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 Tamworth Jockey Club and Function Centre, Taminda,
on Wednesday 13 August 2025

The Committee met at 9:15.

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 thank everyone for coming and being here today. We appreciate your contribution to this very important inquiry. I begin by acknowledging the traditional owners of the land on which we meet today, the Kamilaroi-Gomeroi people of the Kamilaroi nation, and pay my respects to Elders past and present and Elders who may be in the room with us right now.

Welcome to the second hearing for the Committee on Community Services and our inquiry into the Health Services Amendment (Splitting of the Hunter New England Health District) Bill. 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. Members of the public are not permitted to film or photograph proceedings. We thank the witnesses who are appearing before us today and the stakeholders who have made written submissions. We appreciate your input into this inquiry.

Ms HEATHER FRANKE, Secretary and Delegate, Gunnedah District Hospital Branch, NSW Nurses and Midwives' Association, sworn and examined

Dr MICHELLE GUPPY, General Practitioner, Secretary and Treasurer, New England Division of General Practice, sworn and examined

Mr EDWARD STUBBINS, Individual, affirmed and examined

The CHAIR: We will now begin with our first witnesses of the day. Thank you for appearing before the Committee today. As previously mentioned, no-one is allowed to take photos, but we will, and we might use them on our social media. If you don't want to be photographed and don't want to be a part of that, please let us know. We will be happy to comply. Before we start, do you have any questions about the hearing process that we're about to engage in?

EDWARD STUBBINS: No.

HEATHER FRANKE: No.

MICHELLE GUPPY: No.

The CHAIR: Terrific. At the start of our proceedings, each witness or group of witnesses has the chance to make a two-minute opening statement. Mr Stubbins, if you have an opening statement that you want to share with us, we're in your hands.

EDWARD STUBBINS: Thank you, Chairman Barr and Committee and other panel members. I was born in 1946, which makes me the same vintage as Donald Trump. If he helps to make good deals in Ukraine and Gaza, perhaps some of his excesses will be forgiven. I have more in common with Joe Biden, especially in one important aspect. I may have to take some questions on notice today or make a further submission, if such things are permitted. I am here today for the same motivation as serving on hospital boards for more than 20 years, including two terms on the New England area health board; citizenship; and for the same reason I was a member of the founding committee of the Myall Creek memorial and recently spoke at the twenty-fifth annual commemoration of that memorial. I was also a parliamentary candidate on four occasions. I have made it clear in writing what I think should happen about the topic under discussion today. I hope that Donald and I are able to bring about good outcomes.

HEATHER FRANKE: I would firstly like to acknowledge the traditional owners of the Kamilaroi land on which we meet, and I pay my respects to Elders past and present and emerging leaders. Thank you for allowing me to speak today on behalf of my branch of the NSW Nurses and Midwives' Association in relation to the proposed splitting of the Hunter New England area health district. As a branch, we feel that the proposal will not be able to proportionately distribute enough funds to enable the proposed New England North West district to provide services to the smaller communities that are already struggling to recruit and retain doctors, nurses and midwives.

Of great concern is losing the John Hunter Hospital as our major referral hospital, especially as many of the smaller hospitals have no doctors in their hospitals after 8.00 p.m. at night, and nurses must rely on telehealth

doctors to treat patients. These doctors then advise staff to keep the patients in the emergency departments overnight to be reviewed by the visiting medical officer in the morning. Therefore, that day commences with patients already in the emergency rooms. This process is less than ideal, putting pressure on the emergency department staff, and it is certainly unacceptable health standards for our community members. The staff at night in our emergency department is one RN, and they can be looking after five people.

The cost of this proposal will be exorbitant, as the clinical governance for the district is based at John Hunter Hospital. New policies and guidelines would need to be written for the new proposed health district. Buying partners through our collective area health services make purchasing of equipment cheaper as all equipment is uniform across the area health service, and purchasing in bulk is financially viable for all hospitals. Our community members, including the elderly, young children, especially those with complex needs, pregnant women and Indigenous persons would be disadvantaged when it comes to referral for health issues that are now referred to John Hunter Hospital.

Our community deserves better health services to provide better health outcomes. Staff deserve to be able to come to work and have a safe environment that allows them to provide the care the community needs. Our branch is concerned that we and other smaller sites will be disadvantaged by the split, especially if the new area requires a double-up of management that already exists within Hunter New England. This will use a great deal of financial allocation for the health district. Therefore, medical and nursing staff will struggle to provide adequate health care to our communities. We already struggle with staff shortages in our rural areas and it's at a crisis point. Our health system is at a crisis point. Recently, I did over 100 hours in a fortnight because we were backfilling sick staff. It's normally 76 hours.

Our midwives are at crisis. We currently don't deliver many babies at Gunnedah Hospital and our pregnant ladies are sent to Tamworth to deliver, putting pressure on their midwives because we don't have a midwife to send with them to help with that baby and that pregnant woman. Sometimes we are not allowed to go to Tamworth because they're full. We have to send our ladies two hours away to Armidale or four hours to John Hunter Hospital. It's not good enough. We feel that the money would be better spent trying to fix what's broken.

The CHAIR: Can I pause to thank you and the entire health workforce, both past and present, for all the work that you do in our system. Dr Guppy?

MICHELLE GUPPY: I've been a rural GP in Armidale for the last 23 years, so I was here when the New England area health service was in existence. Today I am representing the New England Division of General Practice, which is all of the GPs who work essentially from Armidale North to the Queensland border and out west to Inverell. As part of this process, I surveyed all our members to get their opinions around the issues. Essentially, we share similar concerns to what you've just heard. There is a rural health crisis in medical nursing and the allied health workforce, but not just in this region. That crisis is Australia-wide, and I think we need to look at the context of the health workforce in Australia. We're not convinced that there's clear evidence that reorganising the administrative components of the health district is actually going to lead to meaningful change in the health workforce on the ground.

We would be very cautious and recommend that that evidence be sought before making any decision around splitting the health service. Probably the other main topic that we want to bring up is the issue around referral pathways. As a GP, patients can't have all of their services delivered in the New England region. By virtue of our population size, Tamworth Hospital is never going to be able to deliver open-heart surgery or other major medical services. There is always going to be a need to refer out from this region. At the moment we have clear pathways down to Newcastle, because we're one health service. So splitting the health service would add a layer of complexity for general practice referrals. I'm happy to speak about that in more detail.

The CHAIR: Just for my clarity—and I'm looking at the map here of the Hunter New England health district—in terms of the GPs that you cover, do you not represent GPs who might be out as far as Wee Waa and Narrabri?

MICHELLE GUPPY: That's correct. They would be represented by the Barwon Health Alliance. GPs in Tamworth and south are represented by the North West Health Professionals Network.

The CHAIR: Thank you so much for clarifying that for me.

Ms TRISH DOYLE: I thank each of you on behalf of our Committee for being here and speaking to this particular issue. I would be interested in hearing from each of you to extrapolate on what you think the particular issues are. I'm going to refer to Mr Stubbins' submission, where he refers to the proposal to reinstate a New England health service as demonstrating "a restricted understanding of issues confronting health services in rural, regional and remote New South Wales". He says it's a simplistic solution to quite complex issues. I'd really

like to hear from each of you on that comment, starting with you, Mr Stubbins. What are the issues, those complex issues?

EDWARD STUBBINS: I can best refer to a document I have here; it's the New South Wales Government response to the Legislative Council report issued in May 2022. It says:

> … the committee has found that residents of rural, regional and remote New South Wales have poorer health outcomes and inferior access to health and hospital services, and face significant financial challenges in accessing these services, compared to their metropolitan counterparts. Issues and findings in the inquiry's report included, but are not limited to: shortages in the health workforce causing staff fatigue and pressure; shared responsibilities between the Federal and New South Wales Governments leading to gaps in service delivery; concerns with activity-based funding; cancer patients facing out of pocket costs; sub-optimal access to specialist care and maternity, palliative and ambulance services; concerns with the use of virtual care; issues with patients navigating the health system; a lack of genuine consultation between local health districts and the community—

Ms TRISH DOYLE: Can I just interrupt you there, Mr Stubbins? Would you mind talking a little bit about the virtual care, or the telehealth—any feedback you've heard about that? In all of those issues that you're listing, is there anyone you know who's had experience with telehealth as a model of care?

EDWARD STUBBINS: I am able to comment on that, because I've used it myself with a [redacted by resolution of the Committee] from the device that's available at Warialda MPS. I've had a number of consultations with him. I found that very useful, indeed. I'm aware, for instance, as well, that access to specialists for stroke care, especially through to John Hunter super specialists, is critical, really, because of the time issue that's involved with stroke care. I can make those two comments about it.

Ms TRISH DOYLE: Excellent. Thank you for outlining a list of issues that you see as important to be considered.

EDWARD STUBBINS: Could I just add to that, the point that I'm making with that list there and referring to that document is that, yes, we might have problems and we still have problems in Hunter New England with the delivery of services, in some respects, in this area, but it's not confined to this area. As the lady said, it's an Australia-wide program. Certainly, this program says it's a statewide problem. That's why I say it's a simplistic solution to the problem here.

Ms TRISH DOYLE: Thank you very much. You have articulated that very well. Ms Franke, in relation to that comment that to split the service would be a simplistic solution to complex issues, what is your response to that on behalf of the nurses and midwives in the district?

HEATHER FRANKE: To split it, I think, is just going to complicate it because we are not solving anything, really. The health care in our region is provided, say, through GPs. Many towns don't have GPs, so some smaller MPSs have a GP clinic attached to the hospital. In our town, we struggle with GPs and getting them to come and stay. People can't get an appointment, so of course they present to the emergency department. And then the emergency department is no longer an emergency department; it's an outpatient clinic treating people who can't get in to a doctor. And then we have an emergency come and then people say, "Well, I was here first. I should be seen first." They don't get that it's an emergency department. It's an end to their means. It's a place to go to get relief from their problems. We appreciate that and we do our best, but we've only had two nurses in that unit and we have over 30 presentations a day.

Our biggest issue is staffing shortages. It really is not just a shortage with the nurses; it's with the doctors as well. We have one doctor that will come and start at eight o'clock in the morning and work through until eight o'clock at night and then be on call for what we class as emergencies, which is a triage 1 or a triage 2 cardiac arrest. They will come back for that. Some of these doctors we get are not trained in intubation and so then, to be crude, we are buggered because then we have to rely on the generosity of the two GPs that are in town to come and help with that. One of those GPs has now moved to Tamworth, so he is no longer in the picture. Our community deserves much better than that. We have had suggestions in the past about how we can overcome that, but they don't get anywhere. Doctors are reluctant to come to smaller towns because there is nothing there for their families. We need to create better incentives to get staff into these areas. We are relying on staff that come for short-term contracts, like midwives and things like that. It's hard to get them because when they get there they are like, "Oh, am I the only midwife here?"—yes, you are. "Oh, no, I need backup."

Ms TRISH DOYLE: Dr Guppy, you made reference in your opening statement to this perhaps not being the solution. Would you like to extrapolate on that view?

MICHELLE GUPPY: Yes. I think my understanding of the rationale for splitting the health service is that our local district could then be in charge of its own destiny and have the capacity to recruit and deliver the services that we need, but I think that is overly simplistic in that it lacks the understanding that we would then be competing with other districts, trying to recruit exactly the same people. I don't see that it's clear that doing that would give us any sort of advantage around recruitment of medical practitioners. I do a lot of recruitment in my

current job, so I'm aware that places like the Central Coast are struggling to recruit obstetricians. They're struggling to recruit paediatricians. If places like the Central Coast are struggling, we are also struggling to recruit those specialists. I just don't see that a change in the administrative structure will solve that problem.

Just in response to your question around telehealth, I deliver a paediatric ears, nose and throat telehealth clinic in Armidale. I see children who've been referred by their GP so they only have to travel a couple of hours to get to Armidale, if they're travelling from Tenterfield, for example. We have an ENT surgeon in Tamworth and so I see the child. If they need surgery, we organise for them to have their surgery in Tamworth. If the child has complex issues—and I'll give you an example of a child I saw a couple of weeks ago from Tenterfield who had very complex breathing issues. I spoke to the ENT surgeon in Tamworth. He said it was too complex to be dealt with in Tamworth. I got on the phone to the ENT surgeon in Newcastle and said, "Can you see this patient?" He's going to see that patient by telehealth so they don't have to travel from Tenterfield to Newcastle, and then the only time they'll need to travel to Newcastle is for their surgery.

If we weren't one health district and if I didn't have that arrangement with the surgeon in Newcastle, I could call anywhere to try and get that child services, but they'd go to the bottom of the list again. If you're referring them out of our health district and into a new health district, they're back to square one and they're at the bottom of the list, whereas I can get this kid seen in a couple of weeks. That's just an example of how the referral pathways work at the moment. If we put this divide at Murrurundi, then it just will add that layer of complexity back into our referral pathways.

Ms TRISH DOYLE: Very good point. Thank you.

Ms LIZA BUTLER: Thank you for joining us today. Dr Guppy, in your submission you referred to having the larger hospitals as a training hub. Could you talk a bit more about what would happen if their health district was split and that you didn't have that larger hospital for training?

MICHELLE GUPPY: I have another hat, which is the head of the medical school at the University of New England and I believe I'm talking to you guys again next week about training.

Ms LIZA BUTLER: You are, yes.

MICHELLE GUPPY: I'm happy to answer that question now, or happy to answer it again next week.

Ms LIZA BUTLER: It's in your submission for today.

MICHELLE GUPPY: With training, at the moment when a student graduates and becomes a doctor, they do an intern year where they have provisional registration. At the moment they can work in Tamworth and Tamworth is the only hospital in our region where interns can have their first job; otherwise it's down in Newcastle. Then to become a specialist—to become a GP specialist, or to become any other sort of specialist—the junior doctors need to go through a series of training. At the moment they can do some of that training in Tamworth, some of it in Armidale, but for most of the specialties, they will need to go elsewhere to get the training that they need for their specialty. At the moment that hub is Newcastle. Newcastle will send trainees up to our region. We've got that flow of specialists and registrars flowing from Newcastle up into our region. If the health district is split, those training pathways will be less clear.

Ms LIZA BUTLER: Ms Franke, in your opening statement, you said to fix what is broken and not recreate a new health system. What are the things that could be quick fixes to things you see that are broken, and why do you think that they are happening? Is it the lack of staff that creates the whole problem?

HEATHER FRANKE: I can jump on the bandwagon here and say I've just come from our annual conference, so I'm a bit passionate here. We need more staffing. We need to look at ways to get that staffing. An example is—at a hospital I work at, we created a CNS 2 position to train the younger girls that have just graduated. They come through, and they do 12 months on the ward. Then we transition them through to ED because that is where they're needed. We were helping with that. That position went for 12 months, and it is now no longer there. We stepped back into our CNS 1 role, but we're still doing what the CNS 2 role was.

When we had our role as a CNS 2, there would be three staff on so you were able to help that person and train them up. Now we're not. It's just the two RNs. It's very hard to train someone while you're busy working and doing it. That's one thing. How do we retain staff is the biggest thing. How do we get doctors to come to our smaller areas? How do we get midwives to come and stay? It's a big question. Do we make ratios better? Do we increase our pay? How do we do it? People are only too happy to come from Sydney and Newcastle and be on a four-week contract, because they get incentives, they get paid, they get all of their accommodation, they get so much for meals a day and they get paid the same rate we get. They come and they stay for four weeks. That's a quick fix, because then they leave and you have a new person come.

We really want to retain our midwifery services at our hospital, especially for our Indigenous women. They deserve to birth on Country. If they can't—here, we're lucky. We get to go to Tamworth, and it's still the same Country. But when they go to John Hunter, it's a different Country. There are lots of considerations for us. We have an elderly community. We want them to stay within our community as well where their family can come and help care for them. We rely on families to come and help with our demented patients because we don't have enough staff.

Ms LIZA BUTLER: We heard yesterday that people feel that decisions are made in Newcastle without much communication to the regions. Do you think that's a fair comment? That's open to anybody.

HEATHER FRANKE: I think so, yes. I am also with Dr Guppy. I was around when we were Hunter New England. At that time every hospital had their own board, and those boards worked very hard. We had big auxiliaries that raised lots of money. New England was very wealthy, but Hunter not so much. Then we combined, and the money went for that big regional centre. We were on the outskirts.

Ms LIZA BUTLER: Do you think that part of the solution would be better consultation with the regional areas for major decision-making?

MICHELLE GUPPY: I think your comment is really true. There is a perception, and probably a reality, that decisions are made centrally down in Newcastle that are then not—we're not consulted about issues and solutions for up here. There is certainly that perception, and I think that has been the reality in a lot of instances. I can think, though, of recent examples where the health service management is being very responsive to our workforce crisis up here. I am aware of projects that are underway that are actually targeting recruitment up here and trying to increase the situation here. Recently the health district has been more responsive to our needs, whether that's because of the inquiry and because of this proposal—one great outcome of this would be recommending, if the health service doesn't split, that there needs to be a local recognition of the unique issues up in the New England region.

Ms DONNA DAVIS: Thanks for coming today to the hearing. We've heard today and yesterday about what we can do to incentivise people to work and live in the regions and in remote and rural areas. Money is a contributing factor, but what other creative things could we be doing that you have seen work in other places, potentially across Australia or New South Wales? Yesterday we heard about—and today, Ms Franke, you talked about—birthing on Country and being able to have palliative care on Country. What can we do to incentivise and make it easier for young Indigenous men and women to get involved in the health services? The University of New England has a very strong presence in Parramatta. There's a wonderful nursing faculty down there. I'm sure that there has to be ways that we can try to look at creative solutions. Can you give us some—if not now, on paper?

MICHELLE GUPPY: Speaking for the general practice workforce, Ms Franke was talking about how a lot of the small hospitals are staffed by GPs. This is where the Federal Government and the State Government funding model sort of hits a head. GPs work as visiting medical officers in the hospitals. They're funded by the State Government to do that kind of work, as well as working privately, funded by Federal Medicare, in their private practice. The Federal Government's recent initiatives around incentivising junior doctors to train as specialist GPs has had a good effect. They're looking at leave entitlements for GP registrars. For the first time in quite a while, the GP training program is now oversubscribed for next year. There'll be a three-year lag before those trainees become fully qualified GPs, but at least it's a good start. In no small part, that's been around the incentives that have been put in place by the current Government.

In terms of what incentivises doctors to work in small rural towns, I think Ms Franke hit the nail on the head when saying that if you are the only doctor in that town, you don't get a break. You need to have more than just one person turning up to work to have a work-life balance. For example, Armidale hospital has had half an emergency department specialist for quite some time. It's not enough to have half an emergency department specialist. You probably need four emergency department physicians so that they can cover the roster and support each other. But the way recruitment has occurred to date has just been "All right, we've got one position available. Let's recruit to that one person." That one person turns up, stays for a couple of years but the work is too hard because they're the only person, whereas, if there was a recruitment strategy that recognised that and tried to recruit a group of people all at the same time, I think that would be a way to go in terms of then sustainability of the workforce that you do manage to recruit. Those kinds of recruitment strategies, I think, are what need to be implemented to make the workforce sustainable.

EDWARD STUBBINS: I could just add, I'm thinking that to attract people to come to the country—and, for me, Armidale is almost a city—there has to be real unusual opportunities available for doctors to consider coming, and out of the ordinary. I've written about this. There is history of smallish communities providing finance and other advantages to health initiatives and providing health initiatives in those areas—in other words, raising

money and doing other things. I think there's scope to investigate that. Given the amount of migration coming to the country et cetera, we're going to be short of GPs forever, I think. There has to be something very special about getting GPs and specialist nurses and so on to have an opportunity to find out what it's like to live in the bush. Some of them—not all of them—will say, "This is a lifestyle I rather like."

Ms DONNA DAVIS: Ms Franke, particularly nurses and midwives?

HEATHER FRANKE: We've talked about how better to recruit staff and retain staff, and we feel when we go back to our ratios thing where if we had better ratios, staff would stay. Some of them come and just say, "Really? Is that how many patients you have in a shift?" They're not used to that. But then with our emergency department, looking at that, something we've thrown around for a few years amongst ourselves as staff was to try and get from Tamworth some of their junior doctors to come over and stay, and have three of them come at once—a big ask, but anyway—to rotate through so that we have 24-hour coverage in our emergency department, so that we're not expecting a doctor to work from eight to eight and then have to come back and work if there's an emergency. They will be there for, like, at least four to six hours and then they have to go home and sleep and then be back by eight. That's unreasonable to ask. We thought if we had three doctors that rotated through the emergency department over a period of time with the support of the senior doctors in Tamworth, because that's where they've come, would that work? We haven't taken it anywhere. We've just discussed it.

Ms DONNA DAVIS: You're bringing it here—that's a great idea—and airing these ideas.

Ms FELICITY WILSON: Thank you for joining us today. I really appreciate hearing your advice and experience and suggestions for us. You'd be aware that yesterday we were in Narrabri and we heard very strong views from much smaller communities. I recognise that, Edward, I think you're in Warialda, so another small community.

EDWARD STUBBINS: Yes.

Ms FELICITY WILSON: Hearing the perspective more, I would say—from a Gunnedah, Tamworth, Armidale part of the region—it seems from what I'm hearing that you're saying the issues that the smaller towns face are issues that are also felt in what I call the bigger towns or the cities in the region, just to a different degree. Could you explain a little bit more about the way in which—Gunnedah is not a big city, but Gunnedah is larger than most of the towns we were speaking about yesterday—the healthcare system is functioning in Tamworth and Armidale? Obviously the rest of the region is really looking to Tamworth and Armidale for the vast majority of their more serious health concerns.

MICHELLE GUPPY: I guess the main difference is that the workforce in those smaller towns is provided by general practitioners and they're general practitioners with additional capacity in anaesthetics or obstetrics, or even surgery. So you have a workforce that's primarily working in private practice, who then works for the health district to do certain functions. Whereas in Tamworth and Armidale, most of the GPs work just in private practice. There are some who work for the hospital as well. But most of the hospital workforce in Tamworth and Armidale are non-GP specialists, so specialist obstetricians, specialist paediatricians and specialist surgeons. That's a major difference in the workforce between the bigger cities and the smaller towns. The funding is different in those models, and then the service capacity is also different.

There are certain low-risk obstetric patients who can be delivered in places like Narrabri and Inverell. We have very experienced GP obstetricians in Narrabri and Inverell. But for high-risk obstetric care, they need to come to Armidale or Tamworth, and sometimes even to the John Hunter. So I guess it's mainly a difference in what services are available in each of those communities and then the flow of patients and where they need to go to receive the next level of care—and Armidale and Tamworth are those larger communities. But not everything can be done in Armidale and Tamworth, and so there is still a need to have a big tertiary referral hospital to which we can send people.

Ms FELICITY WILSON: Correct me if I'm misinterpreting, but I get that each of you are acknowledging—and I think these are your words, Michelle, but correct me if I'm wrong—that you can't actually get every single service close to home, and you accept that. It's about the journey and the pathways. You talk about referral pathways. Edward, I can't remember the language you used, but in your submission you speak about, essentially, all the building blocks lining up—having GPs, having nurses, having small hospitals, telehealth being a part of that, all of the way up to the referral pathways to the big cities and then John Hunter and other specialists. Am I accurately interpreting what you're saying?

EDWARD STUBBINS: I think that's fair.

HEATHER FRANKE: In Gunnedah, we have four doctors surgeries. The first surgery has two main doctors, who are both obstetricians, and a part-time doctor and then two registrars. The next surgery has three

doctors, the next one has three doctors and then we have TAMS, who come from Tamworth—that's the Tamworth Aboriginal Medical Service—and they have up to three doctors. Of those three doctors, two doctors provide an inpatient service at the hospital. None of the other doctors provide it; they choose not to. They choose not to have hospital admitting rights because they don't want to treat patients after hours. So it falls back onto, usually, just one of our doctors to accept all of the admissions that are going to come through the emergency department. If he's overloaded and says no, those patients then have to get transferred to Tamworth, and they're like, "Really? Do you really need to send that person over here?" No, we don't really need to, but we don't have another choice. So it's not only putting pressure on our hospital, it's putting pressure on the other hospitals.

Our hospital administration can't force the other doctors in the town to take on admission rights. But they will send patients up to our ED with a letter saying, "Please admit this patient", knowing full well that we can't, unless we just rely on that one doctor. So that's where it's very unfair on our GP services. Our ED is run by—we have two doctors that come for four days at a time and they're both from Sydney. Very skilled, but still, you know, we're relying on them. If they pulled out, I don't know where we'd be. We have a doctor who used to be a GP in Gunnedah, now a GP in Tamworth, who comes once a month, and he's very skilled as well; you're very comfortable with him. That's the other thing. As nursing staff, we have to be comfortable with what doctors are there. We have to be comfortable at night doing an examination of a patient while that doctor is watching so that he can then say, "Yes, this is what's wrong." But what if I get something wrong? What if I don't palpate correctly? It's scary for us as nurses because, if we get something wrong and that patient goes away, what's to stop them from suing us?

That's a worry for all of our staff. Some of our staff are junior. We work on what's called ECAT protocols in the emergency department after hours, so if somebody came in with abdominal pain, as a senior nurse and having completed all of my ECAT protocols, I can administer S8 medication without a doctor's order until that person is seen by a doctor. They have to be seen by a doctor. I can't just give it to them and they go home; they have to be then seen by a doctor. But I can start the process of relieving their pain. If it's one of our junior nurses, they can't. They can offer Panadol and Nurofen and that's it. And it's been known, if we have to wait two hours for the telehealth doctor to come on, that patient can't have any stronger pain relief. That's not fair to our community. It's not fair to our nursing staff who feel terrible about it.

Ms FELICITY WILSON: The visiting rights in hospitals—I'm hearing from you something slightly different to what we were hearing yesterday for some of the smaller, more western, more northern hospitals and towns, where there's a discussion about the fact that they might have GPs in town that want to be given admission rights at the hospital, but are not being given those rights at the hospital. Therefore, the hospitals are becoming part-time, they're going on bypass, the EDs are closing, for instance. You're saying that, in your experience in Gunnedah, you actually have GPs with the skills, but they're choosing not to take on the role of having admitting rights at the hospital.

HEATHER FRANKE: Correct.

Ms FELICITY WILSON: How would you create the environment where those GPs wanted to? Is it about having the extra staff? Is it about the salary and conditions? Is it about the number of nurses supporting them? What is it that would encourage them to do it?

HEATHER FRANKE: I'm not sure. I know the reasoning of one doctor. I'm not going to go into that, but I know his reasoning. But the other doctors—some of them—live in Tamworth and travel over every day, so therefore don't want to come earlier in the day to see patients in the hospital prior to starting their GP clinic. Some of them have families and just would rather be at home with their families at night. I don't know whether they come from the city where, in the city, GPs don't admit patients to hospital. They do it—the other doctors. They send them to the emergency department for admission and then don't see them again until they're discharged and come back to them. Whether they're of that belief that that's how it works out there? We're a small hospital. We have a population of 10,000 in Gunnedah. But we have mines. We've got a big fly-in fly-out community who don't count into that 10,000 and they come from all over New South Wales, Queensland and Victoria to work at the mines in Gunnedah. They come and do their seven days on and then leave for their seven days off. They don't have a GP in town, so they present to the ED as well.

Ms FELICITY WILSON: My final question is around these referral pathways and the connection with John Hunter Hospital. I think, Michelle, you were saying that, if you're not part of the same district, you'll go to the bottom of the list in other districts. But some of the evidence that we've heard across the inquiry—including Heather today talking about the fact that you have Sydney-based GPs that are coming regularly to Gunnedah—is that a lot of the different specialists, particularly that fly in, may be from Sydney, or some come from Adelaide, for instance. That's really, from my understanding, organised from the local GPs or the Aboriginal medical

services or the local hospitals themselves outside of the health district ensuring those pathways for specialist services. So they're doing it, I would say, in a more ad hoc way or having to lead that themselves.

The kind of evidence we're hearing is that that is not what the district is doing for them. They obviously do have those connections into John Hunter—particularly, we've heard from women who have had to deliver their babies in John Hunter if they weren't able to get into Tamworth, or if they're at a higher risk, for instance, they'd have to go to John Hunter. But a lot of the other levels of that, the building blocks of ensuring that you can have specialist services closer to home, are being done by people flying in, but it's not being run through the district. Do you have any observations on that? My view is I think that's feeding into their feeling that the district, in the administrative structure, is not representing their needs, because they're having to organise that themselves and they're organising it outside of the district. Do you have any observations on that or any suggestions about how it could be improved?

MICHELLE GUPPY: As a GP, you do build up your own network of people that you refer to. Ad hoc is probably a good way of describing it. Certainly, people who live in Moree, Warialda, Inverell or Tenterfield often would be referred to Queensland, because it's geographically closer and the GPs over the time that they've been working in those communities have built up their own referral pathways to Queensland and so have created those links and opportunities. In terms of the fly-in fly-out workforce, there is a private fly-in fly-out specialist workforce, particularly that comes to Tamworth. But if patients need surgery, for instance, with those practitioners, they would need to go to Sydney to have their surgery done. They can have their consultations in Tamworth but then need to go to Sydney. I can't speak for the GPs in Narrabri and Moree as to how well they feel the referral pathways within the district work for them, in particular, but I can see that it may be easier for them to be organising patient referrals outside of the district and north to Queensland for various reasons.

Ms FELICITY WILSON: Just on that, if a patient can end up in Brisbane or Royal North Shore anyway, while being in the Hunter New England health district, why does being a united Hunter New England health district mean that you are prioritised within the health district when you already have those pathways out of the district, if needed, anyway?

MICHELLE GUPPY: I guess there are two ways to go to North Shore and to Queensland. One is as a private patient, and so the patient is ending up paying out-of-pocket costs for those services.

Ms FELICITY WILSON: I mean as public—yes.

MICHELLE GUPPY: But as public patients, I think there are some services where they're happy to accept out-of-region referrals, but then there's also extra red tape. Working with Queensland is a completely different government. Organising referrals to Queensland—yes, it can be done, but there's just that extra layer of complexity that's involved, and referring someone to the North Shore or to Sydney is just an extra layer of complexity.

EDWARD STUBBINS: Could I just quickly add one thing, please. Building on your query about out-of-district referrals and so on, when times are critical, it is important to have somewhere to go to quickly. There's a helipad at Warialda MPS, which was next to the facility there, created by public money and local community work. There have been people who've come in with very bad accidents, who have gone from that helipad directly to John Hunter. Time is of the essence. John Hunter is the place to go to, where you can quickly organise attendance.

Ms FELICITY WILSON: But if you weren't in the same health district, would you not be sent to John Hunter in that circumstance?

The CHAIR: Sorry, Ms Wilson, I'm going to have to interrupt. Mrs Dalton hasn't had a chance to ask questions yet, and we are literally into the last couple of minutes.

Mrs HELEN DALTON: Thanks for attending. For you, Heather, I'd like to hear your comments on the culture of health care. You claim a lot, but let's get down and see why people aren't wanting to come into nursing or doctors aren't wanting to work in hospitals. Would you like to comment please?

HEATHER FRANKE: Doctors admitting patients or doctors working in the emergency department?

Mrs HELEN DALTON: You were saying there are some doctors in Gunnedah that choose not to work in the hospital.

HEATHER FRANKE: Yes.

Mrs HELEN DALTON: Why? You talked about their lifestyle and all of that, but is there a problem with the culture in the health system?

HEATHER FRANKE: I don't think so, no. I'm not sure why the doctors don't choose. I know of the reason of one doctor, but he was caught up in something and said, "No, I'm not coming back." Maybe they feel their skills are not good enough to work in an ED when you're there and you're the only doctor there, whereas in the surgery they're supported. If something comes in and they want a second opinion, they've got someone they can call on.

Mrs HELEN DALTON: They probably feel unsupported?

HEATHER FRANKE: Yes, maybe that's it, because we do only have one doctor there at a time. That's the only thing I can put it to. I have to admit, I haven't spoken to these doctors to say, "Why don't you come and work at the hospital?" For some of them, like I said, it could be geographical. They live in Tamworth and travel over to work of a daytime. Not many of them live in Gunnedah. The two registrars should be able to because they would have the support of the two doctors working at the surgery, who have inpatient admissions. But I'm not sure why they choose that. The only thing I can think of is that you're the only doctor there.

Mrs HELEN DALTON: Yes, they are unsupported, maybe. If you cast your mind back 40 years ago, a lot of the training for nurses was done in hospitals at training centres, wasn't it?

HEATHER FRANKE: Yes.

Mrs HELEN DALTON: Even yesterday, offline, I was speaking to someone who had been a nurse for a long time and she remembered back to those times. We didn't have a problem with staffing back then when they were within the hospital. I could see the integration of training in having, say, six weeks in, six weeks to uni, and doing that. How do you see that system? Do you think that that system should be reinstated?

HEATHER FRANKE: I think the idea of a university education was done because we as nurses wanted to be looked at as professionals, not someone's handmaiden. No, I don't think it should go back to that, but there are pathways. For myself, I was an EN for 12 years. I went to TAFE and I did 10 weeks at TAFE, 10 weeks at the hospital, back to TAFE, back to the hospital, and then finished off my 12 months at the hospital. I worked for 12 months. Then I applied to university and worked full-time. I went to university and did my degree over four years, which is the pathway that the University of New England has. A lot of the other universities have that pathway now, so there is still a way of doing that if you want to do it that way. ENs are very important to our profession as well. We don't want to do away with ENs and only have RNs.

Mrs HELEN DALTON: Could you see the integration? You've said we don't feel as qualified or as professional if you go back to that system.

HEATHER FRANKE: I just feel that our members previously, over the years, fought really hard to be recognised professionals and I think their concern, and the concern of union members, would be that if we went back to hospital-based training—

Mrs HELEN DALTON: No, it wouldn't be. I'm not talking about totally hospital based. It's the integration of, say, uni and hospital.

HEATHER FRANKE: I think that could work. I think you would possibly get a lot more staff, actually. Sorry, I misunderstood you at first. Yes, because they would be getting paid.

Mrs HELEN DALTON: They would be getting paid as they worked.

HEATHER FRANKE: To go to university.

Mrs HELEN DALTON: Exactly.

HEATHER FRANKE: Which is pretty much what I did, and a lot of the ENs are doing that now. A lot of the ENs are doing a couple of years, then apply to uni, and then working full time. It's a hard ask as well for those students—

Mrs HELEN DALTON: It is.

HEATHER FRANKE: —because you have to put in 20 weeks of unpaid placement over those four years.

Mrs HELEN DALTON: But if you had paid placement.

HEATHER FRANKE: Yes.

Mrs HELEN DALTON: Of course, the GPs, most doctors, you're going into medicine—or it has been in the recent past—are discouraged from doing a GP specialty. Is that changing now? You talked about incentives from the Federal Government. I've seen doctors at Deniliquin who are there, and of course they've got to go and

do extra training away from the area and they don't even get paid. They have to do it in their holiday times, at the risk of the patients they've left behind. So in their holiday, they've got to upskill. There are a lot of changes that can happen, but GPs—the system has discouraged them from being GPs and saying, "You need a specialty." I know GP is a specialty, but is that changing?

MICHELLE GUPPY: I think the recent Government incentives have improved the number of junior doctors who are wanting to go into general practice training. They do get paid to do their training, but not—

Mrs HELEN DALTON: It's during holidays, though, isn't it?

MICHELLE GUPPY: No, they get paid while they're working and while they're training, but pay has been less than if they continued to work in a hospital setting as a more senior doctor. So there has been a pay discrepancy, but that's slowly improving, I think. General practice is still the second top specialty that medical students want to go into, after physician training, but it is a lot less than it used to be 20 years ago. Twenty years ago, a quarter of students wanted to become GPs, and now it's about 15 per cent.

The CHAIR: Thank you all so much. It has been a rich conversation and I appreciate the questions and the answers that we've heard today. You will be provided with a copy of the transcript of today that you can check against your recollection and what you believe you said, or intended to say, and talk to us about any corrections that you believe need to be made. The Committee staff will also potentially email to you additional questions that come off the back of today, that we as Committee members may develop and devise. I've got a few questions in mind myself. Other than that, thank you all so much for appearing before the Committee today and sharing your insights and expertise.

(The witnesses withdrew.)

Councillor RUSSELL WEBB, Mayor, Tamworth Regional Council, sworn and examined

The CHAIR: I welcome our next witness. Thank you for being with the Committee today and thank you for having us in your LGA.

RUSSELL WEBB: Good morning and welcome to God's country.

The CHAIR: Just up the road from God's country, but anyway. As the member for Cessnock, you'll appreciate that. Please note that the Committee staff will be taking photos and videos to use on the social media. If you have any concerns about that, please speak to us and we will oblige. Before we start, Councillor Webb, do you have any questions about this hearing process? I imagine you've done a few of them before.

RUSSELL WEBB: I've been to a couple.

The CHAIR: Any questions?

RUSSELL WEBB: No.

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

RUSSELL WEBB: I will make just a very quick one. Thank you for the opportunity. When the amalgamation occurred—if I go back in history, I think it was around 2005.

The CHAIR: Correct.

RUSSELL WEBB: They created two into one. I was quite aware at the time of what the impact was on our community for the next few years after that. It was very negative. We saw so many people out of the health profession, I believe; they left on stress leave and a whole lot of stuff. That was 20 years ago, so let's not talk about that too much. But what is actually happening now is this bill that is before us and the one we are talking about has given us the opportunity to talk about some better outcomes.

I don't believe that breaking up the health system again to the New England Health or North West New England and Hunter is feasible, practicable or cost effective. The Government has no money to do what needs to be done to make that happen. What we do need to do is try to get some better outcomes for our communities in the rural and remote areas. If we can get better outcomes for the rural and remote areas, then this bill has done its job. That is my opinion. I think across the nation we suffer a lot from the fact that the rural and remote areas are struggling because young people are coming into the system—whether they be doctors, nurses or what have you—and they are attracted to the cities, which is a better lifestyle and easier lifestyle. They are not

as committed as they would be if they came to country areas, although I think the country areas have got a lot to offer in terms of lifestyle and so forth.

In essence, I think the residents from the north-west and New England probably have seen a constant and gradual decline of services year in and year out since this amalgamation. But it's consistent and it's happening. Of course, a good example, I think, of where we are not getting the services I believe we are entitled to—I am just using this one example and that is the cath labs. We don't have a cath lab 24/7 here in Tamworth, and we should have. We have one in Maitland, we have one in the Mater hospital in Newcastle and we have one in Newcastle. If you go to other health districts, like Orange, they've got one. If you go to Lismore, they've got one.

We are probably the only health district that actually has a large rural and remote area that is actually managed by a citycentric administration, which is right on the edge of our health district. I think that is a challenge in itself. I think there are a lot of things we can fix. I would be very happy to answer some questions, but I think the model is not working that is there at the moment. Residents in the rural and remote areas are feeling very dissatisfied with what is going on. How do we fix it? It's not just our health district; it's across the nation. But we are talking about our health district.

Ms TRISH DOYLE: Thank you very much, Mr Mayor, for being with us today and articulating on behalf of your community what you think some of the problems are and possibly some of the solutions here. In your submission, you state that council is not confident that the bill will solve all health issues and all healthcare issues in this region. You have just mentioned one issue as something that would be useful and helpful and practical, and that was the cath lab. If you were to have the opportunity to speak directly to the Minister and the Premier, what would be, say, two other solution-based ideas that you might put forward to deal with the healthcare issues that you feel your region is suffering, regardless of the bill passing or not?

RUSSELL WEBB: I think everybody sitting down this table would know that the more rural and remote you go, with the tyranny of distance and so forth, the greater the cost is going to be for the delivery of health services. In fact, that's for the delivery of any service across Australia. The further out west you go and the further away from the cities you go, the more cost is going to be involved. The first thing is that there has probably got to be a few more bucks and a few more dollars attached to how this is going to work. I think there has probably got to be a little bit more autonomy and a bit more self-governing in this particular case for our health district. It's all pretty citycentric. I think if we are going to make this work and we are going to get some benefits out of what this inquiry might be about, it's about trying to create a model where, yes, it is as it is, but we need more autonomy in terms of management and budgeting for some of these rural and remote areas, and resourcing and also the employment of staff. Those would be the things that I would say.

Ms TRISH DOYLE: Excellent.

The CHAIR: That was very succinct.

Mrs HELEN DALTON: Can you elaborate on the gradual but consistent decline? You did say, "We don't want to go there. That was in 2005", but I'm really interested in what happened back there. From this point, 20 years post that time, we are here with this inquiry wondering what on earth has happened to our healthcare system. The risk to do nothing is probably worse than what we've got.

RUSSELL WEBB: If you do nothing, it's just going to get worse. If I go back in time—and I did have a bit of involvement; but I don't really want to go too much into that—I had a job and I worked for the government. I was investigating a few things. I won't go into that.

Mrs HELEN DALTON: Oh, I'm interested.

RUSSELL WEBB: There were a lot of workers compensation claims back in those days. There was a lot of stress illness. There were a lot of people who left the system because they just couldn't handle the fact that so much of the service that we had originally—

Mrs HELEN DALTON: Was stripped away?

RUSSELL WEBB: —was stripped away.

Mrs HELEN DALTON: Hollowed out.

RUSSELL WEBB: I'll leave that one at that because I don't want to go too far back in the past, but if we don't do something now, it's going to just get worse. Another example, I guess, is here in our Tamworth Hospital. I'm going on what the medical professionals tell me. I've known lots of people in the medical profession. I'm neighbours and friends to many of them. They tell me that if we had a better budget—there's another operating theatre in the Tamworth base hospital that could be used and there are surgeons wanting to use it, but there's no funds to staff it. Things like that are causing problems. I spoke to someone yesterday who's in politics and they

drove somebody—no, it was the day before yesterday—from Moree because there were no doctors out at Tamworth. They drove them here, and he was a politician. He drove that person here on Monday. We are suffering out west with the shortage of professionals, so there's got to be a better model. I sat on a plane the other day with somebody and we got chatting. He was a urologist from Cairns. They were flying him down here to Tamworth for two days. That's a locum, which we all know about. That's ridiculous.

Mrs HELEN DALTON: Your health district is four times larger in population than a lot of the others.

RUSSELL WEBB: About a million people—950,000 to a million, yes.

Mrs HELEN DALTON: That's right. Would you not see on the coast or at John Hunter—you may as well do your recruitment from London as to do it from there because the tailoring of your needs is probably not in their minds as much as what it would be if they were living here and you were doing it yourself. Could you see Tamworth being perhaps elevated to a significant health district, the district being split; Tamworth holding its own, getting far more resources in here as a solution to perhaps providing better health care for those who are further west? Of course, you've got to remember the further west we go, the shorter our life expectancy is.

RUSSELL WEBB: The shorter your life expectancy is and the more chronic disease.

Mrs HELEN DALTON: Yes, absolutely.

RUSSELL WEBB: There's more chronic disease further west of us than here, particularly in the city areas, because of the lack of services. If people get sick, they can't get help, so obviously chronic disease worsens.

Mrs HELEN DALTON: Could you see not only to have the Country Music Festival in Tamworth but to have a big hospital that serviced the west and to the north?

RUSSELL WEBB: There's no question in my mind. Tamworth's the biggest population centre in north-western New England. Armidale is within the New England, but Tamworth, if we could set Tamworth up not just as a referral hospital but more as a bigger medical centre with more services—cath labs are a good example and the operating theatre I spoke about is another example—if we could have those things happening and be budgeted for and obviously supported by Government, I think it would take away a lot of the unhappiness from people further west of us who could get to Tamworth a lot more easily than they'd get to Newcastle.

Mrs HELEN DALTON: A bit more on country, maybe.

RUSSELL WEBB: Yes. I'm on the advisory board for the Westpac helicopter and I watch what's happening with the Westpac helicopter now. The amount of work that we're having to do and the money that we've having to spend—I know some of that is government money—but the amount of money we have to spend with extra flights to try to get people into areas where they can get the health services they need in cases of emergency, it's just gone—the curve is exponential.

Mrs HELEN DALTON: Do you think the community has been cut out of health care? Your say in what's going on has been limited?

RUSSELL WEBB: Very limited. I'm not quite sure how you'd manage this. People like yourselves would be smarter than me in this space, but we need to have some sort of management group of people who actually fully understand and know what's going on in the health system—not people like me, but people who actually understand the health system—to help administer and provide some of that autonomy and decision-making, not only for staff recruitment but in budgeting and the needs and the wants—probably more so the needs, but also some of the wants—of our communities, which are rural and remote communities. Here in Tamworth—we suffer here. I know out west the suffering grows the further you go in terms of lack of services.

Ms FELICITY WILSON: Thank you very much, Mayor, for having us here in Tamworth today and for joining us. I know you have had a very long period of service on local government. I understand you would have seen amalgamations not just in the health district but also in local government itself. You have a lot of experience in the way administration works in ensuring local voices are heard and reflected. We heard evidence, prior to you joining us, from other people from within the east of this region—around Tamworth, Armidale and Gunnedah—opposing the splitting of the health district.

A significant part of that conversation is around access to the higher level of services in John Hunter Hospital, for instance, and those pathways to ensure that you're getting a GP specialist through to the level of hospital care required et cetera. You said in your submission that you're seeing far too many local patients that have to be sent to John Hunter. You've said to us today that there is too much reliance on locums and that more services should be provided locally. How would you actually go about providing those services closer to home rather than requiring them to be delivered in other parts of New South Wales or even in Queensland?

RUSSELL WEBB: We all know there is a struggle to get people in the medical profession to go bush. That's a struggle, and we all suffer from that. I think we've got to try and encourage—it might be through better remuneration packages that we encourage people to come to the bush, in particular GPs. I know there is a lot of nurses starting to come here. They're Indians. They go to England, they get trained, and they come to Australia and go to various locations. I know from up here at our hospital that we're starting to get quite a few of them flow through the system, but it's about retaining them as well.

Wherever you try and grow a service—and I think that if we can grow a service here, it's very good—we need to be able to grow those service levels in community where there is actually the liveability options that doctors, nurses and other medical professionals want for their families. You're not going to bring people at that level to a city if there is not liveability within that city. That is really important to people that I've spoken to. It's about getting jobs for their partners and all of that sort of stuff as well. I think that's really important.

We need to be making sure that what we're doing is creating opportunity in the system. In many cases, particularly with some doctors—we need young doctors coming into the system. They can live a very easy life in Sydney and earn plenty of money, but they need to come to the bush and probably earn a bit more money. They will probably work a bit harder, but they're earning more money. It's an attraction to them to come further west of the great divide and get involved in their job and working, and then they form part of the community. I think that is very important.

I know from our private hospital here—I've got a few friends that are involved with the private hospital here. What brought them here was obviously the opportunity to do what they're doing and make a little bit of extra money. Once they got involved in that private system, they then tried to reach out and get involved in the public system and do work in the public system, but the resources aren't there to support what they want to do. They get involved in the community themselves, and all of a sudden there is an attraction for them to stay here.

When we bring people into the system, they need to have enough funds to make it worth their while. Once you get them into the system and get them into country areas, if they adapt to those country areas—not everybody is going to want to live in the bush. Some people want to live on the beach. If you can get those people where there's a little inkling that they might like the bush, and if you get them out there and they get a feel for the quality of life in country areas and you can keep them there, that will help us overcome some of those issues. That is in Queensland, and that is everywhere.

Ms FELICITY WILSON: The tree change. You're speaking in particular about Tamworth, obviously. It's your community and your area of expertise. You also reflected that the further west you go, there are higher levels of chronic illness and even less access to healthcare services than there is in Tamworth. You were referring to one of our colleagues earlier, whom I was with on Monday in Moree. I've also spoken to your local member here, the member for Tamworth. His reflection was that we've never seen health staff shortages this significant in the north-west, relative to the population that you've got here. It's an issue that you're experiencing in Tamworth, not just the further west you go across the health district.

You talk about ideas about how to attract and retain healthcare workers, but that is a national challenge we face. It's a global challenge in attracting and retaining healthcare workers. Are there other ways administratively that the district could better operate to better utilise the resources that you've got? We talk about things like the number of locums that are being utilised or the way in which GPs are utilised in different country towns. If we can't access all these extra human resources, can you think of other ways that the administration could be operated to better deliver the outcomes that the community here needs?

RUSSELL WEBB: I think the provision of accommodation is a big problem at the moment. I don't care where you go in this great nation of ours, accommodation is an issue. If you come to Tamworth tomorrow, our rental vacancy rate for houses is 1.2 per cent. It needs to be 3 per cent to be sustainable. Wagga, for example, is 0.8 per cent, so it's even less than us. That's one of the things. We've got to create an environment where the health system may be able to support aspiring young medical professionals to come to a centre like Tamworth, Armidale, Moree or wherever it might be, and where there's support to get into some housing, whether you buy houses or the health service rents some properties and has them available for people when they first come to an area. I don't know whether that's going to work or not. I know it's a tough one. If you have a look at the figures, and those figures are from yesterday—the 1.2 per cent vacancy rate in our housing market—it makes it very difficult.

The one thing that is happening in country areas is that populations are growing. Of course, the renewable energy industry is coming to many parts of country New South Wales. Let's not talk about what's happening with them and the impact on the communities, but one of the impacts is that they're going to take up housing into the future. For the medical system to work properly into the future, you really do need to seriously consider it. If we're going to get betterment in our system, we're going to have to get betterment in our housing supply for medical people that might be coming to Tamworth. I know that nurses really struggle. They like to live up there near the

hospital. Many of them that come in don't have motor vehicles, so they like to live up in that part of town. They tell me that, because I've been around to talk to them. They're issues that they face. They're issues that we face as a community, because we want our health system to work better. Really, the inquiry needs to know that stuff. It's not just about what the system can provide in itself; it's about what you can provide outside of the medical hub.

Ms FELICITY WILSON: With the district based in Newcastle—

The CHAIR: Sorry, Felicity, we've got to move on.

Ms DONNA DAVIS: I've got a question about housing. We heard yesterday that in centres like Wee Waa they have housing; they just don't have the staff to put in that housing. Their council has been quite involved in supporting that housing. Is that something that Tamworth has a history of being involved in or do you tend to be more advocacy?

RUSSELL WEBB: We've actually looked at that in some of our outlying areas within our LGA—in places like Barraba and Manilla—but not in Tamworth itself. We don't see that as our responsibility. What we do see as our responsibility is encouraging investment and developers to come here and build. There's plenty of that happening, but as much of it that is happening, we are still seeing a shortfall. What we're seeing here in Tamworth now is a massive boom in economic development. We've got private money being spent on a particular facility just down the road—$1.3 billion. They're bringing thousands of workers to Tamworth over the next couple of years. The housing development industry is going to have to try to catch up with that. As a council, we don't have the funds, firstly, to do that. We are working with Crown Lands, we are working with Landcom and we are working with the Government to try and create opportunities for housing for essential workers, but a lot of that will be funded through the Federal Government. But I don't believe it's a local government's responsibility to fund housing. We have too many other things to do—fix potholes.

Ms DONNA DAVIS: That's fair enough. I'm a former mayor, so I know the challenges. But that was very good to hear about the work that you're doing with the State Government to identify sites. Has there been any, like you said, for essential workers? I would assume in that you're referring not just to police and paramedics. You're talking to health as well.

RUSSELL WEBB: I'm referring to the health system. We're actually working with the Government at the moment with stuff up near the hospital.

Ms LIZA BUTLER: Thank you for joining us today. I just want to bring it back a little bit because this Committee is looking at the splitting of the health district, whether it's a good idea or a bad idea. Your submission says that while you support the intent, you're not sure if it will actually work. There is also only one bucket of money, so we would be splitting that bucket of money. What things do you think could be done, without splitting the health district, to make the services better here for all the hospitals to work better?

RUSSELL WEBB: First off, probably nine or 12 months ago if you'd asked me, I would've said, "Split it. It's got to be split. It's a dog's breakfast." But after I've been around and talked to so many people in the community, especially those that know a lot more than I do about the medical operation of the whole thing, it has become very apparent that splitting it up is not affordable and it's not practicable. We need to have a relationship with Newcastle. I know that a lot of our patients and the doctors talk between the two hospitals here and other hospitals with Newcastle when they have specialist stuff happening. It's a pretty good system that way.

But what we don't have is we don't have a big enough budget, we don't have enough autonomy in our region to manage our own areas, so really we need that autonomy. As far as splitting it up, I would be only guessing but there would be many, many millions of dollars to create an administration arm that would have to administrate the new health—well, going back to the old way. We can't afford that. I'd rather see that money spent on the health system and then health provision, rather than trying to create another administrative body that's not really going to achieve what we want.

Ms LIZA BUTLER: Do you think that if they put some kind of board where they have more of a say for this side of the Great Dividing Range on their health services—

RUSSELL WEBB: Absolutely.

Ms LIZA BUTLER: —and left it as one large health district, that would be the way forward?

RUSSELL WEBB: In my notes I have here, it's exactly about creating a sort of board type of arrangement where the people up here have the autonomy to make the decisions on staff recruitment and budgeting and their needs, and it all comes together then at some place. We cannot afford to spend money on more administration when we need to spend it on health. We're not spending enough on health out here in the bush now. Let's not create a situation where it's going to be worse. It would take us at least 10 years, in my humble opinion—

and I'm not a medico in any way, shape or form—to get it back to where it would even be looking like it is now, which is not working, if we went into two separate groups.

Ms LIZA BUTLER: Thank you. I think our work here is done.

The CHAIR: The Hunter New England Health submission suggests that the cost of setting up a new layer of administration would be in the vicinity of $111 million, so that would be money taken away from the front end. Even if that number is way overblown by 300 per cent, then it would still be a number suggesting that somewhere around $25 million or $30 million would be required to set up that line of administration. I know your answer because I just heard it. That money can be spent on the administration level or on the frontline service.

RUSSELL WEBB: And that's where it needs to be spent.

The CHAIR: Yes. Can I just clarify something that's in your submission compared to something you said? I'm sorry, if you don't want to answer it because I'm putting you on the spot, that's okay. The start of the submission from council at the moment states:

> Council supports the intent—

to divide—

> … which would divide the current health district …

Is that not your personal view?

RUSSELL WEBB: Yes, it is. It supports the intent of what I was trying to achieve. But if you read through the rest of the submission that I've written, it starts talking about the reasons why we can't probably achieve that by a split. That was written, I think, maybe back in April.

The CHAIR: I was going to ask that.

RUSSELL WEBB: Since then, I've done a lot of work with a lot of people around the local government area and further afield. Whilst I still support the intent of the motion that we might think about that, it's not just thinking about the split; it's thinking about what's a better outcome for our health district. And the better outcome for our health district is better services and more funding, and more autonomy. More autonomy will only come from what we just spoke about, and that is the creation of a governing body west of the Great Dividing Range that can actually have input into how the budget works, how the recruitment processes work and what needs to be done, rather than what it is now.

I know this is a little bit off track, but I sat in front of some senior medical people from Hunter New England Health about two years ago, arguing the case for more palliative care, not here in Tamworth but west of us, because people came to me and asked me would I bat for them. And all the people were interested in was—I'm not going to say who they were, but they were just worried that I might go to the media and say what they said. I said, "I'm not interested in that. I just want a better outcome." We were 17 positions short. They're the sort of things we can adopt, we can fix up a little bit. We're not going to get the 100 per cent fix, but we can fix them up a bit and make it better for those rural communities and remote communities, if we have more autonomy. So, yes, I agree with what I said there and I still agree with it, but it's actually brought it to a head, and I think that's a good thing.

The CHAIR: In its submission, Hunter New England Health acknowledges, openly, that it has 3,000 vacant positions at the moment across its workforce. Obviously, that rolls out in every single medical facility. I just clarify, the bill that's before the Parliament is not what we call a "money bill". There's no money attached to the bill. It's just the same amount of money split differently. This is not a money bill. For clarity, that's worth noting, I think. There is no extra money with this bill. It's the same budget, which makes it difficult, then, to achieve some of the things that I think you'd like to see and spoke about earlier. Do you have a local health advisory committee in Tamworth?

RUSSELL WEBB: Did we have?

The CHAIR: Do you currently have one?

RUSSELL WEBB: No, not that I'm aware of.

The CHAIR: Do you know when that might have stopped meeting?

RUSSELL WEBB: Quite some years ago, from my understanding. I can't give you a date on that; I don't know.

The CHAIR: That's fine.

RUSSELL WEBB: But what I think is, the outcome of whatever happens here, then there'll have to be conversations at the next forward estimates, so there can be money in the budget. I take on board what you're saying about this is not a money bill. But the outcome of this will actually lead to, I think, some conversation in forward estimates about what money is needed to actually help. So if the outcome of this bill is that we have to deal with what I'm talking about, then that's where that conversation will end up going, hopefully.

The CHAIR: I was going to ask about a "cath lab". You used that phrase earlier. I'm not sure what that is. Can you help me, please?

RUSSELL WEBB: If you have a heart attack and you want to get some stuff done, then you step into the cath lab and they put stents in or do whatever they do. I'm not a doctor. We don't have a 24/7 in Tamworth—we do in Orange, we do in Lismore, we do in Wagga, but we don't in Tamworth. But we do in Maitland, Mater and Newcastle.

The CHAIR: Thank you. I was just seeking some clarity around that.

Ms DONNA DAVIS: I wanted to ask about the Hunter New England Health board. We were advised yesterday, and by one gentleman here today, that there are two board members who reside outside of the Newcastle area. Do you think that there should be more representation from this part of the district and would that, potentially, better support the needs of this part of the district?

RUSSELL WEBB: There needs to be. We can't do it on numbers because I think probably two-thirds of the numbers are around Newcastle, Maitland, the central Cessnock area. That's where the population is. We're probably a lot less in population up here. We might be only a couple of hundred thousand in terms of population, where we're talking. So you can't build a board on the numbers. It won't work, because you'll always have more numbers south of you. But it's about having representation and I think the representation is in the form of a board or an advisory group that actually does have some autonomy, and if you don't have that autonomy then you're wasting your time.

The CHAIR: Councillor Webb, are you aware that one of the executive for Hunter New England Health is based here in Tamworth?

RUSSELL WEBB: I am aware.

The CHAIR: Do you have the chance to meet with her to represent the people that you represent?

RUSSELL WEBB: I have done in the past, yes.

The CHAIR: Is that a new position?

RUSSELL WEBB: The lady you're talking about, I think she's been in that job for a while—she's been doing that gig.

The CHAIR: And based up here?

RUSSELL WEBB: Yes. But it's a bit hard, one against 10 or whatever it is.

The CHAIR: There's no doubt about that.

RUSSELL WEBB: I'm not—you know what I mean.

Ms TRISH DOYLE: Mr Mayor, just on a point of clarification—because you've made so many excellent points and articulated very well indeed the concerns of your community and some great suggestions—our Chair asked you about the initial statement in your submission from council about supporting the intent. Would it be fair to say, for clarification, that you understand the intent of the bill but would rather there be very practical steps taken as a result of the inquiry and those recommendations heard by the powers that be?

RUSSELL WEBB: Couldn't have put it better myself. That's perfect. That's what it's about. We want a good outcome. Splitting it up is not going to be a good outcome. I had about 20 million bucks in my head for administration, so I was a long way off.

The CHAIR: Who knows?

Ms TRISH DOYLE: Who knows, yes.

RUSSELL WEBB: But I think what you've said is exactly how we feel. And it's not just me. I'm talking about my councillors and myself. And my wider community is feeling the same way. The medical profession in general feels that way.

Ms FELICITY WILSON: Tamworth has probably the best medical services in the north west, compared to the rest of this district, and you're still telling us it's not good enough or lived experience on the ground is not good enough for your community. You're saying to us as well that splitting the health district probably won't fix that. You're also saying to us that your expectation is, coming out of this Committee inquiry, that something will be done to fix the medical services in Tamworth and further west and north. That isn't the intention of this Committee inquiry. This inquiry is looking at this piece of legislation.

My concern is that, if this inquiry is looking just at the splitting of a health district but we have entire communities that have come to us with a range of problems and concerns that they need to be solved, there is no solution being put on the table. You're talking about additional funding, for instance, and that is not something that is being proposed. If there is no alternative except splitting the health district, do you then support splitting the health district if no-one else is coming up with another option, because at the moment there is no other option that has been put on the table except this proposal—no more money, no more resources, no more focus on services, devolving more services to Tamworth, for instance, or further out in the region?

RUSSELL WEBB: The bill will go before Parliament. It'll do its first reading. I don't know, has it done the second and third reading yet?

The CHAIR: Just the second. It's been introduced, had its second reading and then been sent off to us.

RUSSELL WEBB: I think what I'd love to think that the Committee takes away from this—because that's what you're here for, and that is if it doesn't make it through the Parliament, which it probably won't. That's my take, that's just my opinion—

Ms FELICITY WILSON: A learned opinion.

RUSSELL WEBB: But what I think this Committee has got to take back to Parliament, then, is "Hang on, if that's not going to happen we need solutions to get better outcomes." If this doesn't get up, this isn't the end of the road. We need to talk about better solutions. Those solutions are on the table and I think the answers to those solutions are somewhat in the conversations that you'll probably hear across the table over the next day or two, and you'll hear from me in particular, as to what I think. I'm no expert on this, but I just hear what other people are saying, I hear what the medical professionals are saying.

In particular, I've seen what happened when the amalgamation took place and there was that constant decline from there to now. We can't let that continue, otherwise we'll end up in a bigger mess than we're in now. So I think the Government actually have to bite the bullet after this bill gets voted on into the future, and then you make some decisions from there. Maybe there's another group that comes to us and says, "Well, let's talk to the medical professionals", and whoever you want to talk to outside of the Hunter—but out in the west, to try and work out what some of those best solutions are. Because you're going to have to implement some solutions.

The CHAIR: One of the very best and free things we've heard is communication can be improved. That costs nothing, but clearly it's not happening well enough at the moment. They're the types of things that we are garnering from these conversations.

RUSSELL WEBB: Communication is always the first step in the direction of trying to solve some problems, because out of communication sometimes comes out of the blue you'll get some responses with some potential solutions that can be considered and move to try and get you a better outcome. But I hear what's been said. I know this is not about finding the solutions; it's just about the break-up. But I think once that discussion's finished you can't just let this one go. Please don't let it go.

The CHAIR: Thank you for appearing before us today, Mayor Webb. You will be provided with a copy of the transcript of your evidence for any corrections. The Committee staff will also email to you any questions that we as a Committee may develop in the coming days to forward off to you. We would appreciate you responding to those. That concludes our public hearing today here in Tamworth. I would again like to thank the witnesses who appeared today. I would also, of course, like to thank my Committee members, as well as Hansard, the Committee staff, and the audio-visual team. Thank you all so much. Thanks for hosting us here in Tamworth today.

(The witness withdrew.)

The Committee adjourned at 11:00.