate out of there. Now even the local GPs in Warialda are saying, "We're 70-plus. What are you going to do?" I'm thinking, "What can I do?" We're hamstrung. We get some information from our GPs because we're in regular contact. But we don't get anything from Health.

Ms FELICITY WILSON: Thank you very much, Tiffany and Leah, for joining us here today, and travelling to share your experiences with us. Gwydir shire is a bit unique, even in the New England area. The population of your local government area is smaller than many of the towns across the New England region. Obviously, we heard a lot from Wee Waa this morning. It is similar in some way to Bingara and Warialda. Can you give us a little bit of a sense of what it is like to live in a much smaller community when it comes to things like where to travel if you have to make big purchases or where to travel if you are looking for specialist services? Are you going to Tamworth, are you going to Moree or are you going to Queensland, for instance? Where are you going to? What are the roads like? What are telecommunications like? What are the challenges for a council of small, small communities?

LEAH DALEY: I think we should probably concentrate on health or we will be here all day talking about our communications and our roads. There's been an obvious decline. I would say again, in the past 10 years, being someone that has a son with special needs, and also a local government employee, we used to be able to get what we needed in Gwydir shire, either in Inverell or Moree. Now the services at Inverell and Moree—Moree still has got some services, but Inverell is pretty much non-existent. They can't even get an anaesthetist. We're even more remote because we're looking to Armidale or Tamworth.

My son, for instance, needs specialist dental work, and even though he has private health care, nobody will touch him. He's been on a waiting list for the Moree hospital to go under general anaesthetic for dental work. That was to happen on 22 August. We've waited 12 months for that. I got a phone call last week from a visiting anaesthetist at Moree hospital that said he wasn't comfortable working with my son, and that we now have to go on a waiting list in Tamworth. I don't know how bad my son's teeth are, but know he's got some behavioural problems. I shouldn't be making this about me but I'm giving you real examples, and there are probably hundreds like us. Now my son is on a waiting list at Tamworth and I don't know how long it will be before he gets medical treatment.

There's something about dental. We can't go to a dentist in Queensland. I would love to be able to, if there was something about referrals to there. That's an example of how tough things are. We choose to live where we live. We're not going to sit here and say we want all these services because it's choice—we live where we live.

But it's become an unreasonable burden. To get basic heath services, we're travelling 2½ hours to Tamworth or 2½ hours to Armidale. I don't know what things are like. You hear that medical practitioners, medical professionals are drying up in those areas, too. Will it be Newcastle going forward? That's the sort of thing that we are dealing with where we live. The roads are great in Gwydir shire; other roads, not. Our telecommunications are dreadful.

Ms FELICITY WILSON: You have to say that, don't you. They're your roads.

LEAH DALEY: There's a higher level of risk for people living in our LGA than most, and probably more than what is acceptable, but that's where our lives are.

TIFFANY GALVIN: We choose to live there. We both think it's paradise, and we're in the centre of the universe. It's safe, but we have the challenges of having to go elsewhere . Last week my son had major surgery on his knee. We went to the Mater in Sydney because that's where the specialist worked out of. That was a long haul home with pain relief and a very bad knee. We chose to go that way. I think to your question, in the Gwydir shire, we live in a caring community where everybody knows each other and you wouldn't have anybody dead in the house for a week or a month as you do in bigger areas because everybody knows everybody's business and will knock on the door and find out how they are. We're very lucky in that way, but there is a distance. We've got an ageing population in the whole of the shire, so for them to go all the way to Tamworth or Newcastle—I know somebody, one of my patients who has cardiac issues and he was to go to Newcastle for an appointment. He said, "I just can't make that trek." So he chose not to go there, which is quite sad, but that's his choice because Newcastle is far too far away from him.

LEAH DALEY: Our council runs CHSP. Please don't ask me what that acronym means—the Commonwealth housing and home support program—so transport through that. Council's offering the transport service but it really doesn't extend beyond Tamworth or Armidale with volunteer drivers, et cetera.

Ms FELICITY WILSON: If you needed to and don't have your own transport, you can use the council service to get to Tamworth or Armidale?

LEAH DALEY: Yes.

TIFFANY GALVIN: Yes.

Ms FELICITY WILSON: Is it that you just book it and pay for it? Is it regular?

LEAH DALEY: It's subsidised.

Ms FELICITY WILSON: Bit of a day trip?

LEAH DALEY: Federal and State funding subsidised. I think State funding subsidises the Warialda program and Federal the Bingara program. They pay a minimal amount to do that, and it's often car pooling. It's got to fit in with our volunteer drivers and—

TIFFANY GALVIN: It's all run by volunteers and a car goes five days a week.

LEAH DALEY: What we also neglected to say, and living where we live we struggle for professional staff in all elements, but what the council is doing is we're trying to grow our own registered nurses, for instance. Council is supporting people to go through University of New England for training. We are trying to help ourselves, but when it comes to the higher level staff it's very tricky.

Ms FELICITY WILSON: Thank you, Leah, for sharing some personal stories. I think we need to hear those to better understand the experiences.

LEAH DALEY: I really didn't intend to do that. I don't know why that fell out.

Ms FELICITY WILSON: It's important for us to understand, so thank you for sharing.

LEAH DALEY: They are real, yes.

Mrs HELEN DALTON: Thank you for attending. You spoke about the lack of communication from the New England local health district. You also spoke about the absence of any representatives from say the board, or anyone attending or coming locally out here. Would you like to elaborate on that, please?

LEAH DALEY: Elaborate on?

Mrs HELEN DALTON: When was the last time that council met, or that you had any communication, or that they were present out here from New England?

LEAH DALEY: I have no recollection in my—I don't know—15 years of management where the board has met with council at all.

TIFFANY GALVIN: They've been invited to our health alliance meetings, and there's always an apology. A couple of times—

LEAH DALEY: A couple of times David Quirk had come across to our meetings, but he always seemed like he was unable to give information, or participate, or talk about any future plans or anything that was on the horizon. He was very guarded. In the end we just kept getting apologies for our guided health alliance and it didn't go anywhere. Rural Doctors Network were great, they would always connect over Teams, and primary health networks, but our direct care providers were unable to attend.

Mrs HELEN DALTON: Do you think there's sort of a veil of secrecy to keep you out, or keep their distance so you don't perhaps ask too many questions, or expect too much?

LEAH DALEY: I'm conscious that working in local government in a small country area, I think perhaps they didn't have the answers and they didn't want to be put—it was always a protected environment. There was never any abuse or discomfort, but I would like to think that they didn't have the answers for us and it was easier to stay away than to bluff their way through.

Mrs HELEN DALTON: The other thing, you've been in council a long time; you've been part of it. It just seems like councils these days have got more and more to do, so you've taken on the health. Or did you always have this great interest in looking after health care? Because it always seemed to be a State or a Federal matter, and now it's down to you. Would you like to comment about that?

TIFFANY GALVIN: Yes, I think in a small council area everything becomes our problem. They come to us for everything, and you've got your residents that know you will listen, and know that you care, and it doesn't matter what it is they'll come to you with a problem. For some reason they seem to think we can fix getting doctors, and fixing health, and things like that. But because it's going to better our shire out there, and if we have the proper health system in place, and doctors, and medical practices—we've got two great multi-purpose services.

Mrs HELEN DALTON: Would this have been your job 30 years ago?

LEAH DALEY: No.

TIFFANY GALVIN: No.

Mrs HELEN DALTON: Exactly. That's what I'm saying.

LEAH DALEY: If you follow local government at all, you know that cost-shifting is crippling rural councils.

Mrs HELEN DALTON: Absolutely.

LEAH DALEY: That's what is happening with us on a number of fronts. What I didn't expand to you to say is we not only have the two medical centres so the doctors can come in and run the practices, council has also provided accommodation both in Bingara and Warialda.

Mrs HELEN DALTON: And I bet a car, too? Did you do a car as well for them?

LEAH DALEY: Yes, but so are a lot of other councils. What needs to happen is it needs to be a change of policy. Something needs to change, incentives, so that we can get—we've got the infrastructure. We've got the hospitals that are lovely and new. We've got lovely accommodation. We just don't have the people. I'm sure you're hearing that from everybody.

TIFFANY GALVIN: An example is I had a GP contact me a few months ago who was quite keen to come to Bingara as a permanent GP, and I contacted Barnaby Joyce just for some money to get them there. I know people can say doctors are greedy, but I suppose they want the help to get there. They've worked a long time to get there. We couldn't get extra money. Council was going to provide them with the medical practice that council owns rent-free for 12 months and a house for the locums for 12 months, but it wasn't enough. We couldn't get funding anywhere else, and we tried. I tried. I had to step back because it was a bit of a conflict of interest being a nurse too, but there was no money to get them there.

Mrs HELEN DALTON: So every council is doing what you're doing, putting more incentives. Do you agree that the whole model of health delivery should be changed?

TIFFANY GALVIN: Yes, totally.

LEAH DALEY: Yes, and we hope that by forming this group of New South Wales councils that are interested that we can start to work with people in the know to work out what needs to happen. My local GP who I go in there for a sore toenail and he keeps me in for an hour and a half talking about how bad things are, he tells me that only 10 per cent of people that graduated last year have gone into general practice. That's where we need to start. To make things better for our communities, we need to work out why that's happening and how we can make that more attractive. Little Gwydir shire in itself can't do it, but perhaps if we get this group of New South Wales councils, we can encourage government to change policies, change the training, talk about how we can actually get people that are training out into the country to experience—it's pretty good out there.

Mrs HELEN DALTON: Have you looked at overseas doctors? You haven't gone down that road?

LEAH DALEY: Our GPs aren't in a position to be able to do that, and as a local government entity, we aren't either. But perhaps that's the answer at a higher level than us—State or Federal government.

TIFFANY GALVIN: We can't even get a registrar in Bingara because we have a different locum every three weeks, so we can't even have a registrar there to train them up to perhaps stay.

Mrs HELEN DALTON: And you have no continuity of care either.

TIFFANY GALVIN: That's right. Exactly, and as a nurse that's the biggest problem.

LEAH DALEY: And we want to be part of the solution. We don't want to be just sitting there whingeing and not being productive at all. We want to be a part of the solution. We don't know what the solution is, as I'm sure nobody does.

Mrs HELEN DALTON: I totally understand your frustration.

LEAH DALEY: We absolutely want to be part of the solution. As a community, we have the infrastructure sitting there. We just don't know where to go from there.

The CHAIR: Thank you so much for appearing. We did start late and of course we finish late because you can never remake time. You will be provided with a copy of the transcript of your evidence today for any corrections that you think you were misheard or misquoted or misunderstood. Committee staff will email any questions to you that the Committee may develop over the coming days. If we want to pursue further questions, we will wait for the transcript in developing those questions. The Committee will now break for lunch and return at 1.30 p.m.

(The witnesses withdrew.)

(Luncheon adjournment)

Mr DANIEL KAHL, Business Manager and Director, Merced Farming Pty Ltd, sworn and examined

Mr JONATHON PHELPS, President, NSW Farmers Association, Wee Waa Branch, sworn and examined

Mr RICHARD SCHWAGER, Treasurer, NSW Farmers Association, Wee Waa Branch, sworn and examined

Mr JOHN FOGARTY, sworn and examined

The CHAIR: I welcome our next witnesses. Thank you for appearing before the Committee today to give evidence. Members of the public are not permitted to film or photograph during the hearing; however, Committee staff will be filming and photographing during the hearing. You may request to have your copies of the photos and images, or you may also request to not have those used in Legislative Assembly social media. Before we start, do you have any questions about the hearing process?

JONATHON PHELPS: How would you like us to refer to you? By name or Mr Chair?

The CHAIR: Both. Either. How would you like me to refer to you?

JONATHON PHELPS: Jono.

The CHAIR: Thank you, all. Would you like to make an opening statement?

RICHARD SCHWAGER: My name is Richard Schwager, and I'm the Treasurer of the NSW Farmers Wee Waa branch. My colleague is Jono Phelps, president of the branch. Our branch represents both corporate and family farms from Wee Waa, Pilliga, Burren Junction, Rowena and Spring Plains areas—a vast expanse which is also one of Australia's most productive agricultural areas worth more than $5 billion a year to our country.

Ironically, it is also the area which is serviced by Wee Waa hospital, which under the poor management of Hunter New England Health since 2005 has suffered an alarming decline in services to the point that a part-time satellite emergency department only open between 8.00 a.m. to 5.30 p.m. daily is all that remains of a once thriving 24/7 hospital with local VMOs, inpatient beds, an emergency department and treatment rooms.

Of additional concern, the recent departmental review offers an urgent care model as a way forward. This model lacks an emergency department, which is critical to farming and agricultural operations around Wee Waa and the farms further to the west of the town. The closest hospitals to the west are at Collarenebri, 187 kilometres, Walgett, 167 kilometres, and Baradine, 112 kilometres through the Pilliga scrub. For farms on the western side of Wee Waa, travelling the additional 50 kilometres to Narrabri to access a 24/7 hospital is a dangerous and potentially life-threatening option, especially at night. Why should the thriving community of Wee Waa, with 24/7 agricultural industries, two high schools, three primary schools, an aged-care facility, a preschool and a population living seven hours drive from Newcastle, have a fraction of the health service of similar sized rural towns like Boggabri, Baradine and Collarenebri?

The answer is because of Hunter New England Health's mismanagement over a 20-year period. Being managed from Newcastle, a faraway metropolitan hub, the challenges of rural living are not understood. No hospitals in the Western Health District have suffered the same steep decline in services, because they are managed from Dubbo, a major rural centre, where the importance of properly functioning rural hospitals, even in small communities, is understood. The statement by Hunter New England Health in May 2023 that health services in Wee Waa will be resumed when staff are available is a massive cop-out by an organisation charged with providing a functional hospital for what is already an isolated and disadvantaged rural community with a large Indigenous population.

Since 2023 Hunter New England Health have insisted on trying to recruit nurses before doctors or VMOs. This was in spite of the fact that nurses were reluctant to come to a hospital with no doctor. Hunter New England Health persisted with this recruitment policy in spite of its obvious failure. One can only conclude that the failure to return Wee Waa hospital to full operation was what was wanted by Hunter New England Health so that the funds allocated to Wee Waa hospital could then be used somewhere else in the Hunter New England health district. Furthermore, when the local medical centre, with three doctors, applied for VMO rights in August 2022, a Hunter New England Health manager denied any application had been received until May 2023. Why the delay?

Wee Waa has the doctors. It has a fully equipped hospital building, it has the ambulance service, and the nurses will follow the doctors. What we don't have are health officials to bring it all together. We are not asking for a big new, shiny hospital with all the technology. We only want what we had 20 years ago. Hunter New England Health can't provide our community with a fully functioning 24/7 hospital. We need the health district to split so that Wee Waa can be managed from Tamworth or Armidale, an area more in sync with the challenges of rural living.

JOHN FOGARTY: Good afternoon, everyone. Thank you for coming all the way to Narrabri. I'd like to bring your attention to the map. You should all have a copy. This shows, as you can see, the size of the Hunter New England area, compared to the others. Also, the population is nearly up to four times the size of some of the other rural health districts. I just think the scale for Hunter New England managing it from the Central Coast is too large for them to have an idea of what goes on seven hours away, in other towns. I believe this district should have been split in 2011, when every other health district in the State was split. It's clearly too big.

You would have seen in my original submission, I've had dealings with Hunter New England Health at John Hunter, and I believe there are deficiencies there that should have been corrected. The Wee Waa hospital situation, since 2018, we've had no doctor there, so it has declined. I believe that probably weighs a bit on personal issues that happened to my mother in 2019—and I blame that because she wouldn't go to the hospital without a doctor there. They found her dead in the bed the next day. Pretty much everything else I have has been covered this morning, so I don't really want to bore you with the same stories again.

Ms TRISH DOYLE: Thank you all for being here, for representing your community. It's good to be here in Narrabri and to hear directly from you, further to submissions that have been made. I'm going to start on an interesting element of the situation within health across many communities in the State, but I'm particularly interested in your views on this. Have you had any experiences or do you know of any direct experiences people have had with digital health services at Wee Waa hospital, such as the telehealth doctors? If so, how have you found those services? What sort of feedback can you provide us so that can be incorporated in a report to NSW Health and the Government?

JOHN FOGARTY: Yes, I took a casualty, a person, into Narrabri, I think it was, early one morning. They'd injured their back at work at 3.00 a.m. Wee Waa hospital wasn't open, so I took them to Narrabri. I'm pretty sure it was on telehealth at that stage as well, because there's not always a doctor in Narrabri either—

sometimes it's on telehealth. They were told just to go home, go to bed and go and see the doctor tomorrow. I presume, I suppose, because it's a bad back, it's a bit hard to gather what's wrong with a person, and it looked like they'd just strained it. But they didn't tell them to put a heat pack on it, an ice pack; they didn't tell them to take any medication. From that experience, for initial consultations, I personally don't like telehealth. A second consultation, with some records of tests and so forth, yes. But I find telehealth is not adequate for first-off consultations.

Ms TRISH DOYLE: Would others like to respond to that? Dan?

DANIEL KAHL: I haven't had a personal experience myself. But what I do have personal experience in is a lot of people avoiding going to Wee Waa under the current telehealth offering because they know that, more than likely, that's going to be the help they get. And so I'd be interested whether there is any data around the numbers that I'm sure Hunter New England Health are providing on presentations at Wee Waa, and whether there's any follow-up into who's then presented at Narrabri or elsewhere and their reasons why. I'm sure they might have a case that the telehealth isn't being utilised. But the public perception and the confidence in that and the safety that the community feels around that being their closest option is fairly minimal, and that results in people then having to choose whether they travel or not.

JONATHON PHELPS: I support both those statements. The one that comes to mind for me is [redacted by resolution of the Committee], who I think has already presented to the inquiry. He had a personal experience. He was misdiagnosed with cancer through that telehealth. That's the biggest one that comes to mind for me. I haven't had any direct experience, but I do know that people avoid going to Wee Waa because that facility offers only that type of health care.

RICHARD SCHWAGER: I only know of the one incident. I'm sure there's plenty more. There was a child that was taken to Wee Waa hospital with a pain in the tummy. The telehealth was moved in and that child was sent home with a Panadol. They discovered later on that the appendix was very badly swollen, very badly affected. I'm not too sure of the details after that, but it became quite critical because, as you know, an appendix can burst. This business of telehealth, it's just too remote. The good doctors, particularly in years of old, they laid their hands on the patient. Now if the doctor had have been there, a real doctor, he'd put his hands on the appendix, the patient would scream, and you would know exactly what was going on and you would know how urgent it was to get the treatment done. You can't see that through an artificial lens. It just doesn't happen like that.

DANIEL KAHL: Can I just add to that, I was only reading this morning about an example—not at Wee Waa, so we can talk about other hospitals—at Muswellbrook where a lady who was suffering an ectopic pregnancy was, administered through telehealth, told to go home and to monitor the pain herself. Fortunately she made the choice to drive herself—or a friend drove her—to Maitland. She was minutes away from probably bleeding out in her living room. So it's not just isolated to Wee Waa. And telehealth—I think it was a really good suggestion from Richard—can't be the first point of call, because you can't tell what's going on with someone through a screen.

Ms TRISH DOYLE: Collectively, you're saying there are deficiencies in this type of health care and it can't replace an actual person. Is it fair to say that?

DANIEL KAHL: Absolutely.

RICHARD SCHWAGER: Absolutely. John may be right that as a follow-up it may have a place, but certainly not for the original diagnosis.

Mrs HELEN DALTON: Thank you for attending. It's great to see you here. We hear all sorts of things, and one thing that we've heard is that splitting the district would disrupt existing clinical networks for rural communities, particularly through specialist outreach, telehealth and shared workforce models. Do you have concerns that the bill, should it pass, would potentially reduce access to specialist services for the New England communities?

DANIEL KAHL: The networks being disrupted by any split would be only the networks put in place since those two zones were originally put together. They worked previously, and those networks that are going to be disrupted by a potential split are the ones that are now failing to serve communities like Wee Waa, Muswellbrook and others in the district. I would say to Hunter New England Health, if there's disruption, maybe it's best to disrupt it yourself or be disrupted.

Mrs HELEN DALTON: Jono?

JONATHON PHELPS: I just don't agree with that. The more local you can have decision-making, the better things will be. We shouldn't be worried about the money. The more efficient way to spend money is to have

decisions made locally, in my view, so I just don't agree that the splitting of Hunter New England Health would make it less efficient and less services.

RICHARD SCHWAGER: I think the disruptions are already there; that's why we're here today. That's a big part of what we're enduring at the moment. To say that splitting Hunter New England Health is going to make it worse—I think all these things become quite relative. The point is it's in a mess at the moment. We've got to try something. I really don't see that it's going to create additional burdens; I'd put it that way.

JOHN FOGARTY: I pretty much agree with these guys. We already have people that travel to Dubbo for medical services. We have people that travel interstate. People travel to Sydney. I can't see how it's going to disrupt it anymore by having at least the basics locally.

Mrs HELEN DALTON: Just looking at your map, your population is well in excess of the other health districts. It's a huge thing, so I can understand your sentiments.

JOHN FOGARTY: And I believe that's only going to grow with the population. Narrabri wants to be 20,000, Tamworth wants to be 100,000 and who knows where the Newcastle area is going to stop, so I think it's too much for them.

Ms FELICITY WILSON: Thank you very much for joining us here today. We might have had people from farming families earlier, but you're the first farmers that we've heard from today. We hear quite a bit of evidence—particularly in areas like Wee Waa, Moree and Narrabri—that there is really significant agricultural production and quite a bit of affluence in richer farming families and then a significant disparity to more disadvantaged people in the communities. Not to say that people who have had success on their farms should have to pay for health services if they can—if we can put that aside. Some of the evidence we hear is that there are more choices available to people who have more means. But, as you say, that also means that you're travelling to Dubbo or Sydney, going through private systems or going to Brisbane, for instance. Do you think that there is a real disparity of access to health based upon whether or not you have the financial means to pay for it yourselves?

DANIEL KAHL: Yes, I would say that that's probably a fair assumption or a fair interpretation of what you've heard. I would suggest that a lot of that comes down to not necessarily the cost of the medical care that you might be seeking but the cost of being able to access it. For example, in your electorate, there might be someone of lesser means on the North Shore, but they're still close enough to those medical services to be able to get to them without having to drive hundreds of kilometres and pay for accommodation, fuel and meals, and figure out what to do with their children—whether they're taking them with them or whether someone has to stop work back at home to look after them.

That socio-economic difference becomes exacerbated within our community. While it can be significant, it then becomes twice as much when you're considering whether or not someone has the means to access medical services that you could reach in the Blue Mountains, Parramatta or the North Shore. That is where the disconnect is with the current structure. In terms of people feeling safe to live in their communities, as a business owner I have a legal obligation to ensure the psychological safety of people within my business. For example, if we think of the wider community, like the current health district, as a workplace and you guys are the board and the management, and we are the staff or the employees, I don't feel safe in this workplace—I don't.

I go to work each day to run my business and work in my business and raise my family and I do not feel safe in my workplace, because I don't know if I'm going to be looked after if something happens to me or my staff or anything like that. I think that's a really useful analogy. Frankly, I use it already in the water space, because I don't feel safe about the way our water resources are managed in this State. I'm not going to dive down the water rabbit hole—I promise you I won't.

Mrs HELEN DALTON: I love it.

DANIEL KAHL: Helen, you and me can talk after. But it's a really useful analogy because, as a business owner, my responsibility is to ensure the psychological safety of my staff. This week one of our new members of staff, who has a pregnant wife, had to be at John Hunter two weeks ago and then Tamworth this week. But he's good. He calls me up and tells me what's going on. I say, "You're fine. You'll be paid at the end of the week. You're sweet. Look after your family." I don't feel that in this workplace, if I'm using that analogy.

Ms FELICITY WILSON: Not everybody has access to the ability to take time off work and travel and things like that, as you said. You're talking about your workplaces, if you're talking about your farms. We're talking about towns. Wee Waa is a town and Narrabri is a town—I don't know if you'd call it a city or not, but it's a town. How far from your towns are most of your farms? Are they nearby or are you talking 50 kilometres or more to get to the farms and the farmers you represent?

DANIEL KAHL: We have a spread. We've got farms on both sides of Wee Waa, between 10 kilometres and 25 kilometres from Wee Waa and between 35 kilometres and 55 kilometres from Narrabri. As I said before, a lot of the time when someone gets hurt, we're triaging them ourselves and making a call about whether we send them to Wee Waa or just straight to Narrabri. Ultimately, I don't think we should have to.

Ms FELICITY WILSON: In a farming context, the types of accidents or injuries that you're seeing on farms themselves, the workplace accidents—if you put aside all the normal things with families like chronic illnesses and things like that—if you're talking about things like heavy machinery or vehicle accidents and things like that, are you seeing a reduction in the ability to save lives or limbs or to prevent significant ongoing injuries because of the time lag in getting treatment and having to travel further?

JONATHON PHELPS: It's certainly a question they ask about the health services and education et cetera. Richard mentioned earlier that Wee Waa was well set up for education. It has three or four schools. Part of the attraction to a rural town is also the health services. We're just not getting that at the moment. As part of your question, you were talking a little bit about the rich and the poor. Everyone is entitled to the very basic health needs. The Wee Waa town and district is just not getting that at the moment. Through the day you can go to the medical centre, but if you have to go to hospital, they have to find their own means to get to a hospital after that, because the doctors in Wee Waa can't admit to Wee Waa and they can't admit to Narrabri. This whole thing is about the admission of the Wee Waa doctors.

There are three doctors in Wee Waa, two blocks away from the hospital, and they're not allowed to go to the hospital. That's the core of this whole argument, and Hunter New England Health is not willing to come to the table and negotiate an outcome. It's been going on for two or three years. But doctors are the key to it. I'll say it again: We have three in Wee Waa, just around the corner, who are not allowed to go to the hospital. How crazy is that? One of the problems is the Hunter New England Health bureaucrats aren't telling the people they work for the truth of the situation.

I've heard the Premier talk on 2GB. He wasn't telling the true facts of what was happening. He's been told that, I believe, from his bureaucrats and it's just totally wrong. I can table some examples here, if you wish, but the bureaucrats are running the show. They're making financial decisions. They're not making health decisions. That's the whole problem. There's $1.65 million set aside for the Wee Waa hospital for acute care. There's no acute care. Where's that money gone? There's no carryover of the finances. At the end of the year, that goes back to Newcastle and gets spent down there somewhere. The bureaucrats are the problem.

Ms FELICITY WILSON: Jono, you said you might have documents to table. Can you let us know what those documents are?

JONATHON PHELPS: Yes. It was part of my opening statement, if I got a chance to read that, but I'm happy to leave some copies with you to go through them later on, if that's at all possible.

Ms FELICITY WILSON: What's the nature of those documents so we can understand the contents?

JONATHON PHELPS: There are some quotes from the Premier on 2GB that are just completely wrong, if you'd like me to read one example. One example is the Premier stated, "Just to put it into perspective"—this was on 11 April—"there are 15 beds on the wards. They remain open. Obviously we don't kick anyone out at 5.00 p.m. In order to make it safe, we need two extra doctors." The doctors are just around the corner. I mean, that statement he made is just wrong. Here's another one, "We are 17 nurses short to operate an emergency department on a 24/7 schedule." Hunter New England Health has advised members of the Save Our Wee Waa Hospital group that we need 12, so there's a five difference there. The doctors are available. They're just around the corner. No-one's wanting to come to the table out of Hunter New England Health to make a deal. If those doctors are admitted to that hospital, the whole thing will change.

DANIEL KAHL: Can I just add to the not "kicking anyone out at 5.00p.m.", they actually have been. My three-year-old daughter had a fall at day care and it split the back of her head very badly. They had to glue it back together because there was just a nurse there who didn't want to do a stitch, "Because I'm probably not going to do the tidiest job, but we can glue it. It's back of the head, and it's all fine." We arrived there at 4.00 p.m. At 5.00 p.m., that nurse who I've known my whole life, had to ask me to sign a waiver to say I was happy to take my child home or to take it to Narrabri myself because a child with a head knock needs to be observed for four hours and they had to close the hospital at 5.30. That liability shouldn't be passed to me. I shouldn't have to make that decision. Kids should be able to sit there and eat some jelly and watch something until six or seven o'clock, and we go and get her, "She's sweet. Let's take her home." I was confident there was nothing wrong with her, and there wasn't, but I shouldn't have to make that choice. By the time I drove to Narrabri—

Ms FELICITY WILSON: But imagine if there had been something wrong with her.

DANIEL KAHL: Exactly. I shouldn't have to live with that choice, if there was, for the sake of having a three-year-old girl sitting in there and not causing anyone any issue for a couple of hours and then we send her home, but that nurse had reached the end of her shift and had to lock the door at 5.30.

JONATHON PHELPS: If I could just make one more quote. This is another quote from the Premier, "We've also made sure it's quicker to get from Narrabri to Wee Waa, which is 20 minutes away." How is he going to make it quicker? Someone has told him that rubbish. The Wee Waa hospital website states that Narrabri is 45 minutes away. You're going to have to get a police escort to get there in 20 minutes. These are just three examples there that I think the Premier and the Health Minister have been told rubbish by these bureaucratic people in Hunter New England Health.

The CHAIR: Jono, if you want to table those, could you hand them to the secretariat, please?

JONATHON PHELPS: Yes. That'll be fine. I think there's about eight copies there.

RICHARD SCHWAGER: Chair, can I make a response to the original question? I think the original question was that if people with more means, or people who have more means should pay more. I mean, that's the whole basis that we run the country on in an egalitarian society. It is that those people who've got more, they pay more taxes and that's how we even things out, but sometimes all the money in the world doesn't help you. If you have an accident on a farm, you could have a house full of money—it's useless. It's the provision of that service within a reasonable distance of where it happens. That's the most important thing. That's why it has to be in Wee Waa. All the money in the world's not going to get you to Newcastle in time to save your life if you have an accident. It's the immediacy of it, the timing and the speed with which you can get there. If it's closer, you get there quicker.

Ms DONNA DAVIS: Thank you very much for giving your time today. I may be the member for Parramatta, but I grew up on a farm, so I'm very familiar with farm life. Probably a little bit smaller than your farms. Before the change to the Wee Waa hospital's operating hours, how did you find the quality of care at the hospital? Was it appropriately servicing the needs of the local community prior to last year's change?

JONATHON PHELPS: I believe it was.

JOHN FOGARTY: Not last year's. We had no VMO there.

JONATHON PHELPS: But prior to the change. Recently there was a new helipad put in at Wee Waa hospital.

Ms DONNA DAVIS: When was that?

JONATHON PHELPS: That, I think, would've been about 2021 or 2020 or thereabouts. But that's how important at that time they thought the Wee Waa hospital was. It's only occasionally used by the Westpac rescue helicopter, if they need to drop in there for whatever. But mostly the choppers are flying straight to and from. So I think the needs were being met, as much as a small Wee Waa district hospital can.

Ms DONNA DAVIS: This morning we were told that there were cuts back in 2018 as well. Does anyone want to elaborate on—

JOHN FOGARTY: That's pretty much when the VMO was there. It was still open 24/7 for emergency after that. It was only, I think, last year, they cut that back. But we weren't guaranteed a doctor there every time. Some weekends, they might get a doctor in for a weekend. I forget what that's called. Other than that, we haven't had a VMO onsite or available to be on call all the time since 2018. We get visiting ones every now and then but not regularly.

Ms DONNA DAVIS: Since 2018. Did anyone else want to add anything to that, as well?

DANIEL KAHL: Yes. In terms of being able to service the community, it's not just about emergency care, either, and having people able to be there overnight for observation, like my daughter. In palliative care—in 2019, my grandmother, who was at Weeronga, the aged-care facility next door, asphyxiated at lunch. Not much you can do with a 98-year-old who's inhaled lunch. So she was in palliative care for four days at Wee Waa, in her home town, where we could all come and see her and be there with her through those couple of days. If that was to happen today, she would, at best, be kept at Narrabri for that time. But, if Narrabri's full, we're all having to go to Moree or Tamworth, and she probably doesn't have someone next to her when she finally lets go. But that was a really special, in a strange sense, couple of days where we could all come and go and make sure that someone was with her the whole time, for four days, while that process happened.

There was, at that point—John's right. There wasn't a doctor in the hospital 24/7, but there were nursing staff there who were happy to work there because, during daylight hours at least, there was a doctor there to

support them. That facilitated that for our community. So it's not just about the emergency care. It's about people being able to be there on respite. We're talking about the advantages of telehealth. I can have a major injury and, at the point where I don't need to be taking up a bed in Tamworth or at John Hunter or whatever else but I'm not quite ready to be on my own feet yet, I can be taken back to Wee Waa and cared for for a couple of days, but I'm back in my community. I'm back around the people I love, who can support me and, quite frankly, take half the load off the nurses. Often you walk into a local hospital, and the nurses don't actually have to worry about the person in there because the family's there, fussing over them. But they're in the right place if they do need care.

Ms DONNA DAVIS: Where is your closest rehabilitation centre for those that do come back from John Hunter after a major op or a knee operation?

DANIEL KAHL: If you've had a broken bone or a fracture, you're going to Tamworth to the fracture clinic. It depends on your injury, I suppose. Quite often there, you're probably getting poorer health outcomes because someone is going, "Apparently I have to go to Tamworth three times a month for the next three months." By the second one, they're like, "Nah, my arm is right." How that plays out later in life, I'm not sure. Those things where you've got specialty doctors—I think earlier today you were talking about that GPs aren't multitaskers anymore. They're much more specialised, and that's fine. We understand that to go and see an orthopaedic surgeon, I'm going to have to probably go to Tamworth. There is not going to be one in Narrabri. Having physios, OTs and that sort of staff in your hospital so you can get that follow-up care is really important because it keeps people in their communities.

Ms DONNA DAVIS: We have heard so much about the need to get more health professionals of all different skills to regional and remote areas. What can we do as a government to better incentivise that? For example, with police, we are paying them while they go to the academy in Goulburn. That is helping us to attract more people to become police. What could we potentially be doing? Have you got any ideas that you've spoken to others about on what could be done?

JONATHON PHELPS: There are nurses in Wee Waa who travel elsewhere for work because they have doctors in other hospitals, such as Narrabri. Some of them have told me and others that they would be willing to work in Wee Waa if there was a doctor there. The doctor is the key. My wife is a nurse. They like to work with doctors. That is where they learn. Doctors are the key.

Ms TRISH DOYLE: I would say that doctors can learn from nurses too, actually. Just to make sure we get that on record.

JONATHON PHELPS: That is true. I will hark back to it—doctors are the key. They're two blocks away.

DANIEL KAHL: In terms of incentives, though, I've got plenty of friends—I'm involved with the rugby club. That is where most people who have just finished uni end up—somewhere around a sporting club. The number of teachers that have come from a coastal area and have come regional because they get incentivised to—in terms of, "Come and do three years regionally and then take your pick." How many of them stay here? One in particular, from over in Lismore, who I would never have backed to call Narrabri his home is here a decade later. That same thing will happen with our medical professionals. The hard thing with medical professionals is that they come out of whatever avenue they are following, and they want to work in a big hospital to start with. Maybe it is a matter of, "Go work in a small one for three years, and then take your pick of big hospitals."

RICHARD SCHWAGER: Good point. The other thing I would venture to suggest is that over the years, the Government sends a signal through the taxation department. They give tax incentives. Your rate will be lower if you go out to a small urban centre and stay there for two years. There are many ways to encourage people to go out there. There is a one-off bonus to go out there, housing is offered free—there is a lot that the Government could be doing which, in the past, is what Wee Waa has done. If you could be made aware of what Wee Waa has needed over the years and then went out and did it themselves—admittedly with some government support. We just made it happen because we knew that it was crucial to the survival of the town.

JONATHON PHELPS: If I could just add that I had three primary school teachers that came from Canberra, Sydney and Wauchope. They all married a local farmer and stayed here. It's just another example.

Ms LIZA BUTLER: Thank you for taking the time to come in and see us today. Just on those incentives, a number of us sitting behind this desk are also on the select committee for rural, regional and remote health. A lot of those incentives are actually in place. We are working towards that. In relation to today's hearing for Wee Waa's problems, how would they be solved by splitting the health district?

DANIEL KAHL: Possibly some of my comments earlier might have told you that I was quite pro the split. I actually don't really care whether it splits or not, to be honest. To go back to my analogy, you guys are the

board, and we are the staff in this workplace. I don't think management are allocating resources properly within this business to ensure the wellbeing of our staff. Please don't take this as me being provocative, but, ultimately, if management doesn't act properly within business for long enough, it actually becomes the board's fault, not management's anymore. Whether it's split or not, I think there needs to be a lot more scrutiny on how management is behaving within whatever health district they're operating in, because we've got committees in Wee Waa that are just getting stonewalled and not being fed information at all—or at least limited information. We've got processes that we're not being made aware of. We've got services that aren't being provided.

I get it; money is an issue. Obviously everything after this probably goes through a budget estimates hearing too, and we've got to figure that part out. But there's money that must be in the budget for Wee Waa that's not being used currently because we're temporarily reduced. I would have thought if it's temporarily, the budget has something in there for us to go back to what we were. In terms of funds, this shire produces $4.2 billion in GRP. You only need to spend 1 per cent of that here, and there's $40 million to spend on hospitals, which I'm pretty sure would be close to twice what's in the budget. It wouldn't take much of what this area produces to make sure we've got the services. I would be asking management why that is not the case. If they can't figure it out, then maybe it's time for some new management.

I don't know if this brings—actually, if you look at all the submissions, which I know you all have, there's a whole bunch of councils within the health district and other bodies that have made submissions that have gone, "We can't say if we're pro or against it, because we don't know what that looks like." What that really means is they're not really happy with how it is, but they don't want it to be worse, so better the devil you know. That's my stance. A split would at least give us the confidence that at least the people making decisions about our area—and I'm doing my best not to just talk about Wee Waa all the time, because it's one out of many hospitals in the district—are people who are from this area, because we see that in so many other examples of services. I'm not sure if that answered your question much at all.

JOHN FOGARTY: It appears to have worked—

DANIEL KAHL: The issue, to me, is holding the current management to account. If part of holding them to account is to split it because you don't believe they're capable of managing that anymore, then, great. If part of it is restructuring it so that it's managed from a different part of it, whatever it is, I think that's the outcome. The outcome is that management needs to be held to greater account, because their actions towards the community have been subpar. That's the nicest way I can say it.

JOHN FOGARTY: Pretty much most of you guys are from these other health districts. Do you think it's better since they've split them up, or was it better when they were bigger? You could answer that question better than I can.

The CHAIR: I'm in Hunter New England Health.

JOHN FOGARTY: Yes, but some of these other guys from different areas—

The CHAIR: Murrumbidgee.

Mrs HELEN DALTON: We want a split. Murrumbidgee wants to split.

Ms LIZA BUTLER: I'm in the next biggest health district, and one of my hospitals on the very end suffers the same issues that you're advancing.

JOHN FOGARTY: Was it even worse when it was bigger? I don't know.

The CHAIR: I don't remember it being bigger.

Ms LIZA BUTLER: In your submission, you've got a figure of $5 million there. Are you suggesting a certain sum of money gets allocated, and then you have a health board that helps determine how that money is spent and what staff is employed and how that hospital is run? Is that what you're suggesting in your submission?

RICHARD SCHWAGER: Certainly in an advisory capacity. You don't want your own board there running the whole show. There's certain expertise that comes from above and for people that are being administrators. But you really do need that local expertise, if you like—that local input—as to what the specific needs are in that area, and then you can bring your experts in and try to ensure that that happens. You're trying to say, "Well, will splitting it really make it better?" We say, "Desperate times call for desperate actions." It may be clutching at straws, but it doesn't seem to be a whole lot happening at the moment. We seem to have endless meetings, endless inquiries. We have inquiries into the inquiries. We've got to try something. We just can't keep going round and round like this.

JONATHON PHELPS: If I could also go to your question that Daniel, better known as DK, answered. If the Wee Waa hospital was operating like a hospital, we wouldn't be asking for this, but the present system is not working. How many other hospitals in the Hunter New England Health are suffering the same circumstances?

The CHAIR: We haven't heard from many other than this one.

JONATHON PHELPS: Yes, exactly. So why is it just Wee Waa? They're just not listening. As Richard said, there has been an inquiry. There are several committees. They're just ignoring us. There's something going on with the relationship between Hunter New England Health and the three doctors in Wee Waa. There is just a barrier there that can't be knocked down. I know for a fact that the Wee Waa Medical Centre have put in an application for VMO rights.

RICHARD SCHWAGER: Twice.

JONATHON PHELPS: Yes, twice. It keeps getting knocked back. Someone in Hunter New England Health is a real barrier. It could be a personality clash—I don't know—but it's not working. Get those doctors back into Wee Waa—the local doctors, two blocks away—and I think things will start to roll. The doctors are the key. The nurses will come back if the doctors come back.

The CHAIR: Thank you very much. I'm glad you've raised the issue about other hospitals or other community groups making representations on behalf of their hospitals, because I was going to ask the same thing. At the macro level, this inquiry is about whether or not to split a district in half, and most of what we've heard today—most, not all—is about one hospital in the whole district. We haven't received any submissions from Mungindi, Boggabri, Barraba, Tingha, Ashford, Warialda, Guyra, Uralla or Walgett. In terms of the question about if we should split a health district, if there had been a tsunami of submissions from right across the New England, then that would scream to the problem being everywhere. But it's very localised. I know, in part, that's because physically we're here, and we came here because of the number of submissions. But it's hard to justify breaking up a health district when it sounds like there's a problem at one hospital.

JONATHON PHELPS: Well, maybe it's coming their way. Maybe we're an example of what may happen down the track.

JOHN FOGARTY: Didn't Roy Butler say there have been three requests for inquiries into John Hunter when he put his submission into Parliament?

The CHAIR: Yes.

JOHN FOGARTY: This is not the first place that has had problems.

The CHAIR: I can confirm that the member for Northern Tablelands back in 2008 or 2009 put in a submission about splitting it. The member for Northern Tablelands in 2023 put in a proposed bill about splitting it, and now there is this one from Roy. That would suggest that the problem is widespread. But we've called for submissions. We've publicised, we've advertised, we've promoted and we didn't get submissions from more than 90 per cent of those other places. So, as the chair of a committee, I am sitting here asking, "Is it a widespread problem or is it a very localised problem?"

Ms TRISH DOYLE: It's still a problem.

DANIEL KAHL: I touched on it before. I think you'll have a lot of people who aren't making a submission because they don't know what they're submitting on. To be quite honest, I think this bill being put up is a way of not actually acknowledging that there is a management problem in one site and fixing it. It's actually a bit of a sideshow, frankly. That's my opinion.

RICHARD SCHWAGER: Yes.

DANIEL KAHL: You've thanked us all for our time. Thank you guys for your time. I get the sense that maybe you're wondering why you're here, Clayton. I'm not quite sure either, because I'm not quite sure what it is we're even talking about. What does a split even look like? We haven't even got that far yet. We are saying, "Do we want a split or not?" Do I want white bread or wholemeal? But I don't know what either of those are yet. I don't think the work has been put in place. I think this is a way of having a bit of a show whilst the recommendation is handed down by an "independent panel". It's just on how we fix Wee Waa, which doesn't fix Wee Waa. Ultimately we come back with a bunch of recommendations that absolve some people of having to change too much, and we end up just having to suck it up. I'm sorry if that's too blunt, but that's how I feel about it, frankly.

The CHAIR: No, it's fine.

DANIEL KAHL: I'm not quite convinced that being here will help, and that probably lends itself to the psychological safety piece I was talking about before. I'm just not convinced, firstly, that I'm safe out there or, secondly, that anyone gives a crap.

The CHAIR: I am working on the basis that a split would mean going back to the old New England model and Hunter model, but I do acknowledge that earlier today we had someone suggest that maybe everything west of the divide should be in the Western division.

DANIEL KAHL: That's a fair assumption. I would assume that too, but to assume is to—

JOHN FOGARTY: Split into the other three districts.

The CHAIR: The other question I wanted to ask is about money. I've asked this question a few times today. Do you think that you can get better outcomes without spending more money at Wee Waa or do you think more money needs to be spent to get those better outcomes? In which case, I'm thinking money needs to be pulled from somewhere else across Hunter New England Health or you split it from within New England.

RICHARD SCHWAGER: Mr Chairman, the money is there; it just needs to be spent a whole lot better, or even spent at all. It seems to me that in the last two or three years, they seem to allocate a lot of money and it's not spent there. It goes into that magical pot called "consolidated revenue", I think, and it goes off somewhere else in the Hunter New England health district. If the problem is only in Wee Waa, it makes all of our jobs a lot easier. You might say it's not quite believable. The evidence would suggest that it's definitely believable. If it's only one spot, it should be so easy to fix. You've got a pretty good functioning western division health district there, which seems to understand and work with smaller communities. This was put up by Roy Butler, and I suppose we grasp at it because we think, "Let's have a go at this one"—anything to get something moving. We're tired. We're worn out with this sort of business.

The CHAIR: There are some numbers here in the submission from the farmers that suggests that there's a $5 million annual budget allocated, of which $1.65 million is for acute care. I'll take it on face value that they're real numbers. Where do they come from?

RICHARD SCHWAGER: It's a good question. My wife actually wrote this. She's the brains of the show.

The CHAIR: That is on record.

RICHARD SCHWAGER: Can I retract that, please? I'm afraid I'm a bit like you: I don't know where they came from.

The CHAIR: That's okay. I'm not doubting them.

Ms LIZA BUTLER: It was the same figure we heard this morning.

The CHAIR: Yes, it's a similar figure. We were also told this morning that there was negotiation between VMOs and Hunter New England Health that got to the end and the VMOs weren't engaged by Hunter New England Health. There's a question there, rather than any of us trying to guess and suppose what might have happened in that negotiation. Apparently there was a conversation. Would you guys agree that what you believe to have happened is that there was conversation between potential VMOs and Health?

RICHARD SCHWAGER: Yes.

JONATHON PHELPS: There have been conversations. There have been discussions. But those discussions aren't new. They've gone on over the last couple of years. I think there have been two applications put in by the medical centre, which has got three doctors in it. Again, I don't understand why they're not coming together. They fly a doctor in for a weekend or something. I've heard figures that each day that the doctor is in there, it's a couple of thousand dollars. You've already got doctors in town. Why are we flying someone in? The other big cost is the ambulance services. It's been struck with a high workload because they're transporting people out of Wee Waa to other areas. I've heard figures that a trip to Narrabri, for example, is $800. You've got a hospital right next door.

DANIEL KAHL: There's an ambulance Unimog that just spent the week in Wee Waa. It didn't need to if we had an emergency department and a doctor.

The CHAIR: You would still have your ambulances, though.

DANIEL KAHL: Yes, but we wouldn't need that Unimog stationed here for a week to bring people in and out of Wee Waa, because they would have had an emergency department to attend.

The CHAIR: Sorry, what is it?

DANIEL KAHL: A Unimog is basically like an army truck—the high-level army trucks that can drive through floodwater. Wee Waa has been isolated for the last week with flooding.

The CHAIR: Because of the wet.

DANIEL KAHL: Yes. We wouldn't need that there if there was a functioning emergency department with a doctor in a hospital. In terms of money, we're not asking for new infrastructure. We're very fortunate to have fantastic medical infrastructure. The only extra cost from today is the cost of hiring a doctor.

The CHAIR: This is the bigger problem across Health: There's not a whole bunch of spare doctors, nurses and physios sitting in the cupboard that we're not using. They're not there.

DANIEL KAHL: There is at Wee Waa. There are three.

Mrs HELEN DALTON: There is.

The CHAIR: Unless we can get agreement for VMOs to work inside the hospital and things like that—

Ms FELICITY WILSON: It's all about money.

DANIEL KAHL: If the issue potentially is money between Hunter New England Health and coming to a dollar term agreement, which I can only assume is the issue, then maybe we need to be looking at why there's a wider issue in terms of having a bare cupboard. Maybe it's not being willing to pay enough for our doctors.

The CHAIR: Some of us have been on the Legislative Assembly Select Committee on Remote, Rural and Regional Health. I've got to say, the evidence that I've heard is that the medical professionals are changing the way they want to go about work. They don't want to be nailed down and pinned down to a certain role for many, many hours. They're choosing lifestyle over work style. Locums are a classic example of that. "Don't employ me to a hospital where I have to be there five days a week. I will fly in and out, two days, make my coins, and have the other five days off."

DANIEL KAHL: Yes, like the rest of us.

JONATHON PHELPS: We've got three doctors in Wee Waa that want to work at the hospital. I mean, can you guys come back next week and put Hunter New England Health over there, put the three doctors over there and crack a deal? Can you do that? Because there's something going on there.

The CHAIR: Hunter New England Health are appearing before this committee next week, and certainly that will be one of the lines of questioning. We have to respect there are confidences within a negotiation and we don't know what it's about. We're supposing money—

JONATHON PHELPS: Well, you don't have to tell us. Just come to a deal. It's all I ask.

The CHAIR: It could be about work hours, or anything like that.

Ms TRISH DOYLE: I was going to ask about what you think—if the bill doesn't pass and there isn't a splitting—what the main changes are, but you've just answered that in the last few minutes. You know what your community needs. I just want to acknowledge your frustration. I think that's important to do that. To your point, Daniel, about feeling this sense of helplessness and hopelessness and that deep frustration—a range of inquiries and no resolution—I think the issues are felt across New South Wales in different areas. I want to move my local hospital in the upper mountains out of my local health district, because we're not Western Sydney. So I understand what you're saying, there. But if, for the purposes of our report and all of us speaking to the decision-makers, or holding some of those decision-makers to account around what the bureaucrats are saying to those decision-makers, which may not be factual, what would be the top two main changes, regardless of whether the bill passes or not, that would improve health services in this region? Besides the doctors, because you have talked about that. What would be a second thing?

RICHARD SCHWAGER: I'd like to see proof that the $1.67 million or the $5 million, or whatever the figure is, I would like to see proof that that's spent in Wee Waa.

Ms TRISH DOYLE: Okay, so where the money is?

RICHARD SCHWAGER: Where it went.

Ms TRISH DOYLE: Jono, besides the doctors, what would be the main change—if you could put that directly to the Minister and the Premier—that would improve heath services for your community?

JONATHON PHELPS: Proper consultation through a committee from Wee Waa. I mean, they're not listening to the communities there at the moment.

DANIEL KAHL: I mean, it covers this, and it's probably not really a specific change, but I mentioned the word accountability a bunch of times. Ultimately it's the board's role to ensure management is accountable. That covers things like, "Where is the money? How are you consulting properly? Do the community feel engaged in this so that they can feel safe and confident that they've got the services they need?"

JOHN FOGARTY: Hunter New England Health having an understanding of rural areas, Aboriginal people and further away communities. They've just got no idea—you heard Clifford this morning talking about when Aboriginal people die, they want to be together, and we can't have that in our town.

Ms FELICITY WILSON: You're all very passionate in advocating for Wee Waa, and I know Daniel you're also trying to look at other areas. I don't want us to end the day with a sense in the evidence that this is a Wee Waa issue. I know, Richard, in particular, you were saying things are very different in Wee Waa. The evidence shows that there are problems across the health district. We had evidence earlier today, and we know even from looking at the media that there are constantly hospitals being put on bypass. Last week, there wasn't an emergency doctor in Moree, so you were doing telehealth in what is a larger town than yours in an area that you might actually be sent to for a lot of your healthcare, if needed. So this is a much bigger problem, and there are significant challenges facing this region. It doesn't make your situation better. If anything, it probably shows the domino effect of all of the different services across the region struggling, and how it is also affecting you.

The CHAIR: Is there a question?

Mrs HELEN DALTON: Or is it a statement?

Ms FELICITY WILSON: I'm sorry, Chair; earlier, when you were having long statements, I thought that we were also allowed to make long statements. I wanted just to ensure that you understand that we know the perspective you're bringing from Wee Waa, but we also do know that there is that broader impact across the entire region of the healthcare system. Thank you for sharing that. If there is anything you want to say about the broader healthcare system outside of Wee Waa then I would welcome that.

DANIEL KAHL: I think you've covered it there. I've mentioned accountability. That accountability I would hope would apply to the whole health district. I mentioned Muswellbrook before with maternity services withdrawn there and people having to travel to places like Maitland when they've got emergencies. I consider Wee Waa potentially as a bit of a canary in the coalmine. It's not a Wee Waa issue. We're probably making the most noise on this current issue, but I would hope that the answers found in trying to sort out what's happened at Wee Waa provide a lot of answers to the rest of the health district as well.

The CHAIR: Jono, you were going to—

JONATHON PHELPS: Yes, I just wanted to thank your Committee for being in the Wee Waa district, cotton centre of Australia. It's good to see elected people on the Committee. The previous inquiry into the Wee Waa Health Service was conducted by either four bureaucrats or four ex-bureaucrats and they didn't stick to the terms of reference; you might have seen that in some of the submissions. So I'm happy to see that elected people are at this one. Thank you very much, Clayton. That's on behalf of NSW Farmers, Merced and Queensland Cotton. Thank you very much. It's only 40-odd kilometres to Wee Waa. The road is open, so go to the coffee shop and have a coffee. Thank you very much.

The CHAIR: Thank you for appearing before us today. You'll be provided with a copy of the transcript of the evidence in case you want to make any corrections—or further explanations to your wife. The Committee staff will also email any questions taken on notice today and supplementary questions which we may develop in terms of wanting to send back to you. We ask that you return them as soon as possible. That concludes our public hearing for today. I again thank all of the witnesses who appeared. I also thank the Committee members, Hansard, Committee staff and our audiovisual team as well. Thank you all so much.

(The witnesses withdrew.)

The Committee adjourned at 14:30.