REPORT ON PROCEEDINGS BEFORE

LEGISLATIVE ASSEMBLY COMMITTEE ON COMMUNITY SERVICES

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

At Preston Stanley Room, Parliament House, Sydney, on Wednesday 20 August 2025

The Committee met at 9:00.

PRESENT

Mr Clayton Barr (Chair)

Ms Liza Butler
Ms Donna Davis
Mrs Tanya Thompson

PRESENT VIA VIDEOCONFERENCE

Mrs Helen Dalton
Ms Trish Doyle (Deputy Chair)

The CHAIR: Before we start, I would like to acknowledge the Gadigal people, who are the traditional custodians of the land we are meeting on here at Parliament. I pay my respects to Elders, past and present, of the Eora nation, and extend that respect to other Aboriginal and Torres Strait Islander people who are present here or watching proceedings online, and to all those peoples that we represent as members of this Parliament. Welcome to the third hearing for the Committee on Community Services inquiry into the Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025.

I am Clayton Barr, Committee Chair. I am joined by my colleagues Ms Liza Butler, the member for South Coast; Ms Donna Davis, the member for Parramatta; and Mrs Tanya Thompson, the member for Myall Lakes. Online, we have our Deputy Chair, Ms Trish Doyle, the member for Blue Mountains; and we also have Mrs Helen Dalton, the member for Murray. Welcome to everyone attending the hearing in the public gallery and online. We respectfully ask everyone in the gallery keep mobile phones on silent and refrain from talking during the hearing as this can interrupt. Members of the public are not permitted to film or photograph. We thank the witnesses appearing before us today and the many stakeholders who have made submissions.

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

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

The CHAIR: I welcome you both. Thank you for appearing before the Committee today. Before we start, do you have any questions about the hearing process?

ELYSE CAIN: No.

BEN McALPINE: No.

The CHAIR: You've done all this before. Would one of you like to make a short, two-minute opening statement to kick us off before we start questions?

BEN McALPINE: Good morning. I would also like to start by acknowledging the traditional custodians of the land on which we're meeting today, the Gadigal people, and pay respect to their Elders, past and present, and acknowledge any First Nations people in the room or online. My name is Ben McAlpine. I'm the director of policy and advocacy at the NSW Council of Social Service. With me is Elyse Cain, policy lead for health at NCOSS. We are here on behalf of our 400 members and the many local organisations who work every day for better health and wellbeing in New South Wales.

Communities in the Hunter New England region are facing real challenges. Compared to the state average, poverty rates are higher and more people are living with chronic illness. Of those people living below the poverty line in this region, half cannot afford to pay for medication or to travel to get the health care that they need. Many people simply cannot access a GP when they need to, so these are real and urgent problems. To address these, the Government should prioritise two issues: first, making it easier to access health care and, secondly, improving service planning and resource allocation. Our most important recommendation is to collaboratively plan services with communities so that funding goes where it is most needed. This is especially important for those with lived experience of disadvantage and for First Nations communities. Splitting the LHD may contribute to addressing these issues, but NCOSS believes that prioritising more direct solutions to these practical issues will more efficiently and quickly improve health outcomes for everyone across the region. Thank you, and we look forward to your questions.

The CHAIR: Thank you all so much. I just want to flag with you that, obviously, we have limited time together. We have six Committee members who will want to ask questions. We're on a pretty strict time limit of about five minutes each, so we're going to try to make our questions short. We'd appreciate if you could keep your answers fairly brief as well. That would be greatly appreciated.

Ms TRISH DOYLE: Welcome, Ben and Elyse. Thank you for stepping in and sharing some of your views on behalf of your members—it's much appreciated—and for all the work that you do across the state looking after a lot of vulnerable people. I just wanted to ask you to expand on a statement that you made in your submission, which was that a structural reorganisation of the local health district may lead to better outcomes. Can you expand on that view for us all, please?

BEN McALPINE: Of course. What we're acknowledging there is that there is clearly concern within the sector and community that there are gaps in the health system. Like we said more broadly in our submission, there are real issues around access to health care. Some of those solutions that we put forward would be around transportation, workforce strategy and the like. If we step back and think about what is the problem that we're

trying to solve, splitting the LHD so that government and their agencies are more deeply embedded in the community and have closer connections to local communities, particularly across a broad geographic area, could lead to solving some of those issues. So that's what we're acknowledging: structural reorganisation may be the right contributor. Our concerns, though, are that the process to do that, both in terms of the disruption and any ongoing cost, may (a) undermine some of those outcomes and (b) there may be more efficient and effective ways to achieve them.

Ms TRISH DOYLE: Excellent. Did you want to add anything to that, Elyse?

ELYSE CAIN: Just echoing what Ben said, I think the concern is around—the process to get to a splitting of the LHD would incur quite significant administrative costs and complexities that, in the short term, we feel could be better used to prioritise funding for immediate needs across the region.

Mrs HELEN DALTON: It's interesting. You're talking about a structural reorganisation and not, perhaps, reallocating those funds for that. But I think people in Hunter New England could scream and yell all they like; no-one's going to reallocate those funds. If there's a toss-up between structural reorganisation or putting those funds into health care, how can we push the Government or push the health district to do that? It's plain and clear that people out around Wee Waa and Narrabri are not getting the services that they deserve, and this is what it has come to—to have this inquiry. We can talk all we like, but what is the way that we can do it and how can we make the health district reallocate some of those funds from, say, Newcastle back out west?

BEN McALPINE: I think that's a really important point because the fact that we've reached this point is a clear indication of the fears and concerns and frustrations of the local community. To your question of how we would shift that funding or what we need to do, there's two layers to that. One is that that is a decision for government to be able to invest more funding. There are probably two things that I would be drawing our attention to. One is that co-design of planning and service delivery with local communities alongside a more rigorous, data-driven assessment of needs.

What we see across the state and we hear a lot from our members is that they can see the immense need in a particular area, but the service is lacking, either because the costs are too high or because the funding has been moved to other areas, or whatever it may be. But there is that clear disconnect between where the need is the greatest and where the funding is being allocated. And so, better use of data around that needs-based funding that is taking a transparent and evidence-based approach would be really important, and then doing far more across the region—but this goes across the entire state as well—to be co-designing that planning and service delivery with the local communities.

The other layer to this—I know I said two, and I'm now cheating a little bit by adding a third—is how do we shift more funding and focus to prevention and early intervention away from acute services? I would note that the Productivity Commission released a report last Thursday that included a recommendation to establish a national prevention investment fund designed to overcome the structural barriers that exist in state and territory governments, and indeed the Federal Government as well, that prevent governments from shifting that funding further up the chain. I think that's the type of solution that we should be considering in this State, to figure out is that a way to be changing that environment.

Mrs HELEN DALTON: Thanks for your answer. I think that should be part of their remit anyway. I also feel that those closest to the problem are the ones that can provide the solutions. That's just a comment.

Mrs TANYA THOMPSON: Thank you for coming along today. Can I make one brief comment in relation to that conversation we just had. Noting the executive that we currently have for Hunter New England is so huge, when we speak about structural changes and the costs involved, if you were to split it in half, I think it would be much of a muchness as it is now anyway. I don't think that that costing would really be a factor because you would have two executives in two different regions. I think it would probably zero out to a degree because it is so heavy, the administration within Hunter New England. It's insanely big. There's room to look into that and trim some excess and allocate that into better pathways. Noting that your organisation covers the whole of New South Wales and many different health districts, is there anything about the Hunter New England health district that stands out to your organisation, compared to other districts?

BEN McALPINE: If we look at some of the key statistics of that local region, which are worth calling out, poverty rates in that area are higher than the state average. I think that what's important, particularly in regional New South Wales, is understanding that, while there are higher rates, there are also particular pockets of deeper disadvantage. In Newcastle in Cooks Hill there are one in four people living below the poverty line—25 per cent. Taree—which I know is close to your heart—is 23 per cent. Tenterfield is 21 per cent. There are higher levels of poverty across the region compared to the state average. That also includes the child poverty rate, where one in five kids in the region live in poverty, compared to 15 per cent, which is around one in six.

Drawing on some of our research on patient experience and cost of living, six in 10 people in the region live with a long-term health condition, which is higher than the one in two across the New South Wales average. One of the more disturbing statistics in the analysis that we did last year on the patient experience project was that more than one in three people in the region visited an ED because their GP wasn't available. That was still 23 per cent—one in four across the State—which is obviously a problem that we have to grapple with more broadly. The fact that 37 per cent of people are visiting an ED because their GP wasn't available really goes to highlighting the depth of the health challenges in this region.

ELYSE CAIN: That's over one in three people visiting the ED because their GP wasn't available. That is the highest of all regions in New South Wales. It is certainly worse in the Hunter New England area. It's also worth noting, it wasn't in our submission, but the Hunter New England area is an area that is obviously affected by a lot of the climate disasters and emergency situations that are happening. The long-term health impacts from those emergency situations are unique to the Hunter New England area, so we do need to take that into account.

Ms DONNA DAVIS: One of the things that we heard a lot about last week, particularly regarding Wee Waa but not only Wee Waa, was this challenge with transportation. While we know that there are systems in place for community transport, it's that after-hours transport, that reliance on relatives and friends—we know that it's just not realistic for a lot of people, so they don't get the health care they need when they need it. In your submission, there's a recommendation of an immediate expansion of the Isolated Patients Travel and Accommodation Assistance Scheme and community transport options. Can you elaborate on the current scheme and what you have noticed regarding the availability of community transport options? Did you look at how that could be expanded out to service people over weekend periods and after business hours?

ELYSE CAIN: To your second question around how we might be able to expand those community transport options to after hours and weekend, that's not something that we have looked at, and we would refer to our colleagues at the CTO, which is the community transport peak organisation. As I understand, they have a range of policy positions and recommendations specifically in that space. With specific regard to the Isolated Patients Travel and Accommodation Assistance Scheme, our understanding of the scheme at the moment is that, while community transport is an eligible service within that scheme, it's only eligible if the community transport provider does not already receive government funding. For community transport providers that is usually Transport for NSW—their community transport program—or it's through the Commonwealth home care package funding.

In effect what that means is that, for a lot of people living in areas where they don't have private transport available, there are no public transport options and community transport is their only option; they're not able to access the IPTAAS scheme for the majority of those community transport providers because they are already receiving government funding. That is supposed to be able to keep costs down for patients and consumers, but the operational costs of the community transport sector and the community services sector in general are such that the costs are blowing out to a point now where the out-of-pocket costs that are having to be transferred onto patients and consumers are extremely high, so patients and consumers are out of pocket to be able to travel to health services. Removing that feature or that eligibility restriction within IPTAAS would mean that a significant number of people would be able to receive further financial support to travel to the vital health care that they need.

BEN McALPINE: On IPTAAS, I would note that this has been noted for a number of years that this scheme needs to be reviewed, and the New South Wales Select Committee on Remote, Rural and Regional Health inquiry supported this. It is clearly a problem that does need to be addressed. Without going too far, this also links in with gaps in service delivery. It also raises a role of where maybe digital health and virtual care can help plug the gap in certain regards, but it should never replace high-quality in-person support, which is why transport options are so important.

Ms LIZA BUTLER: Thank you for joining us; it's nice to see you again. You spoke about services being easier to access and that's locally, but when things get worse for a patient and they need to travel to higher level care, we heard last week that the referral process could be a detriment if we split the health system because they go to the bottom of the list. Could you provide any comments around that, when we think of splitting the health district?

BEN McALPINE: I'm not sure that I'm the right person to discuss the referral process, but it does flag something that was also, I think, in the AH&MRC submission around concerns. When we talk about referral pathways—and I know that you're aware of this—you're not just putting a name into a system and then it's happening. These are based on relationships and knowledge and local capability. One of the concerns or—to put it more positively—one of the challenges that would need to be overcome if we were to go ahead with a split is to ensure that those referral pathways are not disjointed and broken. Particularly for those Aboriginal and Torres Strait Islander communities, that trust, that knowledge of who you are referring people to, is so incredibly

important that any changes in that seemingly simple administrative element could really undermine access for those communities.

ELYSE CAIN: I will add that we're not just talking about clinical formal referral pathways; we're also talking about informal referral pathways, where a person of the community who is experiencing complex disadvantage and perhaps doesn't access a healthcare service very often is more likely to go down the road to their neighbourhood centre. That's a soft entry point, to speak to the staff there about their issues, and the staff will refer them on to a healthcare service or further down the line if they need more acute care. It's those service pathways but those kind of trusted relationships and informal networks that we are concerned would be disrupted if we're splitting the LHD into two.

The CHAIR: I want to go back to travel just for a second and the conversation about IPTAAS. My understanding is there were changes to the IPTAAS about two years ago, even the form and process. Have you recognised and acknowledged that? Ben, you made the point that this has been spoken about every time there's a health inquiry since forever. Have the recent changes made things better? Is there still work to do?

ELYSE CAIN: We absolutely acknowledge that there was a review of IPTAAS a couple of years ago, that there have been changes made and those changes have been positive. We've heard particularly from our members at the Cancer Council that that has been working well for the people they support in the community. The remaining issue around community transport eligibility did not get addressed or improved through that most recent IPTAAS review process but is still creating a very real barrier for people out in the regions to be able to use that scheme effectively for community transport options.

The CHAIR: In your submission, you talk about poverty rates, and I thank you for that. I'm not exactly sure on the methodology for how you get these data, but I want to acknowledge that in your submission we would be talking about Tenterfield, Inverell and Glen Innes, who are all in the New England part of Hunter New England Health. You might want to take this on notice. Do you have further breakdowns of some of the higher rates of poverty from a New England versus Hunter perspective? The bill is proposing the split. Where would the greatest poverty sit if a split were to exist? Do you have that on hand, or would you take that on notice and perhaps get some more detail back to us?

BEN McALPINE: I'll take it on notice. I do have some of these, but my confidence of knowing where that line will be drawn is certainly murky.

The CHAIR: Sure. I guess that's something about the bill. We haven't actually clarified exactly where the line would be drawn. I also note in here, obviously, Taree and Foster. I'm not sure if New England was split from the Hunter, where does that leave that Mid North Coast area? This isn't clear either.

BEN McALPINE: I'm happy to provide further information on that for sure.

The CHAIR: In NCOSS's experience, do poorer health outcomes tend to follow poverty?

BEN McALPINE: There is certainly a connection between poverty and poorer health outcomes. One of the pieces that we did recently was assessing the economic cost of child poverty. Across the lifespan on health, just in New South Wales, on an annual basis, the estimate was over $5 billion a year. The overall cost of child poverty on an annual basis in New South Wales was $60 billion. The vast majority of that was related to education and therefore employment outcomes. There is absolutely a clear link between living in poverty and poorer health outcomes.

The CHAIR: In a similar vein, does poverty, or lower socio-economics, tend to find itself in regional communities as opposed to metro?

BEN McALPINE: No, the overall rates of poverty between metro and rural, regional and remote are very similar. I believe the rates are 13.7 versus 13.2. It's not a massive difference. The way that it appears, though, is different. Typically across regional New South Wales, it is more widespread—you are less likely to have those pockets of real depth—although in the Northern Rivers and towards the Far Western area, there are deeper pockets of poverty disadvantage. But, as a general rule, it is more evenly spread. In Sydney, you've got that greater divide between the south-west and western parts of Sydney and the eastern and northern. You will have far higher rates in areas like Fairfield as opposed to the eastern suburbs. While the average rate of poverty looks very similar in metro or regional, regional is more evenly spread, whereas in Greater Sydney, it's much more concentrated in certain areas.

The CHAIR: It might sound like a strange line of questioning, and I appreciate that, but I'm just trying to think about, if there was a line drawn, would that concentrate poverty into one area more so than it currently is as an average across that entire area?

BEN McALPINE: We're keen to provide that. I think it's a really interesting question.

ELYSE CAIN: Just to add to that as well, our research around patient experience did show that people's reporting of their experience as a patient is certainly worse in regional areas. That includes a measure where we looked at people who were saying that they couldn't afford to either access a GP, a specialist or a dentist. While poverty might look consistent across the State, people's ability to afford health care is still being affected far more in regional areas than in metro areas.

The CHAIR: NCOSS only has one office. Is that correct?

ELYSE CAIN: Yes.

The CHAIR: Why do you not have offices right across the state?

BEN McALPINE: If we had more funding, we would have offices across the state for sure.

ELYSE CAIN: We would love to have more offices across the state.

BEN McALPINE: Genuinely, it would make a big difference to our ability to support and advocate for the community if we had greater physical presence across the State.

The CHAIR: Let's say you're a little quasi Hunter New England Health. What do you do as your organisation to better understand the social issues facing somewhere like a New England, Far West or South Coast? How do you go about getting your mindset out of the city and better understanding what is needed out there?

BEN McALPINE: There are three main things that we would do. One would be where we're doing research, for example, on the patient experience, or very shortly we're about to release some research on oral health, we always make sure that we are taking a really clear lens on regional New South Wales, to make sure that we're focusing on those areas—but then in terms of how we get out and really embed ourselves in the community. The second piece would be we have regular meetings, or forums, online specifically and only for regional members, so we can really target and understand the issues that they're facing. We used to do this a lot before COVID. Now we're ramping up again. We have been running regional forums. We had one in Taree in 2024. We had another one in Wagga earlier this year and in Dubbo at the end of last year.

Over the next nine months, we will be doing one forum in each of the seven DCJ districts. That will be a standard thing that we're rolling out for the foreseeable future. The purpose of that is exactly this issue: How do we make sure that we are hearing from local community members and local organisations to understand the issues but also focus on the unique strengths that already exist in the community that we can bring back to Parliament and departments to demonstrate, "These are the strengths that exist, this is what we need to do to build on them, and these are the gaps that we need to fill together"?

The CHAIR: Does your board or your executive have positions dedicated and allocated to regional representation?

BEN McALPINE: I don't believe it is enforced in the constitution, but I'm very confident that a good proportion of the board—either they live in or work in regional areas or represent organisations that have a presence in regional areas.

Mrs HELEN DALTON: Do you think that a dedicated regional health Minister would help alleviate this terrible health crisis we're facing?

BEN McALPINE: Having a ministerial responsibility on any particular area absolutely should be designed to bring greater focus and attention. So, yes, the logic is sound. Whether or not that would be something that NCOSS would recommend, I'm not confident.

Ms DONNA DAVIS: I note that you have referred to virtual care options in your report. Going back to Wee Waa and Narrabri last week, witnesses stated that there were mixed feelings but there was quite a lot of positive about virtual care, particularly in terms of second or third follow-up appointments. There was concern about that option for that first diagnosis. But there was also grave concern about the quality of that virtual care, particularly at Wee Waa hospital. You could hardly even see that there was a person on the screen. I'm sure that's repeated across the health district, particularly in those more remote and regional areas. Can you please expand on your comments and the impact of telehealth services on those communities and any suggestions for what can be done?

BEN McALPINE: The research that we performed—I think it might have been in 2023—that looked at this in detail highlighted a few really critical pieces. One was—and it reflects what you've clearly heard—that people, particularly across regional New South Wales, really valued the option of having virtual care. But two

things were really important. One was that it was important to them that it was seen as a choice, not "This is all you get." The second piece, which is obviously linked with that, is that it should not be seen by government as the solution to the gaps in health care. So that was those two.

We were trying to really understand the barriers to people being able to utilise virtual care, and there were three key things. One was accessibility. Can you actually have access to the systems that you need? An example was that while maybe you can do some telehealth on a phone or an iPad, what you really need to do to have great quality virtual care is probably go to a place like a community centre that has dedicated, high-quality infrastructure and technology—so the accessibility. Linked to that was affordability. It was particularly an issue, obviously, for people on low incomes. You need to be able to afford the right device, the wi-fi, the electricity costs, all these things.

Ms DONNA DAVIS: Yes. Using your mobile isn't really a great option.

BEN McALPINE: And then the capability—you need to be able to understand the app that you have to download, how to access it, how to log in. You've forgotten your password. All of these things that other people may take for granted are really complicated and are absolutely critical. We made a number of recommendations, which I'm happy to share in detail as supplementary information afterwards around investing in community-based infrastructure, like a community centre.

Ms DONNA DAVIS: Thank you. That would be good.

BEN McALPINE: For those areas that don't have existing government health infrastructure, how can we use existing social infrastructure to provide that portal? Similarly, support for these community organisations that Ms Cain referred to—they know their communities. They understand. They are the trusted access points, so how can we use those to improve issues around accessibility and capability? At the time I believe NSW Health was launching a new virtual care strategy, so we were having really good conversations with the ministry at that time. It's really important that the Government is investing in the right technology. If you're looking at Wee Waa hospital not having the right technology, that will undermine trust in the health system. So we need to be investing in that as well. But I'm happy to provide the detailed recommendations from the report.

Ms DONNA DAVIS: Ms Cain, did you have anything you wanted to add?

ELYSE CAIN: No.

Mrs TANYA THOMPSON: There's been some talk that if we split the health district there would be some problems or challenges around GP and specialist services and the retention and attraction of those in both districts. I just wanted to get your thoughts on those. Do you feel that splitting the health service would create huge challenges in securing GP and specialist services in both districts? Or would it actually improve the possibilities of having GP and specialist services in two different districts? Given the data that was shared earlier about access to GP services locally in regional areas and presenting to ED departments, I just wanted to get your thoughts on that.

BEN McALPINE: I think that question is probably best directed at other witnesses later today, like the AMA. But I would just note—and I think some of our evidence has played into this trap slightly—that this is not a binary choice that we're dealing with. It is not "split or not split". If we were able to design a split of the LHD and its implementation in a way that overcame the concerns that are being raised, then that could be a good step. But I think there is a trap here in policymaking where we see the cost of $111 million and we absolutely argue, "How else could we be allocating that money?" We would be arguing for other immediate investments. But it is not a binary choice, and I just think that's worth noting.

The CHAIR: I think it is for us. This bill is in front of Parliament, and we have to choose to support it or not support it.

BEN McALPINE: For the Committee, I agree.

The CHAIR: But for the community and the service—

BEN McALPINE: In terms of policy settings, I would caution the Government away from thinking about this as a binary choice. What is the problem we're trying to solve? There are multiple paths that we could take. This could be a valuable path, but only if we're able to overcome the challenges.

The CHAIR: One final question from me: Do some of your members, some of your organisations who are a part of the NCOSS umbrella, employ health workers of some description? If that's true, do you hear reports of them struggling to fill certain positions because they just can't attract or find the workforce? It may be that your members don't really employ health workers.

BEN McALPINE: Absolutely, they do. For example, in the mental health space or the drug and alcohol space, there is always a combination of more clinical care as well as community-based support workers and the like. We have consistently heard two things from members, not necessarily in this region exclusively but across the State. One is real challenges in workforce retention overall. There is immense need, and there are ongoing issues around recruiting and retaining a great workforce. Those challenges are compounded when you're talking about regional New South Wales. One of the recommendations we were making was around a workforce strategy. Particularly those health-related workforce that are of a more clinical background, we certainly hear that is a real ongoing issue for members and organisations across the system.

The CHAIR: Thank you for appearing today before us. There are three steps from here. Number one, you will be provided with a copy of the transcript and evidence for any corrections. Number two, we will email you copies of the context of any questions taken on notice, so you don't have to worry about the nature of that question and what was being asked; we'll get that to you. The third thing is that we, as a Committee, may develop additional questions in the coming days that we'd like to send to you on the back of some of the things we've heard from you today. Our sincere appreciation for both the submission and appearing live with us today. We value your input and we very much value the work of NCOSS. Keep doing the good work.

(The witnesses withdrew.)

Dr LOUISE WIGHTMAN, Chair and Senior Project Officer, Maternal Child and Family Health Nurses Australia, affirmed and examined

Ms EMMA HARDY, Professional Officer, NSW Nurses and Midwives' Association, affirmed and examined

Mr WARREN ISAAC, Member, NSW Nurses and Midwives' Association, before the Committee via videoconference, affirmed and examined

The CHAIR: Before we commence, do any of the witnesses have any questions about the hearing process?

LOUISE WIGHTMAN: No.

The CHAIR: No? Excellent. I will ask both of the organisations if you would like to make a short opening statement before we begin questions.

LOUISE WIGHTMAN: To give context to where we fit in this puzzle, Maternal Child and Family Health Nurses Australia is a national peak body for child and family health nurses in Australia and our focus is on children and families' wellbeing, through our members who are the specialist child and family health nurses who work around. The interest for us is that children and families benefit from whatever health service we provide and to make sure that it is a high-quality health service.

Ms TRISH DOYLE: Thank you to our witnesses, not just for appearing today and speaking to submissions but for your work every day. It's much appreciated. I'm interested in the NMA as the union working for and supporting its members in a range of different geographical areas and local health districts plus members on the ground in this particular health district we're looking at and the Maternal Child and Family Health Nurses Australia. Does the Hunter New England Local Health District consult you all as stakeholders in terms of best practice to address the concerns of maternity and obstetrics patients? If so, how often? I'm interested in your views about being consulted, not just on this particular issue but generally in terms of gaps and issues and health needs.

EMMA HARDY: Yes, we are consulted. Members contact us regularly with staffing concerns. That's one of the major issues within the health district at the moment, and also resource distribution—we are aware there are issues there as well. In terms of maternity, we are very aware at the moment of critical maternity shortages at Tamworth Hospital. If you were to separate the health districts, Tamworth would be the highest ranked hospital within that new local health district, which means that any high-risk patients would be going there. Tamworth Hospital has had incidents where they've had to go on bypass. Patients have had to go to Maitland Hospital or the John Hunter Hospital because of that. That's taking women further away from their homes. It's taking them way outside of where they should be, and it would be moving them to another health district if this split was to occur. We believe that instead of focusing on managerial hierarchy, there should be a focus on addressing the issues at the forefront of health within Hunter New England health at the moment, and that would be staffing and resources, and equal distribution of those.

Ms TRISH DOYLE: Further to that, yes, there's a crisis now and we've heard from a number of different witnesses and read about people's deep concerns in submissions. On a weekly basis, fortnightly basis, how is the local health district now consulting with you?

EMMA HARDY: I might have to take that on notice. Because I am a professional officer I don't deal with the industrial side of things. Any industrial concerns that we are consulted with we would deal with through a different sector, different part of our union. In saying that, I think it's important to note that we are in regular contact with our members who are working on the ground almost daily with issues that are happening within the LHD itself.

Ms TRISH DOYLE: I'm trying to understand about those members. Obviously there is the union perspective representing their members, but those voices and the views of those working on the ground in the healthcare sector in this area and their voices being heard by the local health district. This hasn't just happened. There's been a lead-up period of time—crises and different needs that should be addressed have been a long time coming. I'm trying to ascertain where in the conversation the nurses and midwives' voices are being heard by the local health district, so some feedback on that would be great. I'm not sure whether you have a view on that, Mr Isaac?

WARREN ISAAC: Mostly the consultation that occurs would be through line management like team meetings and they call it "rounding", where senior managers might come from Newcastle to the New England area and meet with staff. Where the issues happen that have come to the attention of local branches of the Nurses and Midwives' Association, that's usually when there's major problems and then a resolution would be sent to management and then there would be a meeting with management and the issues, we would attempt to get addressed.

Ms TRISH DOYLE: Excellent. So there is a pathway to raise those voices? It's not as though you've been shut out at some point in recent times?

WARREN ISAAC: No, we're not shut out.

Mrs HELEN DALTON: Thank you for attending and your submissions. Would allocating more Medicare provider numbers to rural and regional postcodes help to solve the rural health crisis? No-one's been talking about this. I think it should be in the conversation, because if this bill doesn't go through we're going to have to think differently. What's your opinion on this? That's open to all of you.

LOUISE WIGHTMAN: I did mention that in our submission. If you could allocate Medicare provider numbers to the nursing practice—child and family health nurses work for the local health district but often they also work within GP practices as practice nurses. For a client to be able to access their health record check—in New South Wales, it's the blue book—and look at developmental checks, whether they could access it in the GP or at their local health district, that would mean that clients have a free accessible service. The challenge is if your local health district doesn't provide enough appointments for your child and family health nurse to look at those developmental checks and then pick up development and then refer on, parents often will go to the GP, because that's where you get an immunisation if the child and family health nurse doesn't do the immunisation. But what happens then is parents will make a choice: "It's a well-child check, so unless my child is sick, I'm not going to take time off work or be able to afford a GP visit, so I just won't worry about it. I'll wait until they get to school, they'll do the Best Start screening, and then we'll begin from there."

But children aren't born at three or five. These things need to be picked up early in a child's life, if there are going to be developmental challenges, so that the process can begin to help them support that. If nurses were given Medicare-accessible numbers, I think clients would have a better choice. I was listening to the previous speakers talking about equity and access, and I think that's the biggest challenge. When you're asked to go somewhere else to have that check and if there's not a child and family health or it only comes once a week, then—people need choices. Could you have a child and family health nurse in a hub? Could they access Medicare? That, I think, would be a step in the right direction, and not just for nurse practitioners. We're building that nurse practitioner role—that would be a best place to start—and that needs to be accessible in more communities.

Mrs HELEN DALTON: But not only that too. If we can't find a doctor, people go into the emergency department of the hospital, so the State Government picks up the bill, whereas with Medicare the Commonwealth picks up the bill, correct?

LOUISE WIGHTMAN: Yes.

Mrs HELEN DALTON: Exactly. Would any of the others, Ms Hardy or Mr Isaac, like to comment on that notion of what we're talking about?

EMMA HARDY: I think it's very important to build our endorsed midwifery workforce and also our clinical nurse practitioner workforce, and that is through incentives to get them to be able to work to their full scope of practice. I think that's more the answer here. Last week you spoke to one of our members from Gunnedah branch, asking them if they thought that it should go back to hospital-based training. No, we don't think so. That's devaluing all of the skills and education that we've learnt. Nursing and midwifery are two professions that are based on evidence-based practice and the latest contemporary research. Actually putting money into the workforce to get them to be able to work to their full scope of practice and able to prescribe medication in their scope of practice is really important in minimising these gaps and actually filling these gaps so midwives can provide pain relief and things like that, and the clinical nurse practitioner can provide medications as well, for things that people would normally present to the ED for.

The CHAIR: Thank you. Helen, I'm just going to cut it off there. We might get a chance to come back to you. I'm going to go across to Ms Liza Butler, the member for South Coast, for her questions.

Ms LIZA BUTLER: Thank you for joining us today. We've heard that the split would allow for more local decision-making, which would then allow each district to tailor health services with a more targeted approach. Is splitting the health service the only way? What are your views on that?

EMMA HARDY: We are more focused on addressing the issues at hand before we actually consider splitting the health district. For instance, we've got maternity services that are not available to people in Muswellbrook at the moment. These women are having to travel 50 kilometres to birth. If they're having a precipitous labour or it's their third or fourth child, these women are birthing on the side of the road. This is a town where the average age is 37. That's prime childbearing years. They should be able to have a maternity service. There are 17,000 people within that town, and within that town there is also a billion-dollar mining surplus. We should be putting the funds into allowing them to have that birthing service. They've been crying out for that birthing service since 2022. Would splitting it address that? Probably not. I think we need to actually focus on addressing the access issues that we've got currently and putting funding into that, rather than focusing on managerial levels.

Ms LIZA BUTLER: For Muswellbrook, your example, is the additional funding for 53 extra midwives in this year's budget a step in getting those services back for regional areas in the Hunter New England area? It's not the only one. There are many regional hospitals that have had birthing services taken away over the past seven years or more.

EMMA HARDY: It also comes down to GP obstetricians. That is another reason why Muswellbrook cannot open a maternity service. I don't think it comes down to just funding for midwives. I think it comes down to funding the whole health service.

Ms LIZA BUTLER: Is there a midwifery group practice model that is available in that area, where people that don't need those additional services for delivery can travel the extra distance—women whose second, third, no issues—is that a possibility?

EMMA HARDY: All midwifery group practices are still tied to a GP obstetrician so that, if any complications arise, they can then be progressed through to the medical system. You still need that overarching doctor to be there.

The CHAIR: Thank you very much. That's interesting. Ms Donna Davis, the member for Parramatta.

Ms DONNA DAVIS: Thank you for your time today. I refer to your submission. Would splitting the health district improve the opportunity for First Nations women to birth on Country, or are there other strategies that you think would help to achieve this and increase this number?

EMMA HARDY: In terms of birthing on Country, ideally we would like to see more models allowing that. There are currently no birthing on Country models within Hunter New England health at the moment. The only birthing on Country model within the state would be Waminda, which is purely birthing on Country. In terms of AMIHS models and things like that, which is where they have an Aboriginal health worker who works alongside the midwife, yes, there are those within the LHD, and that provides some cultural support, but we would love to see more birthing on Country models. That would be something where we would need to have consultation with Elders within the community and see what they need. I think that is very important for any LHD. We have actually seen that in Western NSW LHD and Far West, where we've had child and family health nurses and Aboriginal health workers contact Elders and they've created amazing engagement between the communities; it has filled so many service gaps. Ideally we would like to see that rolled out across the State.

Ms DONNA DAVIS: Thank you. Dr Wightman?

LOUISE WIGHTMAN: I'm concerned that we're focusing on acute services and we don't seem to be talking about community health services in this space. Child and family health nurses work in that zero to five space, outside of acute health services. My concern with the potential split of the district is: Are you just going to focus on acute health services? Yes, maternity is a vital piece of the puzzle, but what happens when people take their child home? Are you looking at all the services that would be required in terms of child development, paediatricians, child and family health nurses? What about the community health services? Is that going to be withdrawn? My question is, would it actually serve the community health service to have that service split and more focused on that area, rather than having this very long district where decision-making happens a long way away from that space? That's what I'm concerned about. Because in all conversations in health, we forget prevention and early intervention and we just focus on crises and acute services.

Ms DONNA DAVIS: We do have a focus on community health nursing through another hearing that we are on that has sort of been postponed because of the urgency of this. Trust me, we've just been talking about our memories and experiences with the importance of community health nursing, so thank you. It is something that we do appreciate. It's very important.

Mrs TANYA THOMPSON: Thank you for coming along today. This has been really interesting—thank you for your input—so much so that I got lost in it all and lost my train of thought for my question, actually. I note that you spoke about the reallocation of resources fundamental to the improvement overall for the district before nutting out splitting it in its entirety. Where do you feel, at present, the resources are being mainly distributed? Where do you feel they could be funnelled better? I'm interested, for both you, in where your thoughts on that are.

EMMA HARDY: I feel like that's probably a question that Warren can answer a little bit better than I can.

WARREN ISAAC: Overall, the members of the Nurses and Midwives' Association that I speak with believe that the resources are lacking in New England area, and it's always been that way. There were good and bad aspects of the amalgamation with Hunter but, overall, there's a belief that there needs to be more resources coming to the regional area. Overall, the gap is widening for Aboriginal people. Overall, we need more staff. We need to be able to recruit and retain appropriately qualified and experienced people. That's become harder and harder over the last 15 years.

EMMA HARDY: In our submission we also spoke to nurses from Tenterfield. They said that it's easier for them to go across the border to Queensland, just because of the distance from Newcastle. It would be 500-plus kilometres, so we're losing nurses and midwives because of that.

LOUISE WIGHTMAN: What I see from the child and family health perspective is that decisions are being made in the regional city area about programs and what should be rolled out for families. But they don't give consideration to—is there a multitude of staff? Child and family health nurses work collaboratively with allied health staff, GPs and paediatricians in a collaborative fashion. What we see up there is that a lot of the programs that they think should be rolled out in the child development space might work if it's in a metro area, but it certainly doesn't work when you've got to travel hundreds of kilometres. And then, if you can't have enough people, the reliance on virtual services—which for a lot of clients is not okay, and for the clinician it's very hard to see the nuances of the interaction between children and family through a screen. And then it's about connectivity, all of those things.

At the moment, it seems like there's a lot of executive decision-making but not the decision-making through the clinicians, and the clinicians aren't asked their opinion. They're just told, "This is the next program that's coming through," and there isn't a lot of consultation. MCaFHNA used to attend the child health advisory group, but it changed its terms of reference—and that was statewide—to say it was about more operational. So we are excluded from that conversation now because we also ask too many hard questions. So we'd like that rectified, but there's a process.

The CHAIR: Your organisations represent members and membership across the various health districts within New South Wales and, indeed, Dr Wightman, across Australia. Within New South Wales, Dr Wightman, is Hunter New England health doing anything particularly good or particularly bad in comparison to some of the other health districts?

LOUISE WIGHTMAN: I think they're trying to implement transition to practice programs so that child and family health staff who are training to be child and family health nurses can get support to work in the space. The challenge for beyond Tamworth is who's supporting them. You work as a single practitioner out there, so those models that work well in other districts don't necessarily work out there. I guess the challenge in the child and family health space is having senior clinicians to support junior clinicians coming through. While Hunter

New England tries its best, there's only a clinical nurse consultant for the lower and upper Hunter. Beyond that, there's a clinical nurse specialist grade 2 who does the work of a CNC and has a larger district to cover but is not remunerated appropriately. So they are trying, but I guess the lens is always towards the metro regional hosts rather than rural and remote.

The CHAIR: In your experience, if you can, is that different somehow to what happens across the Western Division or the Far Western division or the Murrumbidgee division, which are also large geographical areas?

LOUISE WIGHTMAN: Similar experiences, yes.

The CHAIR: Mr Isaac, if I'm allowed to ask you this question—if I'm not, just tell me I'm not—are you a practising nurse within the Hunter New England Health District?

WARREN ISAAC: Yes, I am.

The CHAIR: Have you worked in other health districts?

WARREN ISAAC: Yes, I have. I've nursed for 43 years. I'm a psychiatric and general trained nurse. I started off in Goulburn then moved to Canberra and then inner Sydney, in the Sydney CBD, on a psychiatric crisis team, and then moved. I've been in the New England area for 29 years.

The CHAIR: My question is to you and Ms Hardy, and it's similar to the question I just asked Dr Wightman. Do you see things happening in the Hunter New England health area that are significantly better or worse than what you are aware of happening in other health districts? I'll start with you, Mr Isaac.

WARREN ISAAC: When I first moved to New England, I found a much smaller service than I'd been used to in Sydney. I've been pleased to see that, over the last 29 years, it's grown into something a bit like what we have in Sydney. It's a much more expansive and extensive mental health service now. I have a lot to do with the emergency department as well, and I touch base with many other clinicians around the health service in other areas. Our view is that it's much more improved. Where it has fallen down, I think it's that some of the good things that were happening when it was just the New England health service weren't adopted by Hunter; in fact they dismantled some of those things.

There was a very good suicide awareness program and education happening, which Hunter eventually dismantled. There was a very good mental health promotion department which ran some really good programs, providing programs to help staff help patients and clients, and also improving community awareness about mental health problems, which was all about early intervention. That was eventually dismantled as well. But the good thing is that we now have a very good bed management program across the whole area. I think our provision of psychiatrists is pretty well organised, even though they come from Sydney, largely. It just seems a lot more coordinated.

But our big struggle is still to recruit and retain appropriately qualified and experienced staff. The number of people that apply for interviews these days is much smaller than what it used to be. Trying to find people who have the qualifications is really, really challenging. So the challenge these days is trying to skill up people who have an interest in mental health and provide on-the-ground education programs. There isn't anything coordinated on a large scale to make sure that these new people coming in end up providing the right service for our clients and patients.

The CHAIR: Thank you. Ms Hardy, do you have a comment about whether or not things are particularly much better or much worse in the Hunter New England health district compared to—if you can, talk specifically about some of those other large regional health districts.

EMMA HARDY: Hunter New England leads the way, we understand, in its climate action and its climate change sustainability mechanisms. We have a number of members who are really quite active within that space, and they say that it is really quite good. In terms of staffing, as Warren said, that's where Hunter New England is falling down at the moment. But, again, these are circumstances that are echoed throughout the State. Again, with resourcing, it's the same thing. Unless you're in the metropolitan areas, we are really struggling to get the equipment that is working and sustainable within nursing and midwifery.

The CHAIR: Equipment?

EMMA HARDY: Equipment, yes. Often there is equipment that is breaking, and then they wait a long time before it is replaced or before an alternative becomes available.

The CHAIR: The significance of that in a regional area compared to a metro area is what?

EMMA HARDY: It can mean the difference between having a service that is operational versus one that is not, depending on what it is.

Mrs TANYA THOMPSON: Can you give us an example?

EMMA HARDY: We've got members who work in a hospital where the X-ray machine was broken and they waited a really long time for it to be fixed, so they had to send patients elsewhere.

The CHAIR: Can you clarify—was that X-ray machine in a small rural or regional setting?

EMMA HARDY: Correct.

The CHAIR: And there wasn't a second or a backup or an alternate?

EMMA HARDY: No.

The CHAIR: Does anybody want to ask a follow-up question?

Ms TRISH DOYLE: We've heard some very interesting responses today, and I want to acknowledge the degree of frustration that we're also hearing with some of your responses to these questions. To be clear, we come from a range of different areas and different expertise across New South Wales and, as a Committee, with the fabulous Committee staff, we take your responses and that frustration and pull that together in a report for Government. I wanted to acknowledge the frustration I'm hearing, understandably.

In other local health districts, not metropolitan based, where there are issues with retention of staff, where there are GP crises—I'm 1½ to two hours from the city and we're having some similar issues—there has been the suggestion that urgent care clinics stepping in and ambulatory care units being set up in areas might, in the short term, deal with some of the needs that aren't being addressed. Dr Wightman, keeping in mind that you said it's not just about acute responses and emergency but some of that preventative work where a family or an individual needs to see someone, what do you think about these other models of care—whether they're acute or whether they're about preventative work or response work in the community—that might assist, regardless of whether this bill is split or not?

LOUISE WIGHTMAN: I would like to comment about the work that's being done, the research behind hubs and having hubs set up that address preventative issues. They also address acute health issues where you've got a combination of services in the one area that might bring child health nurses for instance, GPs, nurse practitioners, allied health services, mental health services, playgroups—community spaces where people can access support around finance et cetera in that one space where the clients get what we call a warm referral into the next service without having to traipse around. Potentially that would help in terms of infrastructure costs. If we just had the one space where funds were being directed into that, might that assist in terms of funding? Might it also assist in terms of people feeling like they're not an isolated practitioner, that they've got connections?

One of the things for any of the mental health staff and child and family health nurses is access to reflective practice, clinical supervision, education and being able to provide health promotion and education, as Warren was referring to. That's probably something that I would encourage because it puts the least stress on the family. They don't have to go shopping and they don't have to go to multiple different areas. If we're talking about infrastructure costs, might that be an opportunity? The one thing I notice in rural and remote areas is that child and family health nurses are very resourceful, and they're often doing the multiple jobs of sorting out the Centrelink, doing something else for the family. We deal with the family so there might be an elderly person in there who needs to be accessing aged care. There are some strengths in creating these hubs where clinicians and practitioners support each other and the family gets the best service.

Ms TRISH DOYLE: Excellent ideas. Thanks, Doctor. Ms Hardy and Mr Isaac, did you also want to comment on that question around alternative models of care in the community?

WARREN ISAAC: My only comment is that the GP emergency care clinic was trialled in Armidale and I think it had to close because of a lack of GPs.

Ms TRISH DOYLE: What about the ambulatory care unit?

WARREN ISAAC: I can't comment on that.

EMMA HARDY: Echoing what Warren just said, these clinics are amazing and they do fill the gaps, but at the same time we do need the staffing to be there. Warren's comments highlight that there is a staffing shortage that is crippling these services within those rural areas.

The CHAIR: Mr Isaac, I don't want you to answer this question because you have to go back to the office. Ms Hardy, if I made you the CEO of Hunter New England health this afternoon, would you split it up? Would you recommend splitting it up and would you pursue that purpose?

EMMA HARDY: I think there are better ways that you could spend your money and equally distribute that money across all the areas within the LHD and actually focus on the issues at hand.

The CHAIR: Dr Wightman, I'm going to ask you the same question. If I made you the CEO of Hunter New England Health today, would you split it up?

LOUISE WIGHTMAN: Only if I could guarantee that the New England area would get equal. My concern is that because per population there's not the density of the population in the regional areas, would that mean that the Government say, "They don't need as many services"? Or are you just going to duplicate executives? That's not helpful to clinicians on the ground. If you're not going to put the staff in there, is splitting it actually going to help?

The CHAIR: The split would not come with any extra money. We might just allocate the money on a population basis: two-thirds Hunter, one-third New England.

LOUISE WIGHTMAN: Yes. That's my concern.

The CHAIR: This might be a completely unfair question. If the average cost of delivering a service is a dollar, would it probably get delivered in a metropolitan area at an average of 85¢ or 90¢ and probably get delivered in a regional or remote area at a cost of $1.10? Does it just cost more to deliver each service, each widget, in remote and regional areas?

LOUISE WIGHTMAN: I'm not an economist, so I'm probably unqualified to answer that question.

The CHAIR: Nor am I, so you're in good company.

LOUISE WIGHTMAN: In terms of community health, I think you get better value for money in your regional service, because you actually get people who care, at times will flex the service a little more than what happens in metropolitan areas, where it's this and that's all you can do. I think you get a better quality service from clinicians in rural areas because they look broader, and maybe they're doing that off their own volition so, therefore, the costs are hidden. I've worked rural and remote all over Australia: Queensland and Western Australia as well as New South Wales. I think that's the difference, because I think for the clinicians who live and work in those rural communities, they're invested in the community.

The challenge for me, when we're talking about what pops into my head, is when you're talking about getting staff in there, if housing is a problem—years ago, I worked in regional Queensland, and I lived in the nurses' quarters. It made it easy to get staff. When I worked in Western Australia, we had a six-bedroom house with common areas, so it was easy to get staff to come and stay and then build from there. That's the biggest challenge. If you're asking families to move to these areas, what are you doing to provide them with accommodation and access to services? You want clinicians on the ground, but what are you giving those clinicians?

The CHAIR: Interestingly, the Government is reinvesting in some of that type of housing.

LOUISE WIGHTMAN: Yes. You need somewhere to put your head.

Ms DONNA DAVIS: Last week we heard a lot about that in some regional areas there are GPs and those GPs are not signed on as VMOs. What do you think is the barrier, the sticking point, as to why we can't get these GPs to sign up as VMOs?

EMMA HARDY: I might throw to Warren, if that's okay, first of all, and then I can answer.

WARREN ISAAC: I can't really comment on that.

EMMA HARDY: I think it is to do with housing, for one. I also think it's to do with the training and skills. A lot of people go towards these towns and then aren't given the support of access to education, which is a real downfall in the system. Again, I cannot really comment on doctors themselves, because that's not within our remit of nurses and midwives. But I think that housing and training and education would be an important step to getting someone there.

Ms DONNA DAVIS: Dr Wightman, do you have a comment?

LOUISE WIGHTMAN: As I'm not a doctor of that persuasion, a medical doctor, I think it is the same thing. If you want a GP to then be able to support your local service, what are you giving them? What training are you giving and what support? If they're working as a GP and then being called out after-hours and working 24/7

365 days a year, that's not doable. What is the benefit to them in upskilling? Have you provided the upskilling? Where are the nurse practitioners in this model? When you look at midwives, for example, endorsed midwives can fully take care of a client, and if you work as an independent midwife, you don't work under the jurisdiction of a medical staff. If you work as a nurse practitioner, it's the same thing. You have the ability to make those decisions. I think we need to rethink our workforce and what it looks like and get away from the medical model of doing things. I think we need to look broader.

The CHAIR: Thank you, everybody. Can I just clarify that for our witnesses, you will be provided with a copy of the transcript of evidence for corrections. That's the first thing that we will offer to you. The other will be that if any questions have been taken on notice today—I feel like there might have been one. If that's true, we will email to you the transcript and the context around which that question was asked and what was taken on notice. That's the second thing that will happen. The third thing that might or might not happen is that the Committee in the coming days may develop additional questions that we would like to send off to you and seek further answers from. If we do any and all of that, if you could respond within seven days, that would be wonderful. If you can't do that, please talk to us about that.

(The witnesses withdrew.)

(Short adjournment)

Mrs BRONWYN DUNSTON, State Secretary, Country Women's Association of NSW, before the Committee via videoconference, affirmed and examined

Mrs SANDY HARRISON, Country Women's Association, Murrurundi Branch, before the Committee via videoconference, affirmed and examined

The CHAIR: Thank you for appearing before the Committee. A reminder to members of the general public that you are not permitted to film or photograph. By the same token, Committee staff will be filming and taking photographs that we may use in our social media pages. Mrs Dunston and Mrs Harrison, if you don't want to have your image used, please let us know and that will be perfectly fine. Before we start, do you have any questions about the hearing process?

BRONWYN DUNSTON: No.

SANDY HARRISON: No.

The CHAIR: Before we ask you to do an opening statement, if you would like to do that, I remind our participants that we are a panel of six Committee members trying to ask our questions inside the 45-minute time slot that we have with you, so we're only going to get about five minutes each for each Committee member. We're going to try to keep our questions short and brief, and we ask that you keep your answers short and brief so that we can get through as much as possible. Would either of you like to make a short, two-minute opening statement before we begin the questions?

BRONWYN DUNSTON: Thank you to the Chair and Committee members for the opportunity to appear here today. I represent the Country Women's Association of New South Wales, as the honorary state secretary, and appear with my colleague Sandy. With more than 8,000 members and nearly 400 branches across the State, we are the largest women's rural advocacy organisation in New South Wales and our members live and work in the very communities that will be impacted by this proposed change.

Our submission to this inquiry doesn't take a definite position for or against the split. Instead it urges this Committee to focus on what really matters: not lines on a map but the lives and health of people living in the impacted areas. Too often health reform feels like bureaucratic reshuffling of new signs, new names and more confusion but no real change on the ground. As one of our members from Scone, Caroline Carter, put it, "I don't understand why they're doing this. I can't see how it will improve things, but I hope I'm wrong." Caroline's questions are like many members' about the access to services, changes to referral pathways, equity in funding and whether this will lead to more local care or more centralisation, and they deserve clear, evidence-based answers.

From our members' experiences, the core issues remain the same, no matter how districts are drawn: a critical shortage of staff, hospitals placed on bypass, exhausted health workers, families travelling hours for basic care and whole communities feeling dismissed by distant decision-makers. The truth is that women are still giving birth in cars, palliative care patients face dying far from home, and rural, regional and remote towns are fighting

to keep their hospitals and healthcare providers functioning. Whether that failure is due to the size of the current district or systems behind it, it is a real question before this Committee.

We strongly urge you to test this proposal against the five guiding principles. One, will this improve patient outcomes and support health workers? Two, will it reduce inequalities between city and country health access? Will it be informed by genuine ongoing consultation with local people and staff? Will it address, not distract from, the urgent workforce shortages affecting every rural health service or hospital? Will it be monitored, transparently reported on and held accountable for improvements, not just policy announcements? This can't be another reform that looks good on paper and leaves rural, regional and remote communities behind. We appreciate the opportunity to speak today and look forward to answering your questions and supporting any changes that make measurable, meaningful differences to health care for rural families.

The CHAIR: Thank you so much, Mrs Dunston. For context, can I ask you—and you can not answer if you don't want to—what geographical area or district do you reside in?

BRONWYN DUNSTON: I live in the local government area of Singleton. I'm at Jerrys Plains.

The CHAIR: So both of these witnesses are inside Hunter New England health district, as it is.

BRONWYN DUNSTON: Yes.

SANDY HARRISON: Yes.

The CHAIR: For context, Mrs Harrison, do you recall when there used to be separate New England and Hunter health districts. Murrurundi—were you in Hunter?

SANDY HARRISON: I don't remember because I'm on the border. I'm not sure whether it was or not.

The CHAIR: Not important, I was just trying to get some context.

Ms TRISH DOYLE: Hello to Mrs Dunston and Mrs Harrison. Thanks for being with us. In your experience and from those other CWA members that you have spoken with, how are the resources currently distributed across the Hunter New England Local Health District?

BRONWYN DUNSTON: Sandy, do you want to go first?

SANDY HARRISON: No, you go first. I'll think.

BRONWYN DUNSTON: In my area, Muswellbrook Hospital has got no maternity wards, so therefore they either go to Tamworth or down to Maitland, which is the new medical hub, or they go to the John Hunter. You're looking at probably an hour and a half to two hours drive. Palliative care, yes; aged-care facilities, no; hospital staffing, exhausted. I don't care what hospital you go to, there is just not enough staff. Doctors—good luck getting in to one of them in this area. Specialists—you could end up in Sydney, bypass Newcastle altogether and go straight to Sydney. That's not acceptable for somebody who is elderly and hasn't got transport to and from Sydney to see these specialists. To make a specialist appointment in Sydney, they all think you just live around the corner and an eight o'clock appointment is not difficult for somebody who is two hours away.

Ms TRISH DOYLE: You're saying that there is a real lack of resources, in your experience, across all those sectors?

BRONWYN DUNSTON: Yes.

Ms TRISH DOYLE: Mrs Harrison, did you want to jump in on that?

SANDY HARRISON: I deal with a lot in what is around the Tamworth area. Quirindi Hospital, for example, has not had a doctor there permanently for at least six months. I was unable to get a doctor's appointment for a month. They can't even get locums to come in. There is only one GP in town that can access the hospital itself, and it has actually got an ED as well. I think that the doctor situation is—I used to work as a collector for Hunter New England Pathology in Quirindi. One of the big issues I found with the doctors servicing the area, especially when they were doing on-call work on a weekend—they were put in by employment agencies; I gather that's what they were—they would go to the coast, over to Port Stephens, because they would get considerably more money over there than they got in the regional areas out here. To me, that is one of the main reasons you can't get doctors—because they're not getting paid in comparison to the other doctors. It might be because there's Medicare only out here—I don't know. But that's one of the big issues with holding their doctors: they would just be off at another place because they got paid more money.

Ms TRISH DOYLE: Any other comments in relation to other resources besides staffing?

SANDY HARRISON: You've got other resources, as in podiatrists, physiotherapists, all that sort of stuff. Those resources are lacking out here.

Mrs TANYA THOMPSON: I just wanted to ask your views on telehealth and virtual care and how you feel this has or hasn't filled gaps. Does it fill gaps? Do you think that it has made things easier out in regional areas?

BRONWYN DUNSTON: Telehealth is good in a way, but there's lack of connectivity as well. It only works if you've got the actual connectivity to that telehealth. Out in rural, regional and remote areas, that's hit-and-miss at the best of times.

SANDY HARRISON: You've still got to travel. I had a telehealth with an allergist in Tamworth. That was still an hour's drive for me to get to see her, and she was in Sydney. But you're still waiting a long time to get to the telehealth ones as well.

The CHAIR: Can I just clarify there, Mrs Harrison? You drove to Tamworth to have a telehealth appointment with a specialist in Sydney?

SANDY HARRISON: Yes. It was an appointment in Tamworth with telehealth.

The CHAIR: When you're in a telehealth environment like that, do you have a medical worker of some description in the room with you?

SANDY HARRISON: At that time, no, I didn't.

The CHAIR: It was you and a screen and the specialist in Sydney.

SANDY HARRISON: Yes.

The CHAIR: At other times, do you sometimes have a health worker in the room with you when you've got a telehealth appointment like that?

SANDY HARRISON: I've only ever done it twice, so, no, I don't know. We've done telephone conferences with an oncologist in Newcastle. That's done regularly. That's fine. He'll do a video screen as well if he needs to. But we don't need to go down to see him at the moment, so that's good news.

The CHAIR: Do you drive in to a health facility for those types of telehealth or do you do those directly from home as an online telehealth appointment with your specialist?

SANDY HARRISON: With the specialist in Newcastle, we do it from home.

The CHAIR: For oncology?

SANDY HARRISON: Yes. But we have very good internet here.

Ms DONNA DAVIS: Thank you very much for your time and your contributions. In your submission, you mention the need for culturally appropriate services. Can you expand on this, please?

BRONWYN DUNSTON: We have a lot of diverse cultures around our area. How can I say this? I don't think our medical system is up to giving those culturally diverse people the treatment they deserve or how they handle those culturally diverse people when they come in—a lack of education.

Ms DONNA DAVIS: Language being an issue, not having enough interpreters?

BRONWYN DUNSTON: Yes. Language would be the big part of it. Understanding of different cultures is another major concern.

Ms DONNA DAVIS: Trauma? Would you say potentially people that have trauma-counselling skills, those types of things?

BRONWYN DUNSTON: Yes.

Ms DONNA DAVIS: Anything else that you would like to add?

BRONWYN DUNSTON: No, I haven't. Sandy?

SANDY HARRISON: No, we don't have a lot of cultural diversity in my town at all. We've got Aboriginal and Caucasians.

Ms DONNA DAVIS: Just going back to what you were saying before about the travel—this is really for the purposes of putting it on record. For those people that have a procedure at 8.00 a.m. at Newcastle or they may have been referred to Sydney for an 8.00 a.m. procedure, the hospital says, "You need to be here by 6.30 a.m.

or 7.00 a.m." What does that look like in terms of travelling down and accommodation for people that live in your town and in your regional area? How do they do it?

BRONWYN DUNSTON: If you're elderly and you need to get to Sydney early for an appointment for doing a procedure, you'd have to go the day before, because there is no transport to get you to Sydney for a seven o'clock appointment or an eight o'clock appointment. You go the day before. You've got accommodation for probably two nights, if you've got to stay, and then the train back home. If you travel down by car or if you get somebody who can take you by car, depending on what time and which way you go, you've probably got up to five hours travel before you even get to that appointment.

Ms LIZA BUTLER: Thank you for joining us today and thank you to the Country Women's Association for all your advocacy for families, women and children across regional areas. For full disclosure, I am a member of the Country Women's Association. We have heard that the split would allow for more local decision-making, which would then allow each district to tailor their services with a more targeted approach to meet the individual community needs. What are your views on that?

BRONWYN DUNSTON: That's how it used to be and there wasn't a lot of consultation done when the two areas were merged 30-odd years ago. A lot of people who do remember that merge still ask questions as to why it was done in the first place. They couldn't understand it. They weren't told about it. So we've taken another step backwards. Most of us didn't want it to start with. Now that we've got it we don't want to go back. We don't understand why we're going back. We're not getting enough information as to why this is being put back on the counter for more conversation about splitting the areas again.

Ms LIZA BUTLER: Do you think that, instead of splitting the areas, we could put consultative bodies in there to solve that problem instead of splitting the health district?

BRONWYN DUNSTON: There was no consultation when they first merged in the first place. It was just done overnight and everything was hunky-dory. I'm not too sure what you could do. I think there's still going to be issues with consultations and having everybody on the same page as what there was 30-odd years ago.

Ms LIZA BUTLER: Mrs Harrison, do you have anything to add to that?

SANDY HARRISON: No. I was in the city 30 years ago so I don't know what it was before.

Ms LIZA BUTLER: Just now.

SANDY HARRISON: I just think it's a very big—once you get to Tamworth or even, let's say, Maitland, going north-west or west, your services become more and more limited. Then you've got Tamworth and maybe you've got Dubbo. They're two big hospitals. Not a lot in between, and there's a lot of communities out there that need basic services to be able to get to. X-ray is another one that you've got to travel a long way for.

The CHAIR: I want to clarify with Mrs Dunston, there is currently a question before Parliament about whether we should or should not divide. That's been driven by a member of Parliament, it's not being driven by the health district. The purpose of this inquiry is to try and come up with some pros and cons, for and against, around what that might look like, so that Parliament can be well informed when they are asked to vote.

Mrs HELEN DALTON: Thank you for your attendance. I'm also a member of the CWA, of the Barellan branch, which I think has the oldest rooms in Australia. I'm just down the road from there; that's where I live. I initiated the rural health inquiry when I first came into Parliament and I was told by the chair that the health system and services in rural areas has been eroded for the past 30 years. He said that it's going to take 30 years to change it and get it back.

The CHAIR: That was by the chair of that committee, not the Chair of this Committee, right?

Mrs HELEN DALTON: That's right, by the chair of that committee. I don't think we've got 30 years, but you talked about the splitting and the establishment of the health districts that happened 30 years ago. That model of care has seen us decline in our health outcomes. If you could do something today to reverse this decline, what would you do? For example, we've heard this morning, provide housing for healthcare staff—that would be a bare minimum. That's what we had. We even talked about nurses' quarters. People were staying in nurses' quarters back in the day. What else would you do to reverse this decline and get our services back? You belong to great areas. There's nothing to not love about your area.

BRONWYN DUNSTON: Try to get doctors or nursing staff to stay in the bush. They don't want to come any further. We've got traineeships that take a doctor out for six months to do their training. They finish their six months and then they're back in Sydney. There's not a lot more you can offer to keep them in the bush, no matter which way you go. They're still going to want the dollar, and I don't think the dollar takes into account families, wellbeing and health issues. The dollar will always win above everything else.

SANDY HARRISON: I agree. They end up back in Sydney. They might come out for their two years, come in from overseas, get their accreditation, and within the two years they've gone. So all the rapport they had with patients has gone.

Mrs HELEN DALTON: When you talk about the dollar, you don't think there's equity in their salaries? That needs to change?

BRONWYN DUNSTON: Yes.

Mrs HELEN DALTON: What is the cost of life? We look at the costs, everyone has been talking about the costs of splitting or doing whatever, but the cost of doing nothing, do you think that should be quantified in this decision? We know that the further west we go, the shorter our life expectancy is. Some 20-odd years ago, our life expectancy was greater than those in the city, so what is the cost of a life? Should we be looking at costs, or, rather, equity in this decision?

BRONWYN DUNSTON: I'd go equity because the ones that live in the bush, they are entitled to have the same resources as those in the city. I don't think you're going to ever change that, but I would hope that those in the bush can have a better service than we are now.

SANDY HARRISON: I think that's what it is: It's equity. It's equality across the board. There's a bit of a saying when you're out in the bush: Once it gets to anything west of the Blue Mountains, nobody knows anything about us. It's one of those things. Get to the Blue Mountains or the mountain range, and that's it. Everybody else is lost.

Mrs HELEN DALTON: So the health professionals don't really want to come out because they're not supported. They're there on their own, there'd be one doctor in one little town and of course it's 24/7, 365 days a year. So we don't just need one; you need two so that they can have some sort of lifestyle.

SANDY HARRISON: They don't want to do the 24 hours—24/7.

Mrs HELEN DALTON: I find it really interesting. People are worried about that, and rightly so, because they don't want to be the one holding the—when something goes wrong because they weren't supported and they're usually a young doctor. They need to be mentored. They're eroding our maternity. They would rather the risk to the staff—if there's only one person on or two, and they're tired and they've done shift after shift, they'd rather put the risk back on the patient. Therefore we see—and you've mentioned it before—they would rather have women having a baby on the side of the road, and them bearing the risk, than have more staff in a hospital where they could, if they were a well woman, birth locally. Do you agree with that?

BRONWYN DUNSTON: Yes.

SANDY HARRISON: Yes.

BRONWYN DUNSTON: Take Muswellbrook Hospital. They haven't had a maternity ward up there now for probably five years. They were to have funding to redo the maternity ward, but that fell through, so now Muswellbrook people have to either go to Tamworth or Maitland to have their babies, which is just unacceptable. You've got a hospital at Muswellbrook. Some of it is only brand new; they've just been done up. But to go out of town to seek somewhere to give birth, that's just—and it gets worse as you go out west.

Mrs HELEN DALTON: So you put your health risk and financial risk all back on people out in the bush? Would that be right?

BRONWYN DUNSTON: Yes.

SANDY HARRISON: Yes.

Mrs HELEN DALTON: We need a pathway to improve or gain our resources back. Correct?

BRONWYN DUNSTON: Correct.

SANDY HARRISON: Yes.

The CHAIR: Mrs Dunston, given your role as state secretary, do you think that there is a conversation about Hunter New England Health and the delivery of health services in those regional areas that is different from what you hear about CWA members in other regional, rural or remote areas?

BRONWYN DUNSTON: As Sandy said, anything from the mountains out to Broken Hill, we're all in the same position. All rural, remote and regional areas are facing the same issues no matter where we go. And it's usually doctors not staying—

The CHAIR: Whether it's out in Western or Far West? Some of the bigger geographical health districts—Hunter New England Health, obviously, but then we've got Western NSW, Far West health district and the Murrumbidgee health district. Geographically, all four of them are probably mainly west of the divide but large.

BRONWYN DUNSTON: I'd say that we've all got the same issues. We're all lacking doctors, nurses. They have hospital staff that are overworked and underpaid. They're still travelling distances for basic health care. Telehealth out in some of those areas—there is just no connectivity.

The CHAIR: As state secretary, do you hear that from across the membership?

BRONWYN DUNSTON: I do, yes. I've been across this state and I've seen the same issues everywhere.

The CHAIR: Mrs Harrison, I don't want to overlook you, and I appreciate at one stage you were in the city and now you're up in Murrurundi. You probably also travel around. Do you hear or see commentary from other CWA members in other parts of the state experiencing similar, same?

SANDY HARRISON: Definitely, yes.

The CHAIR: In that regard, then, a line on a piece of paper about where Hunter starts and ends, where the New England might start and end, what would be a potential benefit, do you think? Can you think of any potential benefits in terms of attracting new workforce or somehow incentivising workforce or something like that? Can you think of positives that might come from having a new line and a separation?

SANDY HARRISON: I don't think it'll change.

BRONWYN DUNSTON: No. Drawing a line on a map is not going to make any difference. The issues are still going to be the same. There will still be a lack of doctors, staffing in hospitals, nursing. Any issues we have now, a line on a map is not going to change.

SANDY HARRISON: Can I ask the Committee a question, please?

The CHAIR: Go ahead. Please, ask us.

SANDY HARRISON: I would just like to ask the Committee, has anyone asked the medical staff—doctors, nurses—why they won't stay out here? Has that been asked? Has anybody ever surveyed the doctors as to what they need to stay out in these country areas?

Mrs HELEN DALTON: I was over at Finley Hospital on Monday. There were two young trainee doctors in Finley. They just love it, absolutely love it. They were with a great doctor there who was giving them fantastic tuition. They got more experience in that small community hospital than in a bigger hospital. They were allowed to do more things. You've said it too: I don't think they get the pay that they should. Doctors aren't stupid. They want to be paid well for what they do. When they get through, the well-paid jobs are in the cities, with the worried well, and they're not coming out because they know they'll be there on their own, in many cases, and not being supported. That's what I think. It's a matter of retaining them and giving them a few things, a decent lifestyle. I think they deserve a decent lifestyle. I know that there are shortages of doctors, but, by gee, I find it interesting when I can get off the plane in Sydney, walk straight into a medical centre and get an appointment, and I've got to wait about two months in Griffith.

The CHAIR: There have been a number of inquiries around delivery of health services here in New South Wales Parliament over a number of years. One of the most recent ones has been about regional, rural and remote health, and the doctors gave a range of reasons. Part of it was lifestyle. Part of it was about having access to extend the scope and experience of their skills. Part of it was access to ongoing teaching, learning and training. Part of it was about if you go and work in a regional area, you somehow become a second-class citizen in the medical fraternity, because, "What could you possibly know? You're based at Quirindi," or Cessnock, or whatever the case is. They feel like second-class citizens. There's a whole bunch of information around that that Parliament has already heard.

Ms DONNA DAVIS: Later today, we are going to be speaking to the doctors union and to AMA. If you look at their submissions, they speak a lot about remuneration, but they also talk about social isolation, being in a situation where they don't have their friends and family. There's a whole range of schooling, and we know that sometimes for people it's fine to be in regional areas while their children are young, but when they're going to secondary school, there are less options. There is a whole range of things. If you are able to look online at their submissions, that will point to some of those answers for you.

The CHAIR: I apologise; I don't remember if it was Mrs Dunston or Mrs Harrison who was making the point. You were talking about doctors in Quirindi—I don't know if it was permanent or VMOs or locums—and you made the point that they'd prefer to go and work somewhere like Port Stephens because they get paid more.

SANDY HARRISON: Yes.

The CHAIR: I was just going to ask you to expand on that, about the nature of the payment and the nature of the doctor that you were talking about in the first instance, because I didn't quite understand which type of doctoring you were talking about.

SANDY HARRISON: We're talking about GPs.

The CHAIR: A local GP?

SANDY HARRISON: Local GPs. Quirindi Hospital, I believe, Barraba hospital, Manilla hospital—their doctors are put in by an employment service of some sort. They actually work out what the doctors get paid. They also have other areas like the one over at Nelson Bay. In my experience, this particular one, they would get on call. They would go from Quirindi over to Nelson Bay and it was over $1,000 a day difference that they were getting paid.

The CHAIR: Wow!

SANDY HARRISON: Yes. It was a lot of money to be on call. At that point, two doctors in the hospital were permanents, but they haven't had permanent doctors in there in that number for a long time. They had one local GP practice that also has visiting rights at the hospital. Murrurundi hospital does not have a doctor at all. It's all done through telehealth. We now have a doctor from Scone that comes up to our town two days a week. But that's all they can do. But, again, because Scone hospital doesn't bulk-bill, you can actually get into them, because people don't want to go to a doctor that doesn't bulk-bill. I think the major issue out here is the bulk-billing for GPs that don't get paid the same.

The CHAIR: Sorry, just to clarify—

SANDY HARRISON: They'll only get paid the Medicare fee.

The CHAIR: So, typically, they're only getting the Medicare fee. They're not getting an additional gap.

SANDY HARRISON: Yes.

The CHAIR: And that's a socio-economic determinant of the community, I guess.

SANDY HARRISON: I suppose so, yes. But that also determines the GP staying here, because they can't make the business work.

The CHAIR: We are out of time. Thank you for participating today. We thank you both for your submission and the time that you've spent with us for our questions and answers. In particular, Mrs Harrison, it's the first time the Committee has been asked a question, so we really appreciate that. You will be provided with a copy of the transcript of your evidence for corrections. We're going to send that to you, and you can feel free to make a correction if you think you've been misheard or misunderstood. I don't think anybody took questions on notice, so we'll skip that step. However, the Committee may develop additional supplementary questions after our hearing today and hearing what you've said. We may send those to you in the coming days, and we would ask that you respond to those as well. Again, thank you for appearing before the Committee today.

(The witnesses withdrew.)

Ms BRENNA SMITH, Manager, Community Cancer Information and Support Services, Cancer Council NSW, affirmed and examined

Mr BRADLEY GELLERT, Manager, Policy and Advocacy, Cancer Council NSW, affirmed and examined

The CHAIR: 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 taking photographs during the hearing for use on our social media pages. If you have any objections about your image being used for that purpose, please let us know. Before we start, do you have any questions about the hearing process?

BRENNA SMITH: No.

BRADLEY GELLERT: No.

The CHAIR: Excellent. I'm looking forward to someone actually saying yes to that question, somewhere along the line. Would either of you like to make a short, two-minute opening statement?

BRENNA SMITH: Good morning. I'd like to begin by acknowledging the traditional custodians of this land, the Gadigal people of the Eora nation, and paying my respects to their Elders, past and present. Cancer outcomes are among the best in the world in New South Wales. Yet, for people living in rural and remote areas of the State, cancer outcomes remain poor. Sadly, parts of the Hunter New England Local Health District have some of the worst cancer survival outcomes in the State. For example, five-year survival rates are 24 per cent lower than the national average in Narrabri, 27 per cent lower in Taree and Armidale, and 31 per cent lower in Cessnock. We're here today to speak for people impacted by cancer in rural areas and to highlight that access to transport, accommodation and financial support services are essential for people who live far from cancer treatment they need.

Mr Chair, thank you for focusing on health services in the north-west area of the Hunter New England Local Health District. While we're neutral on whether the LHD should be split, we urge the Committee to consider past recommendations of the rural health inquiries, including the reports of the Select Committee on Remote, Rural and Regional Health, which I understand many of the members here today were part of. Acting on these recommendations will make cancer outcomes more equitable in rural areas, including Hunter New England Local Health District.

More specifically, we suggest that transport and accommodation are essential for people in rural communities—they aren't just extras but necessities; that the IPTAAS scheme, which helps with travel and accommodation costs, be reviewed yearly with community to make sure it meets people's needs; that community transport be fairly priced, with clear pricing benchmarks set; that not-for-profit transport groups like Cancer Council be included in the LHD planning of transport services; that practical support services such as accommodation and community transport be culturally safe and responsive for everyone in the area, especially Aboriginal peoples; and that palliative care be accessible to all people in New South Wales, regardless of their LHD. Improving cancer outcomes in rural areas takes ongoing effort, innovation and collaboration. Cancer Council NSW stands ready to help the Government and NSW Health make cancer outcomes more equitable across rural New South Wales. Thank you for allowing us to share our views, and we welcome any questions.

The CHAIR: Thank you so much. I just want to do some context and background. The Cancer Council does assist with travel and transport, generally through fundraised local cars and volunteer drivers for some communities. Is that correct?

BRENNA SMITH: Yes, that's correct. We have 22 Transport to Treatment services across New South Wales, nine of which are located across the Hunter New England LHD footprint. We don't receive any government funding to deliver the Transport to Treatment services. They're delivered through our ongoing community fundraising efforts as a not-for-profit, and we rely on the generous time offered by our volunteer drivers, who transport many people to and from cancer treatment from that particular local health district. I think there's something like just over 350 trips we've provided across the Hunter New England community footprint in the last 12 months.

The CHAIR: Can I just flag with you that each Committee member only gets about five minutes to ask their questions, so Committee members will try to make their questions brief. We would appreciate you trying to make your responses brief as well, so that we can get through as much as possible.

Ms TRISH DOYLE: Welcome to both witnesses. Thank you for your work in this space. I'm just wondering how often the Hunter New England Local Health District consults you as a stakeholder, especially in relation to your experience and your views with people across those communities, on best practice and addressing the concerns of people with cancer across that district. How often do they consult with you? What does that consultation look like?

BRENNA SMITH: As an organisation, because we deliver practical support services, we are in regular contact with the local health district, more so at an operational level than a strategic level. We're in constant contact with healthcare professionals, making sure we're getting people to and from cancer treatment. Often that's where we identify challenges or opportunities for us to partner to deliver practical support services with them. We also partner with Hunter New England Health to oversee the operations of Inala House, which is a patient accommodation facility at Tamworth. That's an accommodation facility that allows people from the regional and remote communities to travel into Tamworth for cancer treatment.

Ms TRISH DOYLE: Excellent. Mr Gellert, did you want to add to that?

BRADLEY GELLERT: No, I don't think I want to add to that.

Mrs HELEN DALTON: Thanks for attending. It's great to see you. You've just stated, really, that the community bears the additional cost of health care. You've also said that we've got a shorter life expectancy, and you rattled off those survival rates, which is really concerning, I think. My question is how can we improve the health system, and will splitting the health district solve this, or will splitting the health district allow more targeted resources into those rural areas?

BRENNA SMITH: Do you want to take that one, Brad?

BRADLEY GELLERT: Yes, I can take that one, Mrs Dalton. You're right. People in regional, rural and remote New South Wales do, on average, have far worse cancer outcomes. That is a function of a few things. People in regional, rural and remote areas in New South Wales, including people in the Hunter New England LHD, have higher rates of cancer risks—smoking, alcohol and they are far less likely to participate in cancer screening programs—and that in and of itself is a function of access and ability to access. There is far poorer access to health care, so GPs—there's a barrier there. There are fewer services and then additional challenges that are faced. There's obviously the fact that travel is involved over long distances, and because of the nature of cancer treatment, it can keep you away from your family for extended periods of time.

But cost is also a really huge factor to take into account, because leaving your area, your place of work, and having to move to Sydney or Newcastle for a month or two is incredibly costly. Those factors are the reasons that we see these kind of worse outcomes. I apologise that I didn't include this in our submission, but I have got a printout, which I will share with you. It's a map from the Australian Cancer Atlas, which is a visual depiction of outcomes across the State. You can really clearly see that the areas where there are far worse outcomes, far poorer access, for the most part are in the Far West of the State, the Hunter New England LHD and the areas that straddle the Victorian border.

So what can be done about it? Equity of access is really the thing that we think is the most important thing. There are lots and lots of good recommendations that were made as part of previous inquiries: the Portfolio Committee No. 2 inquiry and the recent select committee inquiry. These should be fully adopted by the New South Wales Government. Transport and accommodation isn't a nice-to-have; it's a necessity, to access basic health care. It is by far one of the biggest barriers that people in these areas face. It needs to be central to health system planning, regardless of the LHD, but particularly for LHDs where people have to travel long distances into areas.

It's not reasonable to think that you can have the best quality cancer treatment in every regional town across New South Wales and, in fact, there are some good reasons why that actually isn't desirable. But there has to be at bare minimum access to health professionals in towns that can deal with things like symptom management. If you're in between cancer treatments and you're dealing with the terrible side effects of chemotherapy, there's absolutely no acceptable reason why you shouldn't have access to a GP, a clinical nurse, a nurse practitioner, a pharmacy who can help you with that.

Mrs HELEN DALTON: Could splitting the health district really allow a smaller health district to target those resources?

BRADLEY GELLERT: I don't think we've got a fixed view on that. I don't think we're in a position to make a call on that. Whatever happens in the management of that LHD, it needs to be responsive to the needs of the people: funding, allocation of resources. It needs to be based on need, community preferences. There's not a one-size-fits-all model here.

Mrs HELEN DALTON: So basically everything's kind of centralised to Newcastle, the bean counters in the Hunter New England health district are trying to save money, and people in the bush are the collateral damage? Is that what you think?

BRADLEY GELLERT: I probably wouldn't put it in those terms. I don't necessarily have the specific details of the way that the Hunter New England LHD is managed. But, in general, as a principle, funding, resource allocation, health service planning in any LHD, especially those in regional and remote areas of the State, has to be needs based and responsive to community needs and preferences. That has been time and time again highlighted in previous inquiries.

Mrs HELEN DALTON: Would you table that graph, please?

BRADLEY GELLERT: Yes, I'd be very happy to do that.

The CHAIR: I was actually going to ask about that table. Is it possible to pass that up just right now? We might be able to circulate that while you're still with us.

BRADLEY GELLERT: I will provide a link to the Cancer Atlas, which will give you a great more detail.

Ms LIZA BUTLER: Thank you for joining us today. My first question is back to the IPTAAS and the transport services that you provide. Are users able to claim IPTAAS? Because they are not able to claim through the Community Transport Association.

BRENNA SMITH: Users can claim IPTAAS back. However, because we are a not-for-profit and we're delivering that Transport to Treatment service with very limited resources to actually do that, what we encourage patients and clients to do, because we're delivering that service—they're not actually delivering the transport service themselves—we encourage them to nominate Cancer Council as a third-party organisation. They can actually nominate us to get the IPTAAS reimbursement donated back to us as an organisation. Operationally, that is very challenging because IPTAAS is challenging for patients to navigate still. Despite significant improvements made in that space, it's still a tricky space for patients to navigate.

Ms LIZA BUTLER: If they opt for that you get the payment, they then pay no other fee for that service?

BRENNA SMITH: Our Transport to Treatment service is a free service, so we don't charge anything to transport people to and from cancer treatment. What we do is position ourselves to be working complementary to those funded community transport services in community which do charge clients to travel to and from treatment. We have heard stories of quite significant charges being passed on to cancer patients. When you think about somebody undergoing radiation therapy, that can be anything from five to six weeks worth of daily treatment. Those costs passed on to the client actually add up over a period of time, so what we try to do is work complementary to those funded transport services to try to reduce that financial burden being passed on to the clients.

Ms LIZA BUTLER: You talk about the needs and the preferences and the transport locally for what's required. How often does the Hunter New England health district consult with you as a stakeholder?

BRENNA SMITH: We work closely with the Hunter New England LHD, as I said before, at a very operational level. We're working weekly with them to understand how many patients need to be transported that specific week to and from the North West Cancer Centre in Tamworth and into the Calvary Mater or John Hunter in Newcastle as well. So we're in regular contact with the LHD more at that operational level, rather than a strategic conversation about how best we should support transport. But we would welcome that opportunity to have that conversation to make sure that we are working from a community lens, making sure that people can get to and from their cancer treatment in that area.

Ms LIZA BUTLER: This Committee is looking at the splitting. When you answer this question, refer to that. If you had better conversations at a strategic level without splitting the health district, do you think that would improve the health outcomes for people in regional areas with splitting or not splitting the health district?

BRADLEY GELLERT: I would say that more conversations at the strategic level, regardless of whether the LHD is split or not, would result in better health outcomes. We've pretty stridently called that out in previous submissions to inquiries. We really do believe that LHDs across the State, but especially those in regional areas, need to do more to engage NGOs and community providers of health services in the actual planning of services and not just the operations.

BRENNA SMITH: Just to add to that, Cancer Council does make a significant contribution in transport to treatment across that Hunter New England footprint through the delivery of nine distinct transport services. We are picking people up from all different areas across that LHD and taking them to treatment, so I think it would be really advantageous for us to be able to have those more strategic conversations.

Ms DONNA DAVIS: You note in your submission that regional New South Wales has poorer preventative health care. In that context, what do you see as simple improvements that could be made to improve that preventative health care, particularly in the more remote areas of the health district? And you may not be able to answer this now: whether or not you've got some best practice from other health districts or other parts of Australia that we could be adopting.

BRADLEY GELLERT: We're not there yet with getting smoking rates under control. They are, by and large, the biggest contributor to this disparity in outcome between regional and metro areas because the more likely you are to smoke, the more likely you are to develop cancer. And those cancers, by and large, are low-survival cancers like lung cancer. Risky alcohol consumption is also one of the other factors, as well as participation in screening programs.

What could be done? I guess there's a couple of things. We need to do a bit more targeted health promotion and targeted messaging around awareness for people in these communities in ways that are acceptable

to them, so it's not a one-size-fits-all approach. When it comes to smoking, there have to be really accessible quitting services, and it has to be in a way which is culturally safe. We know in this LHD there's a really high proportion of, for instance, Aboriginal people with very high rates of smoking, so those services have to be really culturally appropriate. That can be done at an LHD level, because they are the ones on the ground who fundamentally know their area.

We can really do more to lift screening rates. That would be, again, targeted promotion of services—going out to communities through organisations like ours, but also many others who have good links within community, to promote those screening programs both to target populations but also to health practitioners as well. Where there are areas where there is existing primary care, I think training up GPs through really accessible information and education is a big part of it, too. Sorry, the second part of your question—I've forgotten that.

Ms DONNA DAVIS: You've probably answered it. It was really about whether or not there's any best practice.

BRADLEY GELLERT: We can get back to you on that. We'll take that on notice.

Ms DONNA DAVIS: Did you have anything, Ms Smith, that you wanted to add to that?

BRENNA SMITH: I would say that where we have seen really good uptake of screening in some areas is where Cancer Council has partnered with another organisation to deliver a screening awareness activation at a community-based level. We have 10 community offices across New South Wales, so we have teams of people working from those offices locally, often living in those local communities. We see that when we partner with BreastScreen NSW or we partner with an Aboriginal community controlled organisation to deliver screening awareness programs that are driven by community, we see better uptake of screening in some of those communities.

Ms DONNA DAVIS: And do you think that those improvements require a split of the health district? Or does it require a focus on delivering those services?

BRENNA SMITH: I think it involves better collaboration across services located within a local health district.

BRADLEY GELLERT: As well as commitment and funding from NSW Health.

BRENNA SMITH: Absolutely.

Mrs TANYA THOMPSON: Everyone's asked all my noted questions, actually, and in depth. I would just like to put on the record a thank you for the services that you do. I'm part of the Hunter New England health district in the Myall Lakes, and constituents have to travel very far for treatment in my region. I will ask one question which you may or may not want to answer. We heard from the CWA before and they made the point: Why are we doing this? Why are we asking this question again: to split up or not to split up? The map shows that you have poor outcomes through Hunter New England Health. How did they get to this point? You're right across the State, so you see, through other health districts, what works and what doesn't work. Where did they drop the ball so badly, for want of a better phrase, and what could they actually really do to improve things so we're not having these conversations of splitting up a health district?

BRADLEY GELLERT: I don't think I've got a particularly fixed view—

Mrs TANYA THOMPSON: Yes, it's a pretty broad question. Sorry.

BRENNA SMITH: It's a big question.

BRADLEY GELLERT: —on where the LHD has dropped the ball. But as I outlined earlier, whether it's one LHD or whether it's two LHDs, there's a pretty clear playbook for what should happen to improve cancer outcomes. It would be investment in that prevention messaging, and investment and commitment and partnering to lift those screening rates. Travel and accommodation is just part of health system planning and delivery. It's not a "nice to have"; it's a must. There's obviously much more work that needs to be done to ensure that there is access to basic health services in some of these towns. We recognise there are big workforce challenges too.

The CHAIR: Following on from that, do we have such an abundance of oncologists around the Newcastle area that they're all tripping over each other and that if we split up into a different health district, we would suddenly be able to distribute those resources, we'd find ourselves with more specialist oncologists up in the New England, highly skilled oncology nurses et cetera? Are there so many specialists in this field that we could spread them more thinly? Do we even get to make that choice? Do they make that choice because they're professionals and they get to decide where they live and work?

BRADLEY GELLERT: That's a tough question to answer.

The CHAIR: Let's just go with the first thing first. Do we just have heaps of oncologists floating around the Newcastle health area?

BRADLEY GELLERT: Clearly, we don't have an abundance of medical oncologists in the LHD. I don't know what necessarily is needed, what the ideal ratio would be, but I would assume that we don't have an abundance.

The CHAIR: The oncologists who primarily live and work down at the pointy Newcastle end of the health district, to the best of your knowledge, do they do outreach services where they travel up into the New England to provide services and access to patients?

BRENNA SMITH: I can maybe answer that. North West Cancer Centre in Tamworth is an integrated cancer treatment centre, so it delivers both chemotherapy and radiation therapy services, as do the services in the Newcastle community footprint. Both sites have oncologists and radiation therapists that work from those sites. Sometimes patients are not able to get really specialised care in the North West Cancer Centre and may need to travel to Newcastle for more really specific cancer care. But again, that comes back to the whole reason we're here today, is that then becomes a problem for the client, having to travel to cancer treatment and also requiring accommodation travelling large distances for cancer treatment as well.

The CHAIR: Is a solution to push or force the oncologist to work out in the regions one or two days a week?

BRENNA SMITH: That's really hard for us to answer because it's not really our position to answer that.

The CHAIR: That's fair. Can I ask about the travel arrangements that you assist with? I think most of those would be planned and scheduled travel arrangements, as opposed to urgent, sudden, unexpected. Is that fair?

BRENNA SMITH: That's fair. In order to be able to provide transport to as many people as we possibly can, we try and prioritise those people who need our services the most. By that, I mean that they have no other alternative. They don't have family or friends that can take them. They can't access community transport, because of the cost involved for community transport. In order for us to get as many people in a vehicle travelling to treatment, we do need to schedule in advance, so we take more of a proactive approach to the delivery of our transport-to-treatment services rather than a reactive approach. When we do hear that there's a challenge, that somebody might need an urgent medical appointment to support their cancer treatment regime, that's where we're having conversations with the local health districts to look at what other possible options are available. That's when we're encouraging them to call 13 11 20 and speak to one of our healthcare professionals, who can actually help them navigate what that could look like for them.

The CHAIR: I thought that might be the case. I just wanted to tease that out, because part of the other testimony that we have heard is about somebody needing to jump into an ambulance, they get taken to a hospital facility which might be 100 or 200 kilometres away, and then they get dismissed in the middle of the night because they no longer need emergency. That's significantly different from the service that you operate?

BRENNA SMITH: Yes, absolutely.

The CHAIR: In terms of the map that you have provided—if it's okay for me to make reference to that, and I appreciate that the viewers at home don't have access to this—the hotspots seem to be out in the regions. Would that be the same for Queensland, Victoria, South Australia or Western Australia? Would we tend to see those hotspots further away from metropolitan centres?

BRADLEY GELLERT: Yes, there's a pattern across Australia. There are specific demographic reasons why New South Wales might be more red than a centre in Victoria that would be the equal distance away from Melbourne as it is to Sydney, but by and large, it is a pattern that is consistent across Australia.

The CHAIR: Given that we discussed a moment ago the fact that Tamworth itself has an oncology treatment service for that sort of north-west part of the Hunter New England health district, I note that a number of the hot spots for low cancer survival rates are in and around Tamworth as well. I'm just trying to tease out the tyranny of distance and the cost of being away from home and the access to travel, but there's also a problem there just where a cancer service is. Could you explain to me why the survival rates are so low literally beside a cancer service?

Ms DONNA DAVIS: It's First Nations.

BRENNA SMITH: People who are travelling for treatment to the North West Cancer Centre—that cancer centre is not only supporting people who might live in Tamworth to receive their cancer treatment. A lot of people receiving treatment—I think it's something like 45 per cent of people who are receiving treatment at the North West Cancer Centre—are travelling over 100 kilometres to receive treatment in that area. It's almost like a

satellite service for all of those surrounding communities, who do have that cancer disadvantage or burden of disease in them, travelling into Tamworth for treatment.

The CHAIR: How many Cancer Council offices do you have across New South Wales?

BRENNA SMITH: Ten.

The CHAIR: Ten?

BRENNA SMITH: Ten community offices in regional New South Wales.

The CHAIR: Wow. In the Hunter New England health district, do you have one at Newcastle?

BRENNA SMITH: Yes. We're part of what's called the Hunter Cancer Hub in Kotara, in Newcastle. We co-locate with Camp Quality, Canteen and Hunter Breast Cancer Foundation in Newcastle. We also have an office in Tamworth, and we have teams of people that work from those offices.

Ms LIZA BUTLER: When we talk about splitting the health district and that most people have to access services into Newcastle, we heard last week that referrals could be slower. Do you have a comment about that? Referrals would be slower if you did split the health district, because you're referring from one health district to another. Do you have any comment on that in regards to cancer services?

BRADLEY GELLERT: I don't think we could comment on that. I don't have any specific knowledge on that.

The CHAIR: Asked in a slightly different way, then, if you are a resident who lives in Muswellbrook, are you more likely to be referred down to the John Hunter for your service? Or are there some cancers where you simply have to refer off to other districts?

BRENNA SMITH: The only intel that I could draw on for that would be where we're transporting people to from those community areas. From that Muswellbrook area, people tend to be going down to John Hunter or Calvary Mater for treatment. They're not necessarily going back up to Tamworth, to the North West Cancer Centre, for treatment there.

BRADLEY GELLERT: But there will also be specific cancers where you need to be treated in a high-volume centre because they're so rare, they're so specialised, that you'll have to come to Sydney. And that's why transport and accommodation subsidies are so important.

The CHAIR: So there are some specific cancers where not even the John Hunter can deal with them?

BRADLEY GELLERT: Yes.

The CHAIR: Thank you for appearing before the Committee today. We will provide you with a copy of the transcript of your evidence for correction. Committee staff will email to you any questions you've taken on notice; it escapes me whether or not that happened today. We, as a Committee, may develop additional supplementary questions that we will forward off to you, based on your evidence today and what we've heard and what we want to further explore with you. Thank you again so much for your valuable time and for being with us and, of course, for all the work that the Cancer Council does. The Committee will now break for lunch and return at 1.30 p.m.

(The witnesses withdrew.)

(Luncheon adjournment)

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

Mr REECE FREDERICKS, Executive Committee Member, Australian Paramedics Association (NSW), before the Committee via videoconference, affirmed and examined

Dr TONY SARA, Secretary, Australian Salaried Medical Officers Federation NSW, before the Committee via videoconference, affirmed and examined

The CHAIR: Thank you all for appearing before the Committee today. Members of the public, of which there are none, are not permitted to film or photograph the hearing. However, our Committee staff will be taking photos and footage that we may use on our social media pages. If you have any concerns about your image being used, please let us know and we will adhere to that. Before we start, do you have any questions about the hearing

process? No. Would either of you like to make an opening statement? Dr Sara, I'll let you make the first statement, and then I will ask our two paramedics whether one of them wants to make an opening statement of up to two minutes as well.

TONY SARA: We're happy to make an opening statement. The big picture of health in New South Wales, as the special commission has demonstrated to us, is that it is underfunded. Our experience over the last couple of years with Hunter New England and the waiting list saga some years ago demonstrates that Hunter New England is relatively underfunded compared to the other LHDs in New South Wales. What is being experienced in Tamworth, Armidale, the north-western corner of Hunter New England is to be expected, given the state of funding to health and to Hunter New England in New South Wales. The second big-picture point is that salaries and wages to all staff in health are significantly less—apart from the paramedics, who got their pay rise last year—compared to other States and Territories. We are undergoing arbitration at the present point in time, but essentially it's a 25 to 30 per cent increase of salary, terms and conditions of employment, to go north to Queensland or south to Victoria. The members in the Tweed have made this very clear, and a number of them actually work across the border.

The third big-picture point is that increasing a layer of management by splitting the district in two would suck up even more of the very scarce health dollars. An example is clinical governance. Each district has got a director of clinical governance, by health department policy, and we all strongly support that. If you split this into two districts, you'll have to have another $150,000 to $200,000 to a person doing that job. If you've got a couple of people at your site and a unit at the district of four or five, you're going to have to start duplicating those people, so what you might expect in terms of savings by splitting the district will actually go in administrative costs. It's just not possible to carry out the functions that a district is required by legislation and the national standards without the staff to do the work. It would be a self-injury to split the district.

A number of members have made points to this Committee of inquiry, and we would make the same points, that it's quite possible that referral patterns will be markedly disrupted. A district has an obligation, both professional and managerial, to provide tertiary- and quaternary-level care to sites within its district. You can't have tertiary and quaternary care at Tamworth and Armidale. It's just not feasible; you don't have the staff and the money. There is an obligation on the tertiary and quaternary referral centres to accept those patients. When it's one district, you can apply managerial pressure that they would accept them. We know in the last couple of weeks that John Hunter is short at least 30 to 40 to 50 beds, but they are still obliged to take the tertiary referral cases from Tamworth and Armidale. If you break those managerial relationships, will the tertiary referral patterns occur as well? Our judgement is they may not. Doctors in those sites have made those points to this Committee already.

For all of those different reasons, we do not believe that splitting the district will be of any material benefit. It may, in actual fact, worsen the referral patterns and the amount of money available to direct patient care, so our strong view is that splitting the district is not wise. I would make the point that when the old area health services were split into districts, we were strongly in favour of that because the areas were so large, but there is a sweet spot for the size of a district or an area health service. Our members at the time said—at the time of splitting the districts following Garling—they did not perceive any material benefit because of the way the district is structured and managed, they didn't think that the sites in the north-western corner were big enough to stand on their own. Therefore, our view to Garling was, and our members supported this, we did not support breaking up Hunter New England into two districts, that the losers would be the north-west corner—Armidale and Tamworth. Our position is consistent with our position of some years ago, honourable members, and I'm very happy to take questions as may be required.

The CHAIR: Thank you so much. Now I'm going to throw to our paramedics. Did one of you want to make an opening statement as well?

CODA DANU-ASMARA: I will make a quick opening statement on behalf of the Australian Paramedics Association. Just for the record, I am not a paramedic. I work with the union as part of the office staff. I just wanted to make sure that no wrong questions are directed to me. However, our executive, Reece, is online here to answer any questions about on-the-ground paramedicine. He'll be able to answer those. However, I drafted the submission and work within the industrial and legal part of the union, so I can answer anything regarding that. The first thing I just want to make clear is that the paramedics do not strictly operate under the local health district system. As some of you may already be aware, they have their own ambulance zones and districts that don't necessarily overlap, although in this case, they are quite similar. The Hunter New England ambulance sector is mapped relatively similarly to the LHD. It's split into three zones below the larger sector: the Hunter Zone 1, which is Newcastle; Hunter Zone 2, which is the greater Hunter area, Kurri Kurri and north of that; and then also New England Zone, which is the larger New England area, of which Reece is a part.

As our friend from ASMOF said, there's no question that the north-west has a greater disparity of health care than the Newcastle area, and there's no question that our biggest concern about the splitting of the districts is that the disparity between those healthcare outcomes could greaten if the splitting occurs. Obviously, we're all here because we want the best for that district and that region. I've read the original introduction of the bill, and I know that that's the primary reason for this bill being introduced: the health care disparities, and that the outcomes for the people there should be increased. That's the goal of the Committee today: to find the best way for those to be increased.

However, we worry that if the local health district is split without further funding being given to the New England area, such that the hospitals there become real primary centres of care, as opposed to being forced to transport purely to Newcastle or, in some cases, Orange hospital—hospitals such as Wee Waa, Armidale and Tamworth are currently not up to the task of running the entire local health district. That's the experience of the paramedics we've been speaking to. While they do an admirable job, incredible work for the community they have, the funding is not enough at the moment for them to be able to service the entire community by themselves.

We come with a caveat, I suppose. We worry that the splitting of the local health district at the moment could negatively impact the area. However, with an increase in funding and a plan for how to do the transitions in such a way that those hospitals can be fully funded and reach the level of what we expect major hospital centres to be in a local health district, we believe that would possibly alleviate some of the concerns. As proposed, the bill itself simply just asks for a redistribution of rights and debts between the two local health districts. It doesn't satisfy our concerns that potentially the splitting could lead to more negative outcomes than there are as current. We're happy to take any further questions on this, and thank you for your time.

The CHAIR: Dr Sara, you said that Hunter New England health district is underfunded compared to other local health districts.

TONY SARA: Yes, sir.

The CHAIR: By what measure? By what standard? By what comparison? Where does that come from?

TONY SARA: That's just our views and our feelings following the waiting list saga of a few years ago. Our members say that that's the case. We don't have necessarily the exact facts and figures. The ministry may dispute that, but that's our sense of it, and our members' sense that Hunter New England is relatively underfunded compared to some of the big, rich metros.

The CHAIR: I have a similar question for the paramedics. In your submission, you have written that:

> There is no question that there is a significant disparity of healthcare, treatment outcomes, and funding between the two proposed LHDs.

That is New England and Hunter. On what basis do you say that there would be a disparity between funding if we established in New England separate from Hunter?

CODA DANU-ASMARA: I'm happy to take that question. It comes from two perspectives: one from the text of the bill itself, which asks for a redistribution of the rights and the obligations between the health districts. At present, it's no doubt that the Newcastle John Hunter Hospital is larger than all the other hospitals in the New England area, so if things were to maintain a status quo, there are simply fewer doctors and fewer services in those hospitals. Therefore, the funding would presumably be less. Of course, you can say that's a bit of an assumption or a leap, but I would imagine that in the hypothesis where they were split with no further changes, the funding would primarily go to Newcastle rather than to the regional areas. The primary point of our submission is to be assuaged that such a thing would not happen if those were to be split.

The CHAIR: Can I get you to hypothesise on how the funding might be split? From a population base, about two-thirds or three-quarters of the population would be in the Hunter area and about one-third up in that New England north-west area. We could do it on population base. I guess we could spread the money based on the number of services or the number of beds in each service. Obviously, the funding at the moment is like a—what's that model, doctor fee-for-service? You get a payment for a treatment or something like that.

TONY SARA: It's a combination of fee-for-service and sessional rates for doctors, but the issue is the funding from the ministry is partly block funding and partly on the basis of activity with NWAU. Very small hospitals get block funding. The big hospitals end up with weighted activity funding.

The CHAIR: If we were to split into two health districts, do either of you want to hypothesise on how we might split up the one single bucket of money that is already going to Hunter New England Health? How would we split that into two separate buckets? What might that look like? I appreciate I'm asking you to make some assumptions and some estimates here. I might start with you, Coda.

CODA DANU-ASMARA: I'm happy to answer. I might also give Reece a chance to respond as well. I think the most important thing is that if it's going to be its own local health district, there needs to be service development for the services that John Hunter currently provide. As Reece can tell you a little bit more about in detail, often paramedics in Armidale—which is, as you know, quite far—are forced to transport people down to John Hunter or to Orange hospital, which has the facilities that Armidale, Tamworth, Moree or wherever does not have, and so those sort of facilities—specifically, they're things like radiation or oncology only being available in Tamworth, I believe, one day a week, things like that. If it's going to be its own local health district, it should have services that are befitting of a local health district. Only having something as important as that one day a week is difficult, because you would then have to be transported across the local health district lines every single time you needed to go for a chemotherapy appointment, or something along those lines, if there isn't enough staff to actually tend to these areas. Reece can also speak a little bit, perhaps, to his own experiences transporting between the different districts there.

REECE FREDERICKS: I can't explain how to split the money because I don't know how that's allocated now. The difficulty is, people in the New England need to have access to the specialists that are at John Hunter. As it is now, if ICU beds are full in Tamworth, we filter down to John Hunter. I fear if we get split from Hunter, those people that need an ICU bed could end up anywhere in the State. It's the same with mental health services. If Banksia in Tamworth is full, where are these people going to end up? How do we ensure that they're close to family and loved ones and the support systems that they have and they're going to need?

The CHAIR: Dr Sara, if I tasked you with splitting up the money allocated to the Hunter New England health district into two separate buckets—

TONY SARA: It would be really difficult. You're not going to get the tertiary referral services at Tamworth and Armidale. We don't have the staff, anywhere in New South Wales, so to get extra staff to go there just wouldn't work. It takes years and lots of time and money to establish tertiary and quaternary services. It just wouldn't happen. It's just not feasible. How you would split up the dollars, there would be a fight, and you may, in actual fact, diminish the tertiary services at John Hunter. Then you try and establish them at Tamworth and Armidale, and if you couldn't establish them, it could be very disruptive. In our view, it's just not feasible, it's just not possible to do this. It just becomes a self-inflicted wound on the health system, and on Tamworth and Armidale, for this to go through.

The CHAIR: Thank you all so much, and I appreciate that was a difficult question for me to ask, probably a bit unfair, but I appreciate your thoughts.

Ms TRISH DOYLE: Thank you, Tony, Coda and Reece, for being with us today and sharing some of your expertise, knowledge and views on this particular bill and what it proposes. It's very much appreciated. With all due respect, Tony, to your initial comments around pay increases for healthcare workers, I'm a little biased—I am the mother of a paramedic—and so it is absolutely fantastic and very well deserved that they all did receive a pay rise. I'm interested in hearing from all of you—from an industrial perspective, Coda; Tony, from ASMOF; Reece, on the ground—how often and how does the local health district consult you, as stakeholders, on best practice of providing health care and services in these regional and rural areas?

CODA DANU-ASMARA: I can take the question first. From the union perspective, the union, I would say, is rarely consulted by the local health district. NSW Ambulance is distributed into a different but similar sort of bureaucracy, I suppose is the best way to put it. We do consult with the New England ambulance sector constantly. To be honest, I speak to the head of the sector frequently. His number is saved in my phone. We talk about a variety of things, from high-level consultation to very individual sort of issues. We do have a good relationship there. But when it comes to consulting for best practices about the hospital, generally speaking, we do get consulted about the broader health changes that go on within NSW Health and policies that are implemented within Ambulance, but in terms of the local health district contacting the union, I would say it's quite rare. The only thing I can think of recently is when we did discuss a few years ago the rollout of the Corpuls, which is a machine that tracks heart rates and defibrillations, that was replacing a previous machine. The details aren't relevant to this hearing, but basically we don't have too much communication with the local health district itself.

TONY SARA: Our members tend to be important people in their sites. Therefore, with competent managers—and that's a very guarded statement, Ms Doyle—our members are part of the management processes. When things go wrong, as occurred with obstetric gynaecology in Tamworth and Armidale, we were certainly more tightly consulted: if you remember, there was a shortage of obstetricians. The obstetricians there said, "We can't go on like this." We became involved in trying to work out a better way of doing things. But, of course, if you can't attract the staff, it doesn't matter what you do, other than doing special deals that the ministry don't like but they sometimes have to put up with, otherwise you can't get staff to go there. Our involvement is variable

depending on the issue, depending on management. Our involvement in that part of Hunter New England on some issues—emergency, obstetrics—has been patchy, but we are certainly often part of the processes.

Ms TRISH DOYLE: Excellent. Can I just quickly hear from Reece, from someone with their feet on the ground? How do you feel that your voice and your experience as a paramedic is heard by the local health district?

REECE FREDERICKS: We very rarely get consulted. We're more used as like a bandaid for these smaller hospitals, as Dr Sara could probably tell you. These smaller hospitals like Guyra, Tenterfield, Glen Innes, Inverell and Wee Waa, heaps of them don't have doctors. They're relying on My Emergency Doctor, who often refers to places like Armidale. We're not consulted by the LHD. We're just used to move these patients to where they're able to see a doctor.

Mrs TANYA THOMPSON: Dr Sara, there's a strong reference in your submission around the award and changes to pay and parity, and rightly so, for the work that you all do. I just wonder if you could expand more on that. Do you feel that a change in pay is the be-all and end-all to fix the issues within Hunter New England Health? There are some really strong statements and quotes within your submission. I just wanted to know if you could expand on that. If it isn't, what other suggestions would you have, if the splitting is not your recommendation. How further would you expand the workforce within the district?

TONY SARA: Thank you very much for the question. To answer the first part, pay, terms and conditions is not the be-all and end-all, but if you're operating on a platform with 25 to 30 per cent less than Queensland and Victoria—and we know that specialists in the Tweed go and work at the Gold Coast, we know that it's a factor. Is it the only factor? No, it's not. But we have to make those comments, given that we've just spent six or eight weeks in conciliation, six months in mutual gains bargaining getting nowhere, we're about to run an arbitration case, so as a union, we have to say, "This is a very important thing." Certainly our members believe it's very important. We are losing new doctors, new specialists, to other States and Territories. We are losing junior doctors. Some sites in New South Wales are unable to recruit interns because they're going to Victoria and Queensland. So it is a factor. Is it the only factor? No.

The second point would be that special deals for rural placements, rural specialists, have been a longstanding feature of the health system. The ministry has been trying to undo them where they find out about them. But if that's the only thing that will get someone over the line to moving from Sydney, Melbourne or Orange to Tamworth and Armidale, and if it works, why are we as a health system saying we're going to stop all of them? It's about staff feeling valued. It's about feeling supported. If you're a specialist needing to do on-call and you want two to three other specialists available, you can't do it by yourself, and if it means an extra 20 or 30 per cent of income via some sort of special deal, if we want those sites to be staffed, we should do that.

A number of the special deals would go away if we had a 25 to 30 per cent increase in terms and conditions. It's about doing what's practical and realistic to encourage staff to go. One of the claims we're putting in our award is for a rural allowance. I suspect that it may not get up. Some craft groups, teachers and other groups, get it. Whether NSW Health is going to agree to rural and regional allowances, we don't know, but the health department has been opposed to those for the last 30 years. We need to do something. We've got to get staff out there. You can't run a hospital without enough specialists. Staff specialists do it better than VMOs generally. VMOs have a different mode of practice in the rural spaces, they do more teaching and research, but you tend to get more buy-in in a hospital from a staff specialist. They sit on the committees, they do the community service obligation work, the quality work, the compliance and national standards work. VMOs tend to come in, do their clinical work and leave. The institution as a whole is not as well served by VMOs as it is by staff specialists.

Mrs TANYA THOMPSON: Second to that, we know that locums put a lot of pressure on the budgets of health districts. Do you think that finding some balance on pay with doctors would alleviate that budget constraint?

TONY SARA: Clearly, we support that point of view. We made that point in the psychiatrist arbitration. If you remember, 200 psychiatrists threatened to resign and about 80 of them eventually finally did resign. You pay a locum psychiatrist $3,000 a day. You pay a staff specialist about $1,600 or $1,800 a day. There is clearly an enormous amount of money going into locums in the rural hospitals. We've made that point to the ministry. They don't seem interested. Why they're not interested, we don't know. In the psychiatrists arbitration, they talked about contagion—that if psychiatrists got more money, then everyone would get more money. But their witness from Treasury said we don't think contagion would actually be a real thing outside of doctors. So we don't understand why the rational economist would look at those big amounts of money going to locums and say, "Let's put some of that into the normal staff and see if we can't attract and retain some more and reduce our locum costs." But the ministry don't seem interested in that, and I just don't understand why.

Mrs TANYA THOMPSON: Thanks, Dr Sara.

The CHAIR: Donna Davis, the member for Parramatta, I'm going to come to you now for questions.

Ms DONNA DAVIS: I want to expand on your response to Mrs Thompson. Doctor, it says on page 11 in your submission:

> The solution to chronic understaffing within HNELHD, and indeed NSW at large, can only begin to be addressed through a new Award that secures improved pay and conditions for doctors and further incentivises work in remote and rural regions.

We've also heard that housing is an issue, that isolation is an issue, that schooling can be potentially an issue for families—the choice for doctors to move to regional areas and then choices for their families as their kids get older. What, of those other issues, are you hearing from your members are a concern, as well as pay?

TONY SARA: As you've said, it is schooling and it's about housing. What a number of rural communities do to attract general practitioners is they provide an upmarket house at a cheap rent. I don't think any sites do that for specialists, but if housing is very tight in a town, and you can't buy a house at a reasonable price, then how do you expect a specialist man or woman to move with their family to that town? They just don't. So it is a multifactorial problem. All we can do as a union is put forward our members' views that pay, terms and conditions are an important component of that. It's going to be up to the individual town as to what they do.

Most districts provide high-class, cheap rental accommodation for junior doctors who are seconded. They buy some two- and three-bedroom home units, they buy some three- or four-bedroom houses, so the young doctors have got somewhere to stay. Very few city-based hospitals do that. If you're at a rural allocation centre as a young doctor and you come to Sydney, you may have to stay an hour away in a dive. In terms of junior doctors, sites have already made those sorts of decisions—that if you want to send young doctors to their site, you've got to provide some accommodation that's reasonable at a reasonable price. It's about attracting, recruiting, retaining. Whatever you need to do in a site, you need to do that because, in actual fact, it costs you less money in the long term than paying locum rates.

Ms DONNA DAVIS: Thanks. Dr Sara, is the Federal Government doing enough in terms of accreditation of overseas qualifications? Is there more that could be done to fast-track accreditation, or is that something that is not seen as palatable by your members?

TONY SARA: My own view is that the processes for accreditation of overseas specialists have been turgid. They've been difficult. However, the health Ministers have made a decision and they've instructed the AMC and the Medical Board of Australia to provide expedited pathways for some craft groups. I think obstetrics and psychiatry are in process already. My sense is that they have made it faster without making it unsafe. My own experience with overseas-trained doctors is sometimes they're better than the doctors here, but sometimes they're not. These expedited pathways all provide for a period of supervised experience, so you make sure that the person that is coming is up to the task. They all require some cultural accreditation training. The health system and societal expectations in Australia are different to other countries, other cultures. I think that the Federal Government is doing what it can with those expedited pathways. We won't know for a little while how effective they are. They've only started in the last three to four months, but I think that that's certainly a very welcome step by the Federal Government and by the health Ministers to put in place those expedited pathways.

Ms DONNA DAVIS: When we were in Narrabri, we were hearing about the challenges with transport—transporting patients to other hospitals—which meant that if there was an emergency, that ambulance wasn't in town. Have you done work on what we need to do to expand the services in those rural, regional and remote areas to be able to better provide for the communities? The other part of the question is, I know that some patients, when they're being transferred, can be transferred with a nurse and others are transferred with paramedics. Is that something that needs to be reviewed as well so that we can more easily transfer patients from one hospital to another?

CODA DANU-ASMARA: I'll answer quickly and then hand it over to Reece because he has a bit more experience on the ground. From the union's perspective, as part of the previous hearing about the regional and rural health care, we were asked about something quite similar and we responded that 24/7 patient transport in rural and regional areas—non-paramedic patient transport—would solve a lot of these problems because sometimes people are just simply being taken to doctors appointments that are necessary, of course, but that paramedic's experience may be needed for an emergency. So you don't want to necessarily have them do these transports that are still important but don't necessarily require their expertise. It was a recommendation from the Government that this 24/7 patient care should be implemented as soon as possible, but unfortunately it still hasn't. I can give Reece a bit of time to talk about his own personal experience.

REECE FREDERICKS: I think that the beginning of that problem and the need for people to be transported—you used Narrabri as an example; that's 1½ to two hours to get to Tamworth to see a doctor—is

putting doctors in those centres. So giving practices like Narrabri a doctor would filter out a lot of those unnecessary transfers to places like Tamworth. I think Ambulance has a lot of work to be done in places like Narrabri, Glen Innes, Tenterfield in [audio malfunction] there that can cover the town while they're on the transfer. As it is now, Glen Innes—they send someone out of town at eight o'clock at night, yet your nearest cover is Guyra, which is about 40 minutes away, which means if something happens in that town, help is 40 minutes away, which isn't good enough. The union definitely gets consulted on where staff enhancements are happening but, a lot of the time, Ambulance has made their decision about where those staff are going to go.

Ms LIZA BUTLER: Thank you for joining us today. I'm hearing quite clearly from everyone here this afternoon that there is a great disparity in health outcomes once you cross to the west of the Great Dividing Range. I'm also hearing quite loudly that you don't really support the splitting of the health district. If this bill doesn't pass, what changes would the Hunter New England Local Health District need to make to improve health services for people west of the Great Dividing Range? Are there some key things that could be implemented to help with the situation out there?

CODA DANU-ASMARA: I can pass this one to Reece, if that's all right.

REECE FREDERICKS: I think one thing that could improve things within maybe the next five years is ensuring there's medical staff, like doctors, in all our hospitals, instead of relying on a bit of a flawed system that is the "my ED doctor". Then, in your bigger centres like Armidale, Tamworth, ensuring that there's access to specialists so people aren't having to travel to Newcastle—which is about 4½ hours away—to access those specialists. Also enhancing the number of allied health and people like paramedics within those areas to ensure they can access those specialties or those allied health or mental health supports would improve health outcomes west of the Great Dividing Range, I think.

Ms LIZA BUTLER: How do the hospitals and the regions out there get that information on what they need to the executives in the health district?

REECE FREDERICKS: I think the executive already have that information. I think it's a matter of budgets. As Dr Sara said, it's the matter of spending a lot of money on locums to fill a couple of days, say, in Glen Innes, when they could be looking at the longer term goal of putting a couple of doctors in somewhere like Glen Innes.

Ms LIZA BUTLER: Dr Sara, do you have anything to add to that?

TONY SARA: Not really. We've covered the fact that so much money goes into locums. Would increased terms and conditions get someone into a small town? Hard to know. We're more likely to want a rural generalist in a very small town, rather than an ICU specialist, an internal medicine specialist and a specialist surgeon. The College of Rural and Remote Medicine and the rural generalist movement is picking up. Paying them as staff specialists does work in other towns. It certainly works well in Queensland. I don't really know that I've got much to add to that.

Mrs HELEN DALTON: My question is directed to Dr Sara. Clearly what you're saying is a doctor that walks to work will be a whole lot cheaper than a fly-in fly-out. I know that it's not the complete answer, but will the Medicare provider number allocated to a regional postcode help in some way relieve the doctor shortages in the bush?

TONY SARA: That's a mixed question with a mixed answer. If you're a staff specialist and not exercising rights of private practice, you don't need a provider number. If you're exercising rights of private practice, you are billing Medicare for persons with private health insurance or you're running a general practice that's attached to a hospital and not part of the emergency department, again, you can be billing. There's no easy cut and dried answer to that. If you're a rural GP who does three-quarters of your work in a general practice, having a provider number and being able to bill Medicare is an essential part of the way you practice and make an income.

If you're completely a staff specialist and there's not enough private health insurance in the town, being able to bill private health insurance is of no real relevance. If you run a mixed practice as a specialist, so you do some general practice work and some emergency department work, having a provider number means that you can increase your income and partly, hopefully, keep the low-acuity patients out of the emergency department into separate general practice. I don't think there's a cut and dried answer to that.

Mrs HELEN DALTON: No, but it would go some way to helping?

TONY SARA: Yes.

Mrs HELEN DALTON: Do you think that the Hunter New England health district, the bureaucracy, is bloated, or do you think it's kind of what it should be?

TONY SARA: I don't think we could form a view. We haven't done any comparative work between the districts. Having said that, there's a broad range of functions that a district needs to carry out. You need a director of nursing, a director of clinical governance, a director of HR, a director of innovation, a broad range of staff at the district level to carry out the functions that you need in today's health system. You need teams to look at the national standards. You need teams to look at the morbidity and mortality that occurs. It is more efficient to do those at a district level than at a site level. That goes back to what we were saying earlier, that you would increase the amount of money spent on administration if you split off the north-west of Hunter New England into its own district. It would cost a lot more money and you would struggle to get the staff to do those district-level functions. In terms of a direct answer to your question, we have not done a comparative study.

My sense would be after 40 years in—I'm a medical manager by training. I've got FRACMA. I'm not a paid-up union official. I'm a medical manager by training and experience. My sense is that it would be unlikely that the bureaucracy at Hunter New England would be any more or any less bloated than any other district. There is a significant amount of work we need to do at the management level. I would think that competent managers are not going to spend more money than they need to carry out the functions required of districts by the Acts of the Parliament, the Commonwealth, the national standards and proper clinical governance. I would think it unlikely, but I can't give you a definitive answer, that it is or is not more or less bloated.

Mrs HELEN DALTON: My next question is directed to Coda. Can you confirm that some of the highly skilled paramedics are not paid for their skills and are not allowed to use their skills in rural areas?

CODA DANU-ASMARA: I assume you're referring to the specialist paramedics when you refer to that.

Mrs HELEN DALTON: Yes.

CODA DANU-ASMARA: This is something we testified on in the previous hearing. Obviously, ECPs and ICPs are the specialist paramedics that were being referred to. There was a period of time when the materials would be taken away from these rural areas. Since that previous hearing and the recommendation that they be returned, some of the material has, in fact, returned, and people have been practising more there. But recently, unfortunately, one of the ECP vehicles in the South Coast and Illawarra crashed last week. Unfortunately, at the moment, it's not going to be replaced at least for another four weeks. These sort of critical shortages still exist in the rural healthcare space, where you can use your skills but it's not a priority. That's the tough thing.

The ECPs, as you may or may not be aware, are the lower acuity paramedics, sort of the travelling GPs in a way. These are some of the most important for the rural and regional areas, because they can save people a trip to the ED, the GP or the doctor by setting a fracture or just changing a wound dressing, things that are quite simple that you can do yourself but only a trained medical professional can do. Having an ECP being able to come to do that saves so much money for the health system. It's uncountable. The fact that they're continually depressed within the service is something that's always distressed us as a union. Obviously, after the previous recommendations, the service has put some things in place, but we're not there yet, and the treatment of the ECPs, just seen by the most recent event that I referred to in the Illawarra, shows that there's still a long way to go.

Mrs HELEN DALTON: Are they being paid for their expertise?

CODA DANU-ASMARA: This is obviously a question that maybe I should answer, and I know we're running out of time, because it's a bit of a longer answer. If you are in a position that is accredited to an ECP position, you would be paid for your skills as an ECP. However, if you are an ECP and you want to leave that position and go to another position that isn't accredited for that position, even though you have the skills, expertise and will be using those skills when you're working, you will not be paid for those skills if you accept a position that it isn't accredited for. A lot of the rural and regional areas, despite needing ECPs or ICPs, are not accredited for those positions. That's the short answer, but I'm happy to write out a longer answer for later, noting the time.

The CHAIR: Thank you all so very much for appearing before us today. You will be provided with a copy of the transcript of your evidence for any corrections. The Committee staff will email questions taken on notice, but I don't think there were any, so forget that. We as a Committee may develop supplementary questions on the back of your testimony today that we will send over to you in the coming days, and we would ask you to respond to those as soon as possible as well. I sincerely thank you for your wisdom and your time in appearing before us today. It's helped us greatly.

(The witnesses withdrew.)

Dr TANIA DAY, Chair, Training and Accreditation Committee, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, affirmed and examined

The CHAIR: We are a couple of minutes late and I do apologise for that. We've just had a fascinating session and I'm sure we're about to have another one. Dr Day, thank you for appearing before the Committee today and giving us some of your valuable time. Members of the public—of which we have none—don't take photos. You're not here, so it shouldn't be a problem. We may take photos and video footage and use it for our social media. If you have any objections to that, please let us know and that won't be a problem; we will not use your image. Before we start, do you have any questions about the hearing process?

TANIA DAY: No, thank you.

The CHAIR: We obviously have your submission, but would you like to make a short opening statement before we ask questions?

TANIA DAY: The RANZCOG does not really take a position on where to draw jurisdictional boundaries as they relate to health districts. The primary concern of RANZCOG—well they're manifold, but essentially is the delivery of clinical services to women and families, the quality of training and that that training meets our accreditation standards and ensures that, by the end of training, specialists can undertake the job that the community expects. Finally, around workforce maintenance and ensuring the wellbeing of our fellows, which the primary membership of RANZCOG is specialist O&G, and GP obstetrician gynaecologists.

The CHAIR: We are a Committee of six members at the moment and we only have limited time with you, so I'm going to ask the Committee members to be mindful of the five minutes that you have at your discretion. Please ask short questions. Dr Day, if we could ask you to give brief answers, we'll get through as much as we possibly can. Online, we have Ms Trish Doyle, the member for Blue Mountains. She is the deputy chair of this Committee. I'm going to throw to her for the first questions.

Ms TRISH DOYLE: Thank you, Mr Chair. Welcome, Dr Day and thank you for sharing your expertise and knowledge and views with us today. Our Committee has heard that a split in the local health district would reduce access to structured training, intensify workforce shortages and limit culturally competent care delivery. What's RANZCOG's view on this?

TANIA DAY: I think that the boundaries of health districts are not the purview of RANZCOG**.** At the moment, specialist trainees—the only site that we rotate to in the New England sector is Tamworth. John Hunter rotates a specialist trainee to Tamworth, but so do Sydney hospitals and the structure of integrated training programs does have formulaic rural rotations, but those can be modified on the basis of trainee needs and also on workforce issues. It's not uncommon that due to extended leave—often relating to maternity leave—there isn't a trainee available to rotate to a particular hospital site, and then there might be swaps or changes or people leaving midway. In some instances, a trainee is simply not available to rotate to a particular site. As far as availability of specialist trainees, that is not a health district-based decision in O&G.

I know that Hunter New England does centralised JMO recruiting and then JMOs—the most junior doctors, not specialist trainees—are rotated across multiple sites in the district. If there was a division of the district, then New England would essentially undertake its own recruitment process for JMOs. The interlinking there is that when you're running a specialist training program, the availability of JMOs is really important for the quality of specialist training, because otherwise specialist trainees end up undertaking many of the tasks that should be allocated to more junior doctors, and that dilutes their training experience and contributes to burnout and dissatisfaction with the role. I hope that that addresses the first part, which was around training. Could you just remind me what the other—was it around clinical services?

Ms TRISH DOYLE: Some have said that the split in the local health district—you've covered off the training—would also intensify workforce shortages and limit culturally competent care delivery.

TANIA DAY: I don't see how RANZCOG could reliably predict what will happen with workforce shortages and the exacerbation of those, because we are already in a massive workforce shortage scenario across most of Australia and across every level of practitioner. Junior doctors, consultants, but also midwives, nurses, administrative staff, anaesthetists—the whole team of people that it takes to deliver high-quality maternity and gynaecology services. I don't know how that would change. I think some have stated that recruitment is best taken centrally, others that it's more appropriate done locally. I'm aware of both strategies being employed through the John Hunter, neither one of which has enjoyed very much success.

Workforce is a major problem for reasons that are far outside of jurisdictional boundaries, in that no-one wants to work the way that doctors did 40 years ago. Most of my colleagues—most RANZCOG members—want

to work part time. They don't want to have onerous on-call burdens. They want to have a lot of support from other colleagues across multiple disciplines. What that ends up meaning is you need more people to do the same jobs that maybe 40 years ago could have been done by one person, on a background of a whole medical community and a whole medical science that is much, much more complicated than it used to be.

Mrs HELEN DALTON: You said in your submission that "regional communities have distinct and complex health needs, compared to metropolitan counterparts." Could you expand on this point and then could you go some way to resolving that issue? It's the $6 million question.

TANIA DAY: Yes, I'm afraid I won't be able to go very far into that. The issue of delivery of services in rural and regional Australia, particular to O&G, has been the unsolvable problem generationally, and it seems to be getting worse and worse, as far as that space between what the expectation is and what's deliverable. RANZCOG has tried many different things to try to improve workforce availability in regional and rural areas, and has had limited success. One example is the provincial ITP program, which is the training of specialists in non-tertiary non-capital city hospitals, in the hopes that if you have people move out to those places for their training, they'll stay on as specialists there, and then build a community of specialists that ends up serving that town into the future.

When we ran the data on that, we found that the majority of people who are placed at provincial ITP programs don't stay in those areas. They often return to cities for their advanced training and take jobs in those cities. The rural rotation thing has been much the same. RANZCOG is a college that has a mandatory six months of rural rotation during your specialist training. That has often been sold as a mechanism to attract people to stay and work in rural areas, because the idea is they will enjoy their time there so much that they'll stay on. We've found that does not have any influence and has not changed the rates of people staying and working in rural areas. Anecdotally, I've found that it actually probably drives some people away from wanting to work in rural areas because of the challenges faced by doctors in rural hospitals as far as support, the availability of services, some of the workplace culture issues and how they see the seniors around them with regards to after-hours demands and work-life balance. Those mechanisms have not been entirely successful.

As far as the different needs of rural and regional women and families, I'm not entirely sure I know how to address that. I think the needs of women are generally the same. They need high-quality health care that's affordable, and they're willing to travel for it in many circumstances, but there needs to be a kind of baseline of care that is deliverable in areas by specialists: the basics of gynaecology, colposcopy, ideally abortion care, antenatal care and some sort of decision-making around the location, timing and mechanism of birth. Sorry if that's a suboptimal answer, but I think in general women need the same thing.

Mrs HELEN DALTON: No, thank you. You've done very well.

Ms LIZA BUTLER: Thank you for joining us. We've heard from a number of stakeholders that there has been a substantial decline in maternity and obstetric services in the Hunter New England health district. What do you think has caused this decline, and would splitting the health district improve these services?

TANIA DAY: The word "decline" is one that is highly interpretable. I did want to bring up today an expansion of maternity services that has occurred in the health district which relates to the IMAP service, which is Initial Maternity Assessment and Planning, spearheaded by the maternal fetal medicine subspecialist team at John Hunter. It has this very organised weekly outreach service to the Mehi district, which I may be pronouncing incorrectly—Australian place names get me every time after all these years living here—but essentially to Moree once a week. There is a specialist plus additional services, sometimes midwives or sonographers, either locally or from John Hunter, and subspecialists that provide a face-to-face service once a month and then a weekly telehealth service to bring women into this model of care of an early assessment of their maternity-related risk and then decisions regarding the model of care for the rest of the pregnancy. That includes planning for timing and mode and location of birth.

That has really only been running for a couple of years, but from what I can see and what colleagues have spoken to me about, it has enhanced some of the local capacity as far as midwives and nurses, sonographers and local GP obstetricians being able to expand what they can offer and have that training and education experience working very closely with the specialists and subspecialists from John Hunter. It has introduced a mechanism to bring cases of concern through an organised antenatal care system and prevent some of the emergency transfers that can happen when you aren't aware of all the things that are going on with a particular woman and her baby. I would frame that as an increase in service, a high-quality, innovative service that relates directly to the current health system, combined of a tertiary anchoring hospital and then a large health district.

The people who set that up told me that they really thought it would be quite difficult to have started that and it may be difficult to continue if there are two separate executives, because that entire system relies on a

hospital and health district executive that have placed a priority on antenatal care and risk assessment. Other health districts that have expressed an interest in having that service built into their care model have not been able yet to achieve that because of a lack of buy-in from a separate executive. As far as a way that one could frame the diminishment of maternity services, there are multiple small hospitals that had GP obstetricians providing the bulk of O&G services with agreements around what types of things they would and wouldn't be able to accomplish in that service. Those are the things that indicate referral to either Maitland hospital, John Hunter or Tamworth, if it's not on bypass, and Taree, which are the regional referral centres.

It's been incredibly difficult to maintain those services as the GP obstetrician model becomes less and less feasible in New South Wales. RANZCOG is an absolutely huge proponent of the GP obstetrician model, but we have found that the numbers of people enrolling in those training programs is diminishing. The pressures on that role are ever-increasing. It's quite a huge role when you think about it to deliver O&G services in a small hospital without an onsite specialist and with the hospital that you're referring to usually being a helicopter or a plane ride away. As I was talking about earlier, that onerous on-call burden combined with the high-pressure, high-stakes aspects of emergency obstetric care has just made that a really difficult role to fill. If you don't have those people in those hospitals, you can't provide the service. As far as I'm aware, most of the services that have had to stop maternity, it's been around the clinical provision of care or the need to consolidate services into one place so that you can bring those professionals in from several locations to staff a service.

Ms DONNA DAVIS: Have you done any work to identify what we can do to make GP obstetricians' training more palatable and inviting to young medical students? They don't have to be young.

TANIA DAY: That's not really my area of expertise, to be quite honest. My chair role as training and accreditation committee for RANZCOG is really around specialist trainees, O&G trainees. I really have very little involvement with GP obstetricians.

Ms DONNA DAVIS: No, that's fair enough. We've heard that the proposed split may mean that the New England area will no longer have access to a tertiary hospital. What do you think the impact of this will be on regional areas?

TANIA DAY: As I think was pointed out in a speech around this subject, basically, all the other regional and rural health districts do not have a tertiary centre within them. The Sydney hospitals are all separate health districts. Their service level agreements between the rural and regional health districts and the city health districts around tertiary care services, gynaecologic oncology and high-risk pregnancy are outside of the role delineations for the smaller hospitals, which in many cases are around medical comorbidities and obesity. I would like to think that if other health districts can manage those service agreements and have access to tertiary care through those mechanisms, so could New England. But it does require this enormous investment in establishing a new executive, creating all of those service agreements, figuring out which hospitals are going to provide which services and all the funding arrangements, and looking at existing services and figuring out what to do with them.

I was talking about IMAP—is IMAP retained? At the moment abortion care in Hunter New England really only happens at John Hunter. John Hunter accepts referrals from all of these areas. Does John Hunter continue doing that or is abortion care also taken on locally? It doesn't require subspecialists. It's not a complicated service. The reason it's at a tertiary centre has been mostly about the desire to undertake that kind of work and the availability of specialists who are not conscientious objectors. I've stated that, while not impossible—and I can imagine a situation where one could deliver all the services that they need to and perhaps enhance their own services locally if a health district was separate—it does require this really enormous undertaking to figure out all the new systems that need to be built. That's just from the clinical standpoint.

There are also local policy procedure guidelines within health districts that, at the moment, are Hunter New England wide. Those would have to be specified and rewritten. There's a whole committee of the Women's Health and Maternity and Women's Health and Gynaecology—WHAM and WHAG committees within Hunter New England—that try to ensure their stakeholder input around policies and procedures and the distribution of services and education and support for all the different types of professionals that work within O&G. Those would presumably be reformulated and not involve New England anymore, and New England would need to establish its own committee or process for all of those tasks of guidelines and education.

The final thing that has been brought up to me from some of my colleagues is around the Hunter New England Simulation Centre, which does a lot of outreach training to New England. That's either not charged or it's a highly subsidised cost. The thought there is that that would also have to be revised. If they were being asked to provide those services to an out-of-area health district, it would be the same thing as if one of those sites was contracting with a Sydney hospital to provide simulation training.

Mrs TANYA THOMPSON: Thank you, Dr Day, for your time today and your input. Following on from Mrs Davis's questions, you note in point two, "Access to Care", the funding often being favoured for metropolitan areas. I would imagine through Hunter New England, that funding funnelling in through Newcastle, let's say. If you could reconfigure it, would you make suggestions on how that could better be managed so that there would be more fairness for the New England area? Is there a way so that it wouldn't have to be split, or would you make some other suggestions to create better fairness? Would that make a significant difference, do you think, in the overall outcomes for health and staffing?

TANIA DAY: I'm a clinician and my volunteer role with RANZCOG is around training. So I really have very little intelligent to say about funding and how it streams to different areas. I'm an employee of Hunter New England, and I have to say that the premise that John Hunter is extremely favoured in funding doesn't feel correct when you work at John Hunter.

Mrs TANYA THOMPSON: But you see, and we have seen it as well, in the New England area from Tenterfield all the way down through to Tamworth, hospitals on bypass, after bypass, after bypass, and you don't see that so much in the services in the Newcastle area.

TANIA DAY: What I might say about that is that in Hunter New England, John Hunter can never close. We're never, never on bypass. I mean, we're the busiest ED in the State, right? The operating theatres are running 24/7 with life-threatening emergencies at all times, as is the birth suite. So it's not an option for us to go on bypass. I think that the idea of bypass, as I understand it, is less about money and more about who you specifically have in a hospital at a given time to provide that service. In O&G, you need anaesthetists and specialists and midwives and administrative staff and theatre nurses and all of the staff required to run theatre, and if you have a shortfall of any of those areas, you can't provide a maternity service. To me, that speaks more to issues around workforce recruitment maintenance than it does around funding models. I do want to preface that with I'm not an expert in funding. All I know is that if you're the tertiary service for an area the size of England, you stay open, no matter what.

Mrs TANYA THOMPSON: Absolutely. No doubt about that.

The CHAIR: Thank you so much. Fascinating. I could listen to you all day. I think you made mention a little moment ago that, of the regional health districts, Hunter New England is the only one with a tertiary hospital. In the Western district, the main hospital is Dubbo. That's not a tertiary hospital?

TANIA DAY: No.

The CHAIR: Far Western district, the main hospital is Broken Hill—that's not tertiary. What about the Murrumbidgee? The main hospital is Wagga Wagga. Is that a tertiary?

TANIA DAY: No. Those—from RANZCOG perspective—are rural/regional rotations. With the exception of a provincial ITP program that is run alternating years out of Wagga and Orange, they essentially are rotational sites where the O&G trainees are based at a tertiary centre. One way to define tertiary centre is what they do as far as training. A more practical way to define it is around the services that are available. The full spectrum of specialist services 24/7, operating theatre, ICU, ED. The other thing that makes a tertiary centre usually is the academic aspect, the alignment with a university and researchers and that kind of integration of clinician researchers into the front-facing clinical work that's done. So, yes, it's quite an interesting question: What is a tertiary hospital? But, no, I wouldn't define Dubbo or Wagga and certainly not Broken Hill as tertiary centres.

The CHAIR: Early in your evidence, you spoke about the fact that there's rotation of O&G practitioners from the John Hunter into Tamworth. Is that correct?

TANIA DAY: Yes.

The CHAIR: You also see some rotations coming out of the Sydney health districts into Tamworth as well.

TANIA DAY: Correct.

The CHAIR: The one from the John Hunter into Tamworth makes sense to me easily because it's the one health district. What does that mean if they're coming from Sydney into Tamworth, where they're crossing these lines that we've drawn on maps—the boundaries of health districts? How does that work and why does it happen that way? Is it just that Sydney have got an interest or it's a fee for service?

TANIA DAY: No Again, I'm not a financial expert but, as I understand it, the O&G trainees are hired by NSW Health as registrars on that award and they're given a four-year contract. During their mandatory rural/regional rotation, an arrangement is made where they don't leave the contract they're under for their training program, but they are paid by the receiving hospital for that time. O&G specialist trainees are required to spend

12 months away from their base hospital. At a place like John Hunter, that means that they'll usually spend three years at John Hunter doing O&G specialist training and then six months at either Taree, Tamworth or Port Macquarie, and six months at Maitland.

At any given time, we have 20-plus specialist trainees in O&G based at John Hunter, and each of the Sydney tertiary centres has their own complement of trainees, each of whom needs to spend six months in a regional and rural area. There are service employment agreements for rotational placements. Many of them span health districts and some span state boundaries as well. I don't know if this is still going on, but trainees from Sydney would sometimes go to Darwin for a six-month rotation, and trainees in Victoria will spend six months in Tasmania sometimes. It's not really about jurisdictional boundaries; it's that every training site needs to have enough rotational options to get all their people their requirements. It's not going to work out in Australia that that always falls within health districts.

The CHAIR: With that description, if there was to be a separation, there would be no reason for this Committee to be concerned that that would suddenly terminate that arrangement between John Hunter as a training and tertiary hospital and the rotation of O&G specialists into Tamworth? We shouldn't fear that?

TANIA DAY: Yes, I think that's true. I wouldn't fear that in particular. As the culture of training and the relationship of employees to employers and training programs changes, trainees have more input into what they are and are not happy to do. Also, as we expand training numbers across Australia while simultaneously having more extended leave, there are many sites that are accredited for training that do not receive trainees. Sometimes that is kind of a one-off, because the person allocated to go there happens to not be available, but sometimes that's a result of trainees not wishing to go to a particular site because it is an unfavourable training environment or an unfavourable workplace culture experience. Sometimes it's too far away from home. Many of our trainees are women with small children and working partners, and relocating for six months to a distant site is extremely problematic for the management of their families. Sometimes it's a decision taken by hospitals where their trainees report that they're not happy with the experience they're receiving, and they have many options to choose from as far as where they send trainees, so they elect to not send trainees to a particular site.

The CHAIR: Thank you. I just wanted to draw attention to that being a lower risk in terms of it ceasing.

TANIA DAY: Correct.

The CHAIR: The Hunter New England Health submission specifically talks about some other outreach services that would absolutely be at risk of ceasing service. You mentioned the IMAP, into what you and I both call the Mehi River area, up to Moree. There are a number of other projects that were listed in the Hunter New England Health submission as well as some very specific Aboriginal health programs that at the moment deliberately, consciously, extend up into the New England. Their submission on those types of specialist programs is, "If they weren't part of us, we wouldn't do that work." That's different from the gynaecology model in terms of how they move around for their training.

TANIA DAY: Yes, that's right. I think the main difference there is one of training rotations that are part of completion of the RANZCOG specialist training program versus clinical services that are delivered often by trainees and specialists but have been established through long negotiations around the funding and logistics of setting up a service somewhere. I imagine that many of those clinical services would be at risk if there was a splitting and the Hunter aspect of the new Hunter health district decided that it was no longer a priority to facilitate services extending into New England with staff based at John Hunter. Because of the geography and the way that hospital tiered networks work, most specialists are always going to be in Newcastle. The subspecialists in particular can't work anywhere else. Gynaecologic oncology services—women's cancers—are only ever going to be at a place with big theatre teams, an ICU, a blood bank and multiple different contributing specialty services, like colorectal, urology and physicians. Those are complex patients, complex surgeries, and that work just can't be done in a small hospital.

The CHAIR: As the member for Cessnock, if there was a separation, I would still be in the Hunter health district. As a resident there, if they were spending money and resources into an area that wasn't their responsibility—e.g. the New England—I would probably be sitting in the Hunter health district going, "Hang on. Why are we spending money up there when we haven't got A, B, C and X, Y and Z in our own area?" That would be the challenge of not being in the one district. I can't make that comment at the moment because we're all together. We're all one big family.

TANIA DAY: We're one big family. That's right. But it's a point well taken that the work that would have to be done is establishing these service level agreements. Again, not being a finance person, as I understand it, smaller districts contract with larger hospitals for certain types of services. All of those negotiations would have

to be sorted out because no-one would want to do that work under the current arrangements, which are very much more around trying to cover the whole area with something that resembles an adequate public health service.

The CHAIR: I'm going to ask you a question that's got nothing to do with the inquiry at the moment but I'm intrigued, and it's the first time we've had a specialist like you in the room. The shift in obstetrics and gynaecology away from the general practitioner model as GP obstetricians, in my mind, has to do with the health and wellbeing of the mother and the baby, survival rates, lower mortality, lower morbidity, things like that, which are pushing us towards that specialist model, I think. My parents were born in lounge rooms and verandahs. I was born in a hospital with my local GP as my mum's GP obstetrician. My kids were born in a specialist service because from Cessnock we have to drive into Newcastle or Maitland, so we had to drive down there. But the health outcomes—even though children are being born on the side of the road sometimes because it's so far away—surely we are seeing a downward trend in the number of deaths for both mums and babies under this model. Is that right or not right?

TANIA DAY: Perinatal mortality in Australia is very low on the world scale, and so is maternal mortality. That's a metric that is a bit difficult just because it's such a rare outcome—thank goodness. I think the larger question is around overall safety, how that is perceived by the public and how that might be different to how it's perceived by medical practitioners. But it's a moving target. Women now are not the same as they were 50 years ago.

The CHAIR: Physically you're saying they're not the same?

TANIA DAY: Yes, I am sort of saying that. For example, I just was looking at the maternity statistics from the 2023 *New South Wales Mothers and Babies* report. Twenty-three per cent of the women in the Hunter New England district are obese. Nearly 50 per cent are in the overweight or obese category. It's not a matter of weight so much as the comorbidities that travel along with that. Essentially, nearly a quarter of women have gestational or pre-existing diabetes; hypertension, either in pregnancy or chronic hypertension; or some other major cardiovascular condition that complicates their pregnancy.

And we have older mothers now than we used to, because women want to have careers, and they have more medical problems, and we simultaneously have a different expectation of which babies can and should survive and which women can and should be pregnant. Fifty years ago, for example, if you had a renal transplant or a lung transplant, the assumption was you weren't going to have a baby and that if you did so, you might die in that effort. Now the expectation is, almost regardless of your medical problem, there are specialist obstetric physicians and maternal-fetal medicine specialists with an interest in maternal medicine who will shepherd you through that pregnancy and get you the best possible outcome.

As all that's also happening, we have a situation where 24 weeks used to be considered the threshold of viability. It often gets pushed back to 23, even high 22 weeks. The amount of resources that go into trying to maximise the chances of a baby in that gestational age for intact survival, so to speak—a baby that is going to potentially be able to live an independent life—there's a huge amount of resources that goes into that and then also into the next pregnancy, preventing a recurrence of that extreme preterm birth.

This is all a very long-winded way of saying that everything is way more complicated now. I haven't really even gotten into combined first-trimester screening and all the different genetic and medical conditions that we can now identify, and then women can make informed choices about maintaining that pregnancy. The care location and the care delivery around that pregnancy, how and when they're going to birth—everything is so complicated. That's just obstetrics, which I don't even do. I'm a gynaecologist.

I think the answer to your question is that everything we're doing is so different now and the patients are so different, that if you're going to be really excellent at the job that you do, there's this intellectual pressure to define that downward into something where you can know basically everything there is to know about that small field. My field is vulva, which most people are probably not going to want to get into. There is a lot of pressure to specialise, and while that doesn't take away from the importance of generalist work, it is extremely difficult to know enough now and to have enough exposure in your training and in your career to maintain excellence as a generalist and deliver the outcomes that people expect now. Everyone needs access and wants access to all of these highly intellectualised, evidence-based, continuous quality improvement resources.

Ms LIZA BUTLER: Can I ask one question following on from that—sorry, just because we're now in our break so I'm using our time now.

TANIA DAY: I'm very happy to talk as long as you want.

Mrs TANYA THOMPSON: We're down the rabbit hole.

Ms LIZA BUTLER: I'm from a regional area and because women were having to travel a long way to give birth and they wanted to give birth locally, we're seeing a lot more women decide to deliver at home with a doula. We've just expanded, with a lot of effort on my behalf, the midwifery group practice model in the hospital, but they still have to drive a distance. We are going to expand that to be homebirth deliveries. Have we seen more adverse outcomes with homebirths and doulas regionally? Do you have that figure? We are seeing that. Women are then putting themselves at risk because they might be in a higher risk category. I totally understand what you're saying, but with the midwifery group practice, when it's within the hospital there's those boundaries and those stopgaps to go, "Okay, you're a high risk, you really should go to that specialist service. We don't think you're eligible for that service." It's a real catch-22 because we're forcing women in one way to take a much riskier approach to giving birth by not providing those services.

TANIA DAY: I don't have answers about numbers. I think that argument is made in a lot of different scenarios. A not dissimilar scenario is one around breech birth and many hospitals not offering elective breech birth services. John Hunter does. In hospitals that don't, the argument is, "Well, if we're not offering it then some women will elect to do that at home." I'm not entirely sure that the public health system can entirely mitigate that sense of forcing people into one choice or another. What I'm thinking about your question about regional services. Midwifery group practices are an excellent way to bring women into care in a way that feels supportive and normalising, while still having the backup of specialist services when things aren't going well. That's a great model. It is a very resource intensive model because essentially you have midwives doing that same on-call type duty that private specialists do. You need to maintain quite a large number of midwives to do that so that the work is not excessively onerous.

I think that there's a lot of drivers of the phenomena of unassisted or doula-assisted births, so births that women elect to do completely outside the medical system. I don't think that the medical system is the only driver of that. I think there's a large cultural mistrust, institutional mistrust theme in our society and internationally that encourages that thinking that medical services have been a net negative rather than a net benefit for women. You can imagine that anyone who's trained in O&G finds that to be quite a disappointing outcome, because if there's any field that has saved millions of mothers' and babies' lives over the last hundred years through medical intervention, it's O&G.

The CHAIR: Hear, hear!

Ms LIZA BUTLER: Thank you very much.

Ms TRISH DOYLE: I just had to swing in as a huge supporter of homebirth, in making the point that whilst you absolutely, in the last number of decades, have saved countless lives and do so much good work, there are very good reasons—and very safe reasons—that women choose to birth at home with the assistance of a well-trained homebirth doula.

TANIA DAY: I'll just interrupt. One quick thing there is that RANZCOG does support models of homebirth, as does John Hunter, with a midwife present—in fact, it's usually two midwives—with these very well circumscribed boundaries around transport to hospital and who is eligible for homebirth. The doula is essentially a community support person. They have no meaningful medical training, and you really do need someone assisting you at birth who can get the head out, who can manage the placenta, who knows how to recognise a postpartum haemorrhage or a uterine inversion, and can recognise labour that is not taking its normal course. Homebirth is very appropriate and there's an international acceptance of homebirth for certain women, with a midwife—a medical practitioner—available. But unassisted birth, either by yourself or with a lay doula, does pose substantial risks to women. I think health services, where they can, should try to be inviting to avoid that situation of women feeling that that is the best option for them.

The CHAIR: Thank you so much. Viewers and listeners, this is the Committee on Community Services with Dr Tania Day. We thank you so much. We have greatly appreciated your wisdom. Obviously those last couple of questions have nothing to do with the inquiry we're undertaking at the moment. However, it was fascinating. You will be provided a copy of the transcript of your evidence today for corrections. If you think you've been misheard, misquoted or misunderstood, please let us know. You didn't take any questions on notice today, so we don't have to worry about that. The Committee may develop supplementary questions that we will send you in the next couple of days. If you could attend to those, that would be greatly appreciated. We are now going to take a very brief afternoon tea break before our final witness of the day. Dr Tania Day, we cannot thank you enough for sharing your wisdom and your precious time with us. Thank you so much.

(Short adjournment)

Ms FIONA DAVIES, Chief Executive Officer, Australian Medical Association (NSW), affirmed and examined

Dr IAN KAMERMAN, Secretary, Rural Doctors Association of NSW, affirmed and examined

The CHAIR: Thank you for appearing in person. A reminder that members of the public are not permitted to film or photograph during the hearing. However, Committee staff will be taking photos and videoing during the hearing for possible use of images on our social media. If you would like to not have your image used, please let us know. Before we start, do you have any questions about the hearing process?

IAN KAMERMAN: No.

FIONA DAVIES: No.

The CHAIR: We have your submissions. Dr Kamerman, do you have an opening statement you'd like to make?

IAN KAMERMAN: No, I don't.

The CHAIR: Ms Davies, do you have a short opening statement?

FIONA DAVIES: Good afternoon. On behalf of AMA (NSW), we're grateful for the opportunity to make a statement today on the Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025. AMA (NSW) does not support the proposed split of the Hunter New England Local Health District because we believe a split would exacerbate the challenges already faced by the doctors, nurses and other health workforce in the community and result in unnecessary strain on existing resources. In making this submission, we acknowledge the significant issues facing the health system and the community of the Hunter New England, and we recognise those are challenges that are faced by far too many of our rural and regional communities. I've travelled to the district and certainly seen the strain in places like Tamworth and Armidale. To draw a specific example, we've got Tamworth maternity service, where in 2024, the hospital, which is a critical hospital for services, was on bypass for more than 14 days and struggling to provide services for more days than that. There are crisis issues in Wee Waa and critical issues in so many of the other hospitals, so we do acknowledge that.

We also acknowledge that NSW Health is under significant financial strain. Last year, many doctors reported that their local health districts were facing significant budget shortfalls. We're experiencing a significant workforce crisis, particularly in our rural and regional areas. We submit that New South Wales needs to deliver 40 per cent more activity per worker to meet forecast needs, and the workforce gap is estimated at nearly 6,000 practitioners. Workforce shortages are particularly prevalent across rural and regional areas, to which Hunter New England Local Health District is not exempt. But we believe the split will not address the problem and will only put strain on scarce resources. Recruitment and retention of workforce is a challenge in rural and regional areas, and as the major trauma and teaching hospital outside of Sydney, John Hunter hospital offers diverse training experiences for medical graduates and also a capacity to escalate specialist services. We are concerned by the estimates of the likely cost, which we agree would be around over $100 million in the split.

Our other significant concern is that New South Wales has been the beneficiary of a networked health service system, and we saw during COVID the advantages that that provided to the people of New South Wales. While our district boundaries are imperfect, we believe it is essential that local health districts have access within their district to the highest levels of hospital that they can. In that regard, both John Hunter hospital and John Hunter children's hospital are currently under the local health district. Removing that would leave the district without level 6 tertiary adult or children's hospitals. We are concerned that districts without tertiary hospitals do struggle to operate self-sufficiently. Interestingly, in Victoria, where they have recently shifted to a local health district system, they are proposing that each of their networks is able to achieve 85 per cent self-sufficiency.

We're concerned from other districts that where you're actually not able to access tertiary services, the public struggle more to get that service assistance. An example of this is Southern local health district, that does not have a level 6 tertiary hospital and would be similar in nature to the proposed Hunter New England split district. Approximately 25 per cent of Southern's patients are required to travel to the ACT for health services, and that's a scenario we would not want to see for the people of the Hunter. We very much welcome the focus of this inquiry and the interest in improving health services in regional and rural New South Wales, but we can't support this proposal. Thank you.

The CHAIR: We heard testimony from one of our witnesses earlier today, who said that Hunter New England health district is underfunded compared to other health districts. It was an anecdotal comment without evidence. Would you agree with that? Is there any reason to give substance to that claim or comment?

FIONA DAVIES: We think all local health districts are underfunded. That's the advice we have received. What we have seen is that the last two Health budgets have not increased health funding across the state sufficient to meet the ongoing costs. Rural and regional districts, by and large, suffer more for that because of the amount of their resource that they are required to allocate to attract and retain workforce. But I couldn't comment on whether Hunter New England is any worse off than other regional districts. I'm happy to take it on notice, but I couldn't otherwise be specific.

IAN KAMERMAN: I wouldn't be aware of any relative underfunding.

Ms TRISH DOYLE: Thank you both for being with us today and sharing your expertise and knowledge and some suggestions, which is the point I'm going to go to. Ms Davies, you very clearly outlined why you wouldn't be supporting this proposal. Regardless of this proposed legislation passing or not, besides the obvious need to address the deficit in the health workforce, what other changes does the Hunter New England Local Health District need to make to improve health care and services in that region, in your view?

FIONA DAVIES: I think within the existing district structure, there needs to be much clearer accountability at management level for those hospitals outside John Hunter. We get regular feedback from those hospitals that, rightly or wrongly, they feel that there is far too much focus on John Hunter. Whether that is a different governance structure or, within the district—there are obviously those models that are there, but there needs to be much clearer accountability for clinical engagement and engagement of the medical staff in the hospitals outside the John Hunter area.

At a statewide level, we urgently need to address ways in which we attract and retain doctors, nurses and allied health to rural and regional areas. The Australian Medical Association is currently—literally, as of today—arbitrating the visiting medical officer determination and many doctors in the district are covered by the visiting medical officer determination. A key aspect of our claim is that there needs to be a much more significant differential payment. There is a differential payment under the rural doctors arrangement, but we need enhancements to attract doctors to go and work in rural and regional areas.

Critically, we need that for all specialities. Nursing—the shortages and issues at Tamworth are driven by the fact that they cannot attract and retain midwives. You can get a $20,000 incentive to go to Tamworth, but if you are currently working in Tamworth, you're going to be paid the same—as a nurse or midwife—as you would be working in John Hunter, and the system needs to address those things as a matter of urgency. We know doctors, nurses and allied health staff working in rural and regional areas are working more onerous rosters with fewer workforce, and people are increasingly choosing to simply remain in major metropolitan areas and work in those spaces and we need to start actively addressing it. Those are some of the solutions that we'd like to see for the community.

Ms TRISH DOYLE: Thank you. Doctor Kamerman, did you want to add to that?

IAN KAMERMAN: If I could answer your question, probably by taking it a bit sideways, I don't think it's something Hunter New England necessarily needs to do. I say this from my experience as I was on the board of New England Area Health Service and also then Hunter New England Local Health District, and it's the way that health districts are forced to operate by the system. The priorities are funding activity and beyond that it's surgical waiting lists and emergency department wait times. None of these really affect rural hospitals significantly, other than the fact that their activity is not counted within the activity-based funding model. Consequently, there's no incentive at all for health districts to provide services to more rural areas. Consequently, what happens is services then get downgraded, there's lack of infrastructure. Consequently, we're entering a period now where doctors are getting much older, they're getting worn out, and the young ones are not staying in New South Wales. They're moving interstate. What I would do is I would have service level agreements that actually provide for appropriate quality services closer to home, so you need to drive funding and activity models that provide that level of care.

The CHAIR: Thank you. I just want to jump across to Liza Butler because she wanted to make a comment about something Ms Davies said.

Ms LIZA BUTLER: We were out at Wee Waa last week, and you've referred to that in point 6 of your submission. We were told that there were three or four local GPs that were happy to go and do VMO services at the hospital to get it reopened, but nobody could tell us why that was not happening. You've just referred that it's in arbitration today. Would that be the reason why?

FIONA DAVIES: No, it wouldn't be. People are still continuing to provide services while the determinations are being reviewed. Also at Wee Waa they would be working under what's known as the rural doctors package, which is ongoing. People are continuing to work while this is all being investigated.

Ms LIZA BUTLER: Are you aware of what the issue is?

FIONA DAVIES: I'm not sure at all.

Ms LIZA BUTLER: We've got three or four doctors willing to be VMOs at the hospital and there's some barrier there.

IAN KAMERMAN: I'd love to know where those doctors actually are from. I operated the last general practice out of the hospital there that closed in 2019 because of a number of circumstances, largely around the lack of support from the local member, who essentially would not support a GP model out of that hospital at that time. And I recognise this inquiry has come from that. He supported the other practice in town, which is fine, but that practice has never supported VMO rights in that hospital themselves, so I'm curious where these doctors are.

Now, maybe times have changed in six years since I've run that practice, and there have been shortages for doctors there. But we were there for 2½ years providing general practice services to that community out of the hospital and keeping the hospital open 24/7. It worries me that we're talking about dismantling the health service, not necessarily for what I would see are the right reasons. Rural GPs are a funny lot. We've got our own reasons for doing things and for not doing things. But if there are doctors that are there and willing to go in, I think that would be great. The question is whether they would be supported not only by the local health district, by the local GPs and the local community.

Ms LIZA BUTLER: They are the local GPs. You answered the question.

IAN KAMERMAN: Okay, cool.

The CHAIR: I recall, in one local area, everyone in the community was telling me that there are local GPs that want to be a VMO, but they weren't. So I wrote to every local GP—there are nine of them—and they said, "Nah, we don't want to do that." And that was a lifestyle, personal thing: "We live away", and all that sort of stuff. The rumour on the street was different from the reality in practice, on that occasion.

Ms LIZA BUTLER: The Rural Doctors' Association refers to "the importance of understanding the diversity of the region and the community's needs." We've heard a lot about lack of consultation with the small towns out west of the Great Dividing Range. Can you expand on what makes the region diverse and what those actual needs are, and how we get that to the executives at the Hunter health region?

IAN KAMERMAN: In rural doctor life, there's a saying, "When you've seen one rural town, you've seen one rural town". They're all very different. They've all got their own needs. I would like to think, at least when I was involved in the local health district, most of the staff—the executive staff—had a good grasp of the nature of each town and what's needed. Part of the issue that you're describing is health literacy within communities. It's not a blame thing, but also the need to recognise that there are only so many services that can be provided, particularly in very small rural towns. There are benefits in networking services and I recognise also that when you look at a number of communities which have identical size towns, sometimes you actually need to move resources from one to another simply so that becomes sustainable. How does that consultation work? It's a matter of sitting down with communities and working them through the steps. Unfortunately, at the end of the day, no-one likes losing services, even if, at the end of the day, they might get access to better quality healthcare.

FIONA DAVIES: There are some excellent recommendations in the Special Commission of Inquiry into Healthcare Funding about the need to realign health services planning to be community focused and outward, and I think it's one of the best reports I've seen into health. I say this as a person who worked really hard to say we didn't need that inquiry, and I was completely wrong. I think the Government does need to look at implementing a number of the recommendations around starting with community and going outwards, rather than potentially—yes, being realistic—bringing the community on. We are not going to return to the health systems of 30, 40 years ago, but we should be starting with community and going out, as opposed to a statewide level or a district-wide level and coming in. I'd really commend those recommendations from the commission on the way we should be rethinking health system planning.

Ms DONNA DAVIS: Ms Davies, is that also focusing on community preventative at that local level?

FIONA DAVIES: The number one recommendation from the special commission of inquiry is a focus on prevention. Anybody working in health has paid lip service to that over the years, but that is a priority that we need to be really bringing to communities. For rural and regional communities, it should not be about just good enough access. We need to be really addressing the fact that the health outcomes for rural and regional communities are not the same as they are for metropolitan areas and the factors that are contributing to that, so that recommendation of taking that preventative message genuinely, and giving rural and regional communities access to not just good enough, or a body, a doctor, a person, but actually aspiring to the highest-quality healthcare

services that they can give. We should not shelve that recommendation of a preventative agenda. We really need to take that recommendation seriously.

Ms DONNA DAVIS: Dr Kamerman, your submission mentions concerns about under-representation of rural voices and that this could be addressed by enhancing rural representation on the Hunter New England board and creating region-specific advisory councils. Could you speak about the advisory councils? But also, would that be expanding the board by an additional member or members from the New England area or converting existing board member positions to the New England rather than Hunter-focused?

IAN KAMERMAN: It's a great question, and you do have problems with too large a board, but it's important to ensure that people with an appropriate insight and lived experience of being in a rural community and accessing health services get representation at a board level. Certainly I was one of the rural people on both those boards. Again, it's hard to think outside your own community that you're living in. It's only by having some sort of network that you can talk with people who exist in those communities. Often, health districts around New South Wales have struggled with local advisory committees. Sometimes they're really good and high-functioning. At other times they lack the people with appropriate skills to actually provide the best advice that could be possibly given at a board level. That communication and having a local group of people that you can discuss impending health changes with and hear the health needs of the community are really important, but I think there's probably a large role here for local government as well, who are elected to represent local communities and their interests.

Ms DONNA DAVIS: It's interesting you say that, because there were quite a few councils last week that didn't have direct contact with Hunter New England and would speak to John Hunter regularly.

The CHAIR: The local health advisory committee seemed to have fallen over around COVID, if not before, and restarting them seems to be taking some time despite the fact that was a recommendation of Portfolio Committee No. 2 as well as an ongoing recommendation of the Select Committee on Remote, Rural and Regional Health.

Mrs TANYA THOMPSON: Thank you to you both for coming along and your contributions. Fiona, we have met before. You've contributed a couple times now, actually, so thank you. I just want to get your thoughts on the impact that telehealth and virtual care have had on rural, regional and remote areas given the shortages that we have in GP and specialist services and workforce shortages. Second to that, we heard a lot, and we hear on the ground too, the length of time it takes even within the health district itself in employment services for transfer. I think that contributes a lot to the problem for workforce as well. People get frustrated with that system. I just wanted to put that out there and get some thoughts on that topic from you both, please.

FIONA DAVIES: Obviously telehealth is a critical part of health service delivery, and we recognise and support that. It is an adjunct to health service delivery; it is not a replacement to health services delivery. It provides a sense of connection not just for patients but also for doctors, nurses and allied health services, but it does need to be seen as an adjunct, not a replacement. I think we need to have a much more sophisticated conversation about what is still the role of the need for in-person care and where does telehealth contribute. Again, I think if we start with the premise of what is best for the patient and what is best for the community and make the decisions from there, that is how we should be looking at telehealth. With regard to the workforce frustrations, I'd completely agree. That's probably one of the big challenges of the size of the district. There is an enormous level of distrust from all of the other hospitals who are not John Hunter, but it's worth noting that John Hunter is an incredibly large hospital that services an enormous level of demand in the community at a very high-acuity level, so they struggle to attract and retain, and we are really seeing this across the system. Then going out, each level is struggling, so you've got falling dominoes.

I think this district really needs specialised resources to make sure that there is a different cohort who attract and retain people to rural and regional areas, because then—and we will both have seen this experience—if you find workforce, you need to grab them straightaway and you need to be responsive to those needs. Every part of New South Wales and, in fact, the rest of the country will take that workforce if you do not have good processes to attract and retain people at a local level. Because John Hunter is struggling, Tamworth is struggling, therefore Armidale is struggling, therefore Muswellbrook is struggling. The further you get down the line, the bigger the challenges are, so we really need districts to be accountable. Good districts that have attracted workforce have actually put specific resource into units that focus on finding and retaining workforce, and I think the district needs to be really accountable for making sure they have processes where they are attracting—that if you are interested and you are willing to consider the district, they're accountable for finding people, getting them on board and working as soon as they can.

IAN KAMERMAN: I think it's really important to acknowledge that we actually have a really good health system that has a whole lot of good outcomes. I love what I do. I'd like to say not 100 per cent but probably

90-something per cent actually do love looking after people and working within the health system. It's incredibly frustrating from time to time. I'm not a fan of virtual care, particularly when they use non-GPs and metropolitan-based specialists to provide emergency-level care. It just doesn't work out well because they don't know the local resources and they don't understand the communities. Part of what we're all talking about is understanding communities.

I would likely slightly disagree with you there, Fiona, about attracting a workforce in Hunter New England. Hunter New England is actually the perfect size to train a workforce. They've got two medical schools within their catchment. They've got more than two universities that train health professionals within their catchment. They've got a whole lot of health facilities. They should be looking at models and gaining funding to actually train your own. The trouble is, if it shrinks down, I think you would lose that potential.

FIONA DAVIES: I couldn't agree more. That district should be a model for self-sufficient training.

The CHAIR: When you say a model, do you mean for an area that has a regional—

FIONA DAVIES: Yes. This has been AMA policy; it's been RDA policy. There needs to be far more regionally based training. When people tend to go into specialty training, they often have to leave their district. The Hunter district, as it's currently structured, should be able to provide—and does—incredible training opportunities for the vast majority of specialists to have that experience of being regionally based. It could, and it does, but that is one of the big advantages. If you compare it to a district such as Southern, that has really significant issues with junior medical workforce because it is unable to provide that rotation and the different levels of services.

Mrs HELEN DALTON: Thank you for your attendance. You've touched on it, Ms Davies, but do you think that the delivery of rural health needs a completely different model, obviously, for us in the bush?

FIONA DAVIES: In terms of governance or in terms of funding or—

Mrs HELEN DALTON: All of it; to make it work.

FIONA DAVIES: Not necessarily, although, as Ian has indicated, the funding pressures for rural and regional are so different to how we fund health in metropolitan areas. I think there does need to be more oversight and more accountability. How you maintain that while also recognising the need for an integrated and networked model is an important consideration, but Ian and I we are just discussing the fact that there probably does need to be a system of greater oversight about the health outcomes for rural and regional communities. Obviously that has been explored at length in the many rural and regional health inquiries.

IAN KAMERMAN: I'd say that the service agreements between the ministry and LHDs actually define what LHDs do. I don't recall much of those service level agreements talking about service provision to rural areas and access to care. Largely, as I said before, your activity is very much controlled. There's no incentive to actually move surgical procedures, obstetrics and anaesthetics out to the smaller hospitals, even though it could be done quite safely, so those communities get deprived of services. Everything winds down as the doctors that were doing those services there leave the hospitals and never come back. I'd be changing those sorts of agreements rather than working on governance and boundaries.

Mrs HELEN DALTON: That's exactly what's happening in my area. I'm in the Murrumbidgee Local Health District, and that's absolutely true what you're saying. Doctors that walk to work are cheaper than and more invested in the rural area than a fly-in fly-out doctor. Do you think that permanent doctors should be employed, perhaps for a five-year tenure, rather than just employing costly locums?

FIONA DAVIES: Obviously we would much prefer arrangements that incentivise people to live and work in rural and regional communities. Locums do play an important role, and I think it has been unfortunate to see the level at which they have been criticised. We will always have locums, but, as we indicated, the health system—

Mrs HELEN DALTON: We need them, at a level.

FIONA DAVIES: Yes, we do. You're right. Certainly the challenge where it is financially far more lucrative to be a locum than it is to be based in a rural and regional community is something we need to address. That will need a recognition that the working arrangements in rural and regional are more onerous and that the financial incentives should be greater for doctors. I can only speak for doctors, but if I were representing nurses, I think there should also be a differential. We should have a system that prioritises people to live and work in rural and regional communities for the time in which they wish to. It may well be that that's for their whole career. It may well be that that's for five years or a period of time. The AMA and RDA have lots of policies on how we should make it easier for people to live and work in rural and regional communities. But yes, we need industrial

arrangements that it should not be that if you happen to live and work in a regional community, you can get less benefit than if you are a locum. That's what we have in New South Wales.

IAN KAMERMAN: It might be an old-fashioned view, but the gold standard would be having a highly skilled GP or a rural generalist working out of a practice and also providing health and hospital services. You talk about a five-year contract. The question is: Are they employed to work in general practice or are they only to work within the hospital system? This is where you come down to that state and federal divide between general practice being a federal responsibility. I think we need a joined-up system with state and federal funding going in to provide that sort of model. I think the second-last choice is locums; the last choice is a virtual service. But the workforce crisis that we're facing really requires major change to what we're doing at the moment. From a Rural Doctors' Association perspective, our industrial negotiations, that were so promising to start with after the inquiry, have essentially frozen. We've agreed on decisions, but they haven't been signed off by the ministry and my understanding is they haven't been signed off by Treasury. We're still waiting for those to take place so we can actually try and have a model we can use to bring doctors back into the bush.

Mrs HELEN DALTON: Do you think we need a dedicated rural and regional health minister?

IAN KAMERMAN: I'm not into disintegrating services. I'm a GP, so I like having everything integrated under the one roof. My concern that was floated was it would remove rural from the main game of the health ministry all up. Would I believe in something like having an independent rural health commissioner with some power? Absolutely. I'm very glad that Luke Sloane has been appointed as a deputy secretary for rural health within the ministry, and it's really important to have that sort of voice. Would I support a separate ministry? No, because I don't think it'll make a huge difference.

Mrs HELEN DALTON: You said a commissioner with some power. What power would that be?

IAN KAMERMAN: To actually provide advice to government, very similar to what the Rural Health Commissioner does on a federal level, to provide advice to the Minister as to the directions that should be taken, the issues that exist and the solutions.

The CHAIR: I want to go back to a couple of comments you were making just a moment ago, Dr Kamerman. The Single Employer Model that has recently been rolled out across New South Wales, which is sometimes you're a GP in a local practice and sometimes you're a health practitioner, is that not the model you were describing a moment ago?

IAN KAMERMAN: I think the Single Employer Model is one particular solution. It's not for GPs, it's for trainees within the system, so it's only at a registrar level. Do I believe New South Wales has got the model right? Absolutely not. It's a hopeless contract. I wouldn't sign it, because it puts all the risk away from the ministry and onto the individual general practice who has the trainee within their boundaries. The whole national model that was set up was to be locally responsive models, to look at local needs, local incentives, where the workforce shortages are and bring doctors still working within the hospital system into essentially private general practice as well as maintaining a hospital role and maintain their entitlements. The issue is in New South Wales we've introduced a statewide model that's inflexible.

The CHAIR: Ms Davies, in your experience representing, obviously, medical officers right across New South Wales, do you see something that Hunter New England health is doing particularly well or particularly poorly in terms of rolling out the services compared to Western district, Far West district or Murrumbidgee district, those other regional areas?

FIONA DAVIES: That's a really good question.

The CHAIR: The suggestion at the moment is that Hunter New England health is broken.

FIONA DAVIES: No, I would not agree that it is more broken.

The CHAIR: Not from you.

FIONA DAVIES: The challenges that we hear from Hunter are very similar to the challenges we hear in Western and Southern. I think the community's frustration is possibly that other regional districts don't have as large a base hospital; the structure is just slightly different. But the frustrations are echoed in every regional district that we see. I couldn't suggest that Hunter is profoundly different. I think, again, the dynamics of the district, which are a little unusual, probably contribute to people's sense of frustration because there's such a disparity between the types of facilities, but the issues that we hear in terms of workforce, access, funding are very consistent across all of the regional districts in New South Wales.

The CHAIR: Just to clarify a turn of phrase, "It's a little bit unusual in the Hunter New England district," is that because you had that tertiary-level service at one end going out to much smaller facilities?

FIONA DAVIES: Yes. But similar tensions exist in Western, where Orange is obviously far bigger, but it's just magnified really in the Hunter district. I think that, understandably, leads to frustrations from communities about where resources are, but they're very similar themes across all of the regional districts.

The CHAIR: Dr Kamerman, do you think that Hunter New England health are doing something particularly fantastic or particularly bad when you think about the references to all of your membership across the State?

IAN KAMERMAN: I've had a lot of good relationships with Hunter New England executive members.

The CHAIR: And I don't want you to burn any of those today.

IAN KAMERMAN: I've always found them really approachable, and I think most of my colleagues would tend to agree with that. You might disagree on outcomes, but they're always really approachable. I think some of the work that they've been doing around clinical streams, the support from a tertiary hospital, or really a quaternary-level hospital, like John Hunter—it's really unusual for it to be in the same area as a whole lot of rural communities. Yes, it can be done a whole lot better, but I think actually having that resource within your district does make life simpler somewhat. Things they do really badly are contracts and getting positions for VMOs. I've found it incredibly frustrating. Maybe this is a reflection of what's been happening in Wee Waa, if doctors are wanting to go. Simply, it's been 14 months for me to get a VMO contract for my registrars in training, working under me at Werris Creek MPS. It's been difficult to get those actual contracts so they can get hospital experience. These are rural generalist registrars; they're not GP registrars. So it's getting into the system, and that level of frustration is probably shared amongst my colleagues around Hunter New England to a lesser extent than in other districts.

FIONA DAVIES: I'd actually agree with that. I think other regional districts are probably a bit more amenable to—we have standard contracts—seeking variations to those contracts than I've found Hunter to be.

The CHAIR: Specifically, is that a negotiation through the HR department? Is that where that's negotiated?

IAN KAMERMAN: No, you negotiate theoretically with your director of medical services and the health service manager, who then bump it up to the—it's bizarre. They kept bumping it up to the locum recruiters within the district, which to me is really quite bizarre. I kept saying, "I'm not after a locum position. We want permanent positions. We're actually providing a permanent workforce." It was quite bizarre, really. But eventually it got sorted out and contracts are on the way. If you actually want to provide services in rural communities, it can really be quite difficult. Again, a lot of communities cannot support a general practice without doing the hospital work as well, and you haven't got many GPs who actually want to do hospital work as well as rural communities. When those sort of people come along, you'd think that they'd jump for it.

The CHAIR: Yes, I'd be grabbing you with both hands as soon as you showed an interest. Thank you both for appearing before us today. You'll be provided with a copy of the transcript of your evidence for correction. You didn't take any questions on notice. We can skip that part. We may, as a Committee, develop supplementary questions in the coming days that we will send off to you and ask that you also respond to them based on something that might have come out of today's hearing et cetera. That concludes our public hearing for today.

I again thank all of the witnesses who appeared today, the rest of the Committee, the Committee staff, Hansard and the audiovisual team who made it possible. This Committee will be reconvening on Friday for our next and final day of public hearings before moving to reporting. Thank you again so much for all the work that you do and for your precious time being given to us this afternoon.

(The witnesses withdrew.)

The Committee adjourned at 16:00.