Submission No 382

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Organisation: Warrumbungle Shire Council

Date Received: 11 December 2020

warrumbungle
SHIRE COUNCIL

Office of the Mayor

Cr Ambrose Doolan

9 December 2020

The Hon Greg Donnelly MLC
Chair
Portfolio Committee No. 2 – Health
NSW Parliament House
SYDNEY NSW 2000

portfoliocommittee2@parliament.nsw.gov.au

Dear Sir

Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

Council welcomes the Inquiry and our submission is attached. I would encourage the Committee to carefully consider the issues raised.

There are many concerns locally that patients in country hospitals are receiving a poorer quality of care than our metropolitan cousins and that many medical protocols are not suitable or practical for rural health.

It is vital for the Inquiry to address the problems with staffing and metro-centric protocols that do not work for smaller towns and hospitals. Staffing in rural facilities are suffering from low morale and there is not enough money being spent on this resource.

A lot of the rural hospitals are understaffed and this is dangerous. Similarly the skills of medical staff at smaller hospitals are also of a concern.

We thank you for considering our submission.

Yours sincerely

COUNCILLOR AMBROSE DOOLAN
MAYOR

CC:
Cr Linda Scott, President Local Government NSW
Cr Ken Keith, Chair NSW Country mayors Association
Roy Butler MP, Member for Barwon
Sam Farraway MLC

Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

Submission by: **Warrumbungle Shire Council**
Date: **4 December 2020**

Background
The Warrumbungle Shire is situated on the north western slopes and plains of NSW and is traversed by the Newell and Golden highways. The Local Government Area covers an area of 12, 380 square kilometres and in 2019 had an estimated population of 9,278. Approximately 60% of the population resides in town or village areas.

Of the population there were 4,701 males and 4,577 females. The median age of residents in the Warrumbungle Shire is 49 years while at the same stage it is 38 years for residents of NSW and Australia. Further population statistics are provided in Attachment 1.

The Shire incorporates the townships of Coonabarabran, Baradine, Binnaway, Coolah, Dunedoo and Mendooran as well as several small villages such as Bugaldie, Cobbora, Goollhi, Kenebri, Leadville, Merrygoen, Neilrex, Purlewaugh, Rocky Glen, Uarbry, Ulamambri, Weetaliba and Yearinan. Coonabarabran is the largest centre, providing regional retail, agricultural and business services and is home to Council's main administration office.

The Shire boasts a broad range of cultural, sporting and recreational activities with quality education opportunities, schools and health services. Warrumbungle Shire has a rich Aboriginal cultural heritage. The northern part of the shire is home to the Gamilaraay people while the southern part of the shire is home to the Wiradjuri people. The nations of the Weilwan and Kawambarai (Werriri) come into the Shire on the western border. Indigenous history, traditions and culture are an important part of the Shire's history. Approximately 13% of the Shire population identify as Aboriginal or Torres Strait Islander.

The Warrumbungle Shire has a predominantly a rural based economy. The main industries include sheep and cattle farming, cropping as well as tourism and some manufacturing.

Summary
This submission has been prepared by the Warrumbungle Shire Council (WSC). It is felt that the matters being studied by the Inquiry are particularly pertinent for our Shire.

In order to prepare and research this submission, Mayor Ambrose Doolan convened a meeting of local medical practitioners, which was held 24 November 2020, with 8 doctors in attendance.

One of the young doctors at the meeting summarised the situation very well, *"We are expected to do more and more with less and less!"*

This Inquiry has been triggered by some media reports (links below); since the reports that triggered the Inquiry there has been other media attention, including a report on *60 Minutes*. We feel that all small rural hospitals are vulnerable to such incidents and welcome the opportunity that this Inquiry offers to highlight areas for improvement and to make suggestions. We welcome the Inquiry and the focus on how our rural communities are significantly disadvantaged.

There are 12 Terms of Reference; we shall address each one.

(a) health outcomes for people living in rural, regional and remote NSW

That rural and regional communities all around Australia have poorer health outcomes is something that has been well documented. We are no different in WSC.

At the Federal government level we have observed intense investment in rural medical schools, relocation and retention grants and infrastructure grands.

However we have not seen similar investment and energy put into rural health services by NSW Health. Instead we have observed an increasing tendency for our local GPs to disengage with the LHD and drift away from Visiting Medical Officer (VMO) work, which is what underpins our rural hospitals. The reasons for this disengagement are almost always rooted in poor communication from the LHD, mismanagement by the LHD and the LHD setting up VMOs for failure.

(b) a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW

To the best of our understanding, NSW Health is the peak organisation that collects and owns such data. NSW Health is responsible for funding and coding of patient encounters. NSW Health also manages the Electronic Medical Records.

Therefore to address this Term of Reference (TOR), WSC could only rely on NSW Health. Accordingly, WSC cannot contribute to this TOR in a meaningful way. We are concerned that any meaningful analysis and comparisons would highlight the great divide between urban and rural areas.

(c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services

Access to health and hospital services is a significant problem in WSC. Whilst we are doing well in terms of GP services compared to some other rural LGAs, access to allied health services and hospital services is not good.

We have three small hospitals in our LGA, Coolah, Dunedoo and Baradine; these are now classified as MPSs. We also have Coonabarabran District Hospital; however this hospital is not afforded the same staffing, respect or level of service by NSW Health as other district hospitals in Western NSW LHD, such as Mudgee, Parkes and Forbes.

It has now become common practice for Coolah, Dunedoo and Baradine not to have in person medical cover, especially on weekends and after hours. This places more pressure on Coonabarabran Hospital. Whilst Coonabarabran Hospital is meant to have 24/7 in person medical cover on an on-call basis, it has had times when it has had to rely on telemedicine due to the LHD not being willing or able to supply in person cover.

Even though this Inquiry has largely been triggered by concerns over telemedicine and the consequences of not having in-person medical cover, the LHD persists in its insistence on telemedicine being the way of the future.

As recently as this week, Coonabarabran Hospital nurses have been forced into mandatory training for telemedicine, even though they and the medical staff at Coonabarabran Hospital have made it abundantly clear to management that Coonabarabran Hospital is too busy for telemedicine and should have in-person medical cover. This is a classic example of the top-

down management approach of our WNSWLHD; the voices of the front line clinic staff are simply disregarded.

Moreover, calls by Coonabarabran medical officers for nurses to be upskilled in emergency procedures, paediatrics and obstetrics have been disregarded by management.

Many of the nurses at the hospitals in WSC are junior, agency or overseas trained; whilst well intentioned and diligent, many are still struggling to master in person care with in person doctors. It is a significant leap in responsibility and skill to expect these nurses to manage without the support of doctors and deal with the complexities of telemedicine.

Our comments are not to be interpreted as being dismissive of telemedicine. Telemedicine offers clear benefits, especially in the small towns that struggle to recruit and retain medical officers. Telemedicine can also provide important clinical expertise from peers. There is no question that many of the smaller centres would lose their medical officers if telemedicine was not available as a safety net.

Telemedicine is a vexed subject.

In our LHD, hospital telemedicine takes 2 forms. The Virtual Rural Generalist Service (VRGS) is the service that fills in when a hospital or MPS does not have in person medical cover. The other service is vCare, which offers specialist advice to doctors and nurses at the peripheral sites. vCare also oversees transfers between facilities.

At this point it is worth mentioning some key factors in the evolution of VRGS and vCare:

(i) a failure on the part of the LHD to implement effective recruitment and retention policies;
(ii) a failure on the part of the LHD to give hospital managers and nurses clear instructions on how to deal with low acuity presentations to the emergency departments in a way that is safe, discourages misuse of the emergency departments and minimises burn-out of on-call doctors and duty nurses;
(iii) an increasingly complex and defensive nature of hospital clinical practice.

At its best, telemedicine can:

- improve clinical expertise offered to the patients;
- relieve pressure and fatigue for the clinicians at the peripheral sites;
- speed up transfer of patients to appropriate locations of definitive clinical care
- encourage clinicians in small towns to feel supported.

At its worse, telemedicine can:

- create obstruction and conflict for clinicians on the ground when the telemedicine clinicians over-rule
- transfer patients excessively and inappropriately
- create a disincentive to in person practice

Contrary to the triaging policies of the LHD, it is still common for patients who ring or present to the hospitals without in person medical cover to be told by hospital staff that there is no doctor and to go to a hospital with in person cover.

It is also our view that Coonabarabran Hospital should be given extra resources and staff to allow for the increased work load that it has had to take on as a result of covering for the other hospitals in WSC that are often doctor-less. There is clear evidence that patients bypass certain hospitals when they know that there is no doctor on call.

With respect to hospital services, we opine that NSW Health and Western NSW LHD (WNSWLHD) be open and honest with our rural communities and rural clinicians. We want clear indication as to what services we can expect to be available and when. Such clarity is fundamental not only for health professionals but for the community at large. Decisions to live, work and invest in a town are often predicated by availability of health services.

WSC is not well serviced with allied health services; it relies very heavily on visiting services from Dubbo and Gunnedah.

Whilst each of the 6 centres in WSC have retail pharmacies, there are no after hours pharmacy services.

Access to health services also goes beyond staffing; it is also a question of equipment and basic stock. Running out of basic medicines and equipment has become a weekly, if not daily, occurrence.

Another serious issue in the facilities within WSC, applicable across NSW, is that for many years the smaller hospitals have had an effective ban on the admission of children. This means that children are often being transferred to Dubbo and Orange for conditions that could and should be able to be treated in the smaller hospitals. This matter has been raised many times by Coonabarabran medical staff and for years the LHD has said that it would address this. So far nothing has happened.

Example 1:
it is not uncommon for the hospitals in WSC to run out of basic antibiotics. The arrangements in place make our hospitals too reliant and exposed to Dubbo Base Hospital Pharmacy and its courier arrangements. More flexibility has to be built into the system to allow for access to medicines through our local pharmacies and wholesale channels.

Example 2:
Any attempt to source basic medical equipment is also mired in red tape and excessively tortuous approval pathways. At the WSC doctors meeting, the Coonabarabran doctors recounted the trouble that they are experiencing in sourcing a basic, cheap apparatus to administer Biers Blocks. This would streamline treatment of upper limb fractures and other injuries. Even though all the VMOs in Coonabarabran are qualified to use such equipment, they have been waiting well over 6 months and there is still no sign of the equipment being approved or supplied.

Example 3:
A mother brings a child with moderate croup to Coonabarabran Hospital at 9pm. She lives 45km out of town and has a husband at home with 2 other children. The doctor is sufficiently concerned about the child to want to observe the child overnight. Sending the child home is risky and a 90km round trip on country roads back to the hospital if the child deteriorates. The doctor rings Dubbo and the paediatrician says it is ok for the child to be observed in Coonabarabran overnight. However the Coonabarabran VMO is told that the child must be sent to Dubbo because the nurses are no longer comfortable to be caring for a child in our hospital and that the nurse manager says we are not accredited to admit children.

Accordingly the doctor is over-ruled by the nurse management and an expensive ambulance transfer is arranged to Dubbo. The next morning the paediatrician tells the mother that the child is safe for discharge. Somehow the mother has to find a way back to Coonabarabran.

(d) patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW

See our response to TOR (b); NSW Health is the custodian of such data.

(e) an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW

Our observation is that WSC has not been party to any planning of systems or services; as a result it is impossible for us to offer any analysis.

As mentioned in TOR (c), it is important for NSW and WNSWLHD to be clear with rural communities as to what we should expect in terms of services.

We also note that many obstetric, surgical and other services have shut in rural NSW hospitals in the last 30 years. Coonabarabran Hospital until the mid-1990s, enjoyed a broad surgical service, an obstetric service and the ability to do provocative cardiac testing. All this has been lost. There has also been a significant loss of beds in Coonabarabran Hospital over this time.

The dismantling of these services is quite deliberate by the LHD; it is not as they say simply because they cannot get staff. This is evidenced by the deliberate stripping of equipment and medication. In Coonabarabran, examples of what the LHD has deliberately stripped from the hospital include: surgical instruments, obstetric labour beds, CTG machine (to monitor foetal movements and uterine contractions for pregnant women and their babies), cardiac stress-test treadmill, neonatal crib, and paediatric beds. *In none of these examples were local VMOs consulted and there was no com munication.* The VMOs just turned up to work and found these things gone!

Therefore it would be most helpful for WSC and similar Shires to be given access to the planning and projections that lead to such decisions, as they have a serious and deleterious effect on our communities at many levels.

It is our view that the opposite should be occurring, especially in Coonabarabran. There is considerable pressure on beds in Dubbo and Orange. The smaller hospitals often have empty beds and low occupancy. There should be an effort made by the LHD to re-introduce services to the peripheral hospitals. This would achieve important outcomes in terms of workforce, service provision, quality of care and would bolster local economies. The Coonabarabran Endoscopy service is evidence of how well a surgical service can run. Specialties such as ENT, ophthalmology, gynaecology and general surgery could all establish services in Coonabarabran if the LHD would permit these.

The meeting with local doctors also bore out the fact that there is a significant detachment and disengagement between planners and clinical staff. With respect to meetings with doctors, basics such as circulation of agendas, quality of minutes and actioning of resolutions is not good. This results in doctors losing interest in attending meetings, compounding the disengagement.

We recommend that WNSWLHD puts more effort into its communication with the VMOs.

Example 4:

Coonabarabran Hospital has had numerous repairs and renovations performed over the last 5 years, many of which relate to problems with leaks in the roof and air conditioning. These works have often resulted in bed closures. There have also been times when the emergency department has had to relocate to other parts of the hospital to allow for the works. Communication with VMOs to advise of the changes has been non-existent or poor. Instead the VMOs literally come to the hospital to find beds closed or the ED temporarily relocated.

Example 5:

Coonabarabran Hospital has an endoscopy service, over 2-3 days per month (except January). Whilst we have had the same visiting endoscopist for over 16 years, the WNSWLHD has refused to provide a consistent anaesthetist to the service. This has resulted in inconsistency with respect to patient selection and risk stratification. The result is that many patients in recent years have had procedures cancelled in an untimely way, causing great disruption to their patient journeys. It has also meant that the endoscopist's and nurses' time is not optimally utilised. For the referring GPs, this has also undermined the confidence in the service. An excellent, valued service is therefore at risk because of mismanagement on the part of the LHD.

(f) an analysis of the capital and recurrent health expenditure in rural, regional and remote NSW in comparison to population growth and relative to metropolitan NSW

As per our comments in TOR (b), only NSW Health can provide such data.

(g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them

There appears to be an increasing reliance on agency nurses and locum doctors in all the facilities within our Shire, including the Residential Aged Care Facilities.

Despite NSW Health having a *Settlement Package* with the Rural Doctors Association of NSW, which remains reasonably generous for many rural Visiting Medical Officers (VMOs), NSW Health is often doing deals with doctors and medical corporations outside this package. Only as recently as last week, WNSWLHD and Ochre Health signed a big contract, effectively handing over all primary medical care in Bourke, Brewarrina, Collarenebri, Coonamble, Lightning Ridge and Walgett.

The weakness in the *Settlement Package* relates to the smallest towns, in our case Coolah, Baradine and Dunedoo. In such towns, the *Settlement Package* does not adequately compensate doctors for sacrificing personal life, family life and other work in order to be on-call. Rather than correct this problem by introducing a minimum fee for doctors in such town, NSW Health has preferred other models, such as telemedicine, locums or simply not having any medical cover at all.

Therefore we have witnessed situations whereby doctors from these smaller towns do locum work or telemedicine work for the LHD whilst leaving their own towns with no in-person cover.

It is hard to understand why WNSWLHD and NSW Health are willing to offer generous minimum terms to locums and telemedicine doctors, yet remain unwilling to do so for its resident VMOs.

WSC views the tendency towards blanket tenders with corporate entities with serious concern. Similar arrangements have already had a disruptive effect in Coolah and Dunedoo. Medical practitioners and medical practices have important roles in rural communities that extend well beyond the daily clinical work. Having doctors live and invest in small towns is of great importance to the social and economic fabric of the towns; the smaller the town, the more important this is.

The push towards tenders and telemedicine discourages doctors from moving to small towns, which is then devastating for the towns, as it often leads to closures of other businesses (e.g. pharmacies and allied health), job losses and harm to other businesses. Every time patients go out of town to see doctors, they inevitably get their scripts dispensed and do other shopping out of town.

Such *ad hoc* deals between NSW Health and corporations also muddies the waters for the bulk of NSW rural VMOs, for it creates uncertainties about tenure and income.
The tendering arrangements also present the following problems:

- Disincentive for new doctors to move to an area to set up house and practice;
- Restraint of trade if a doctor seeks VMO rights and is unwilling to work for the corporate;
- Lack of scrutiny of local hospital management, policy and services by local medical officers.

(h) the current and future provision of ambulance services in rural, regional and remote NSW

WSC is concerned about patients being transported to appropriate facilities, obstructionism when isolated rural doctors are trying to get patients to higher level care and the way ambulance co-ordinates rosters and call-outs.

Example 6:

A woman goes into labour in New Mollyan, 45km away from Coonabarabran and 100km from Dubbo. The ambulance knows that Coonabarabran Hospital has no obstetric service yet still transports her to Coonabarabran. The doctors and nurses in Coonabarabran then have to book an ambulance again to transport the woman to Dubbo. The ambulance co-ordination makes this process difficult because the woman is in labour and demands a midwife to escort the patient. Coonabarabran Hospital has no midwife on duty. During this time, the woman continues to labour, putting a lot of pressure on the limited medical and nursing staff in Coonabarabran. Three hours after calling the ambulance, the woman is still in Coonabarabran when she could have been in Dubbo within one hour. When the ambulance finally agrees to take the woman to Dubbo, two ambulance officers are each paid an after-hours call-out fee.

Example 7:

An elderly woman has a fall in Baradine on a Sunday morning. She looks to have a fractured wrist. The ambulance take her to Baradine Hospital, fully knowing that there is no doctor there and no xray there. The telemedicine service is then engaged and the nurses in Baradine have to spend an hour

arranging a transfer to Coonabarabran or Dubbo for the patient to have an xray and further assessment. When the transfer takes place, each of the two ambulance officers is paid another after-hours call-out fee.

(i) the access and availability of oncology treatment in rural, regional and remote NSW

Cancer patients would prefer not to drive a few hours to a regional centre for 30min of chemotherapy, then drive all the way back.

All the major NSW regional centres have multidisciplinary oncology services, with only Dubbo lacking radiation oncology. WSC patients can access oncology services in Tamworth, Dubbo and Orange.

Due to the action of our local doctors, Coonabarabran Hospital has a satellite oncology service. It is an example of what can be achieved elsewhere (link supplied).

(j) the access and availability of palliative care and palliative care services in rural, regional and remote NSW

Palliative care can be effectively and safely delivered by competent rural GPs and local nurses, who have intimate knowledge of the patient, the patient's carers and loved-ones. Rural hospitals and rural residential aged care facilities can offer palliative care as well as anywhere else.

(k) an examination of the impact of health and hospital services in rural, regional and remote NSW on indigenous and culturally and linguistically diverse (CALD) communities

See TOR (b). Medical and health journals are replete with evidence regarding these topics.

(l) any other related matters

We hope that this Inquiry shall lead to improvements in staffing and equipping the hospitals in WSC and all of rural NSW.

We wish to draw your attention to some key points in the 2008 Garling Report:

1.73 During the course of this inquiry, I have identified one impediment to good, safe care which infects the whole public hospital system.... It is the breakdown of good working relations between clinicians and management which is very detrimental to patients. It is alienating the most skilled in the medical workforce from service in the public system. If it continues, NSW will risk losing one of the crown jewels of its public hospital system: the engagement of the best and brightest from the professions who are able to provide world-class care in public hospitals free of charge to the patient.

1.74 So serious is this problem that I have approached it at each level of the public hospital system. ..... At the hospital level by reconnecting clinicians with management through devolving more power from the area chief executive to local managers, including program, stream and unit leaders. At the clinical unit level by involving clinicians (along with allied health professionals and patient representatives) in the re-design of clinical practices and by involving them in the monitoring of all safety and quality of care data for the individual unit or ward.

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References

Examples of media reports highlighting poor outcomes in NSW Rural Hospitals
https://www.abc.net.au/news/2019-11-01/doctors-call-for-judicial-inquiry-into-regional-health/11630746

https://www.smh.com.au/national/nsw/baby-s-death-leads-to-extraordinary-discovery-of-2000-unchecked-results-at-hospital-20200911-p55uom.html

https://www.abc.net.au/news/2020-10-12/review-of-telehealth-ordered-into-gulgong-hospital-death/12758644

Examples of NSW Health stepping away from the RDA Settlement Package, preferring corporate model
https://ochrehealth.com.au/news/major-contract-win/

https://wnswlhd.health.nsw.gov.au/In-the-media/Lists/Posts/Post.aspx?ID=1584

Link to NSW Health – Rural Doctors Association (NSW) Settlement Package
https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2020_033.pdf

Examples of satellite Oncology service in Coonabarabran
https://www.canrefer.org.au/services/coonabarabran-outreach-chemotherapy-clinic

Link to Garling Report
http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0011/258698/Garling-Inquiry.pdf

Attachment 1

Warrumbungle Shire Estimated Resident Population
The Estimated Resident Population in 2019 of the Warrumbungle Shire was 9,278 with an Estimated Resident Aboriginal and Torres Strait Islander Population 1,165.

Of the population there were 4,701 males and 4,577 females. The median age of residents in the Warrumbungle Shire is 49 years while at the same stage it is 38 years for residents of NSW and Australia

Estimated Resident Population by age and sex as at 30 June 2019

Age	Males	Females	Total
0-4	242	248	490
5-9	270	277	547
10-14	323	352	675
15-19	353	265	618
20-24	189	135	324
25-29	166	138	304
30-34	184	199	383
35-39	173	202	375
40-44	232	254	486
45-49	265	288	553
50-54	311	307	618
55-59	338	344	682
60-64	391	345	736
65-69	356	324	680
70-74	356	326	682
75-79	244	207	451
80-84	169	180	349
85 and over	139	186	325
Total	**4,701**	**4,577**	**9,278**

Attachment 2

BARADINE	BINNAWAY	COOLAH	COONABARABRAN	DUNEDOO	MENDOORAN
DOCTORS – MEDICAL PRACTICES					
Dr Dr	N/A	Dr	Warrumbungle Medical Centre – Dr Dr Dr Dr Dr Coonabarabran Area Medical Centre – Dr Dr and Dr	Dunedoo Medical Centre – Dr Dr	N/A
CHEMISTS					
PharmaSave Pharmacy 24 Wellington Street, Baradine Open – Monday to Friday 9am to 5.30pm closes for lunch 1-2pm	Binnaway Pharmacy 16 Renshaw Street, Binnaway Open Monday to Thursday 9am to 5pm Friday 9am to 4pm	Coolah Pharmacy 55 Binnia Street, Coolah Open Monday to Friday 9am to 5pm	Coonabarabran Chemist 41 John Street, Coonabarabran Open Monday to Friday 9am to 5.30pm Saturday 9am to 12pm Your Discount Chemist 77 John Street, Coonabarabran Open Monday to Friday 9am to 5pm Saturday 9am to 12pm	Dunedoo Pharmacy 86 Bolaro Street, Dunedoo Open Monday to Friday 9am to 5.30pm Saturday 9am to midday	
HOSPITALS					
Baradine Multi Purpose Health Service 37a Macquarie Street, Baradine		Coolah Multi Purpose Health Centre Martin Street, Coolah	Coonabarabran Hospital – Edwards Street Coonabarabran	Dunedoo War Memorial Hospital 31 Digilah Street Dunedoo	
AGED CARE FACILITIES					
Baradine Multi Purpose Health Service 37a Macquarie Street, Baradine		Coolah Multi Purpose Health Centre Martin Street, Coolah	Cooinda Nursing Home Neate Street Coonabarabran		

BARADINE	BINNAWAY	COOLAH	COONABARABRAN	DUNEDOO	MENDOORAN
COMMUNITY HEALTH CENTRES/SERVICES					
Baradine Multi Purpose Health Service 37a Macquarie Street, Baradine	Binnaway Community Health Centre – 3 Renshaw Street Binnaway Monday and Wednesday 9am to 3pm Friday 9am to 2pm	Coolah Multi Purpose Health Centre Martin Street, Coolah	Community Health Cassilis Street, Coonabarabran Monday to Thursday 8am to 4pm		