Submission No 460

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

Name: Ms Kate Stewart

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Mr Greg Donnelly MLC
Chair
Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales
By Electronic Submission

15 January 2021

Dear Mr Donnelly MLC,

First, I'd like to thank you for the opportunity to offer a submission to the abovenamed Inquiry.

Second, I'd like to indicate my scepticism that this Inquiry will do anything to improve access to health and hospital services; much less lead to improvements in the experience of rural, regional and remote New South Welsh health outcomes.

Third, I have lived in a few rural, regional and remote communities in New South Wales. It is my contention that at no point in my life time has access and quality of outcome been worse for rural, regional and remote New South Welsh people. The significant cost shift on to the citizenry from successive governments intent on defunding, devaluing and destroying rural, regional and remote communities is, in and of itself, an extraordinary liberty when juxtaposed against successive governments claiming that we live in a country with universal health care. The reduction in services offered to communities partly because of treasurers failing to balance community need against the expectations of their Party donors and their own Budget stress, and partly because of the apparent attitude of the Colleges of the medical fraternity attempting to centralise their population as close to the Sydney Opera House as possible, has been startling. And the lack of recollection even in the Parliament of service reductions is, while not atypical and possibly convenient, a dreadful state of affairs.

Fourth, the views I express are my own; though, in addition to my own experiences, some are informed by a range of other rural, regional and remote residents.

Fifth, I have included some commentary on matters related to the health system which are impacted by poor health, poor health services availability and/or which impact health.

I recognise that my submission is lengthy, it could have been longer – much longer. It could have covered other concerns – many other concerns. I'd love to have provided bullet points instead. But I think that to do that would be to join the conga line of people who seem to just write off the bits that aren't Newcastle, Sydney, Wollongong and the Blue Mountains.

I hope this is a real chance for reform. I hope that the powers that be will actually pursue some real improvements. But, as I said, I remain sceptical.

Kate Stewart

Introduction

In 1987, when I was 7 years old; after years of regularly seeing doctors and absences from school (Tumblong Public School, South Tweed Heads Public School and Ungarie Central School); I had my tonsils removed at West Wyalong District Hospital.

The Ear Nose and Throat Specialist regularly attended patients in the West Wyalong district. The regularity of their attendance meant that local restaurants could receive fresh shipments of seafood direct from the Coast. But it also meant that a range of illnesses and afflictions existing in the communities surrounding West Wyalong could be addressed with relative ease.

I was second in on that day's list. But I was the last to return to our Ward. As a result, my drip holder was one of those ones that was attached to the bed. I was the only person in our Ward who was required to bed pan because West Wyalong Hospital did not, at that point, have sufficient drip holders on wheels for all of those operated on that day. Why was I last back? Well, I didn't come round. I remember being asked to count backwards (which, in the arrogance of youth I thought I'd easily do … I think I got to 7 down from 10); the next thing I remember was being in a strange place which didn't look like the Ward I had been on the night before. I have a vague recollection of my mother being there and a nurse or an orderly. I recall waking up there twice, maybe three times. Then I remember being wheeled through a corridor. I remember getting back to our Ward and later it was dark. Then waking regularly to vomit; and, because the first time you vomit you rip your stitches, mostly it was blood. At some point I remember my mother leaving and the mother of two of the other children who had had procedures that day sitting near my bed for a while. My mother then drove forty two kilometres in the pitch black to return home to have a shower and report back to the rest of the family; the rest of the family that had assumed, wrongly it turns out, that I'd be right and that they'd have been in West Wyalong visiting me before lunch. At least, that's how I remember it.

I have subsequently been told about the nurse calling my mother in from the waiting room after what seemed like much longer than the patient before me. I have also been told that while I was regaining consciousness I was asking for my father (a couple of years later, when recovering from having an appendix extraction at Lismore Base Hospital, my sister was asking for me; my mother indicated that she feels quite aggrieved about these things). I can imagine these things, but I know little else other than the name of the drug I am allergic to (which, incidentally, is one of two drugs which have the same name – and I have no idea which is which); and that I was so angry that I had to have the drip holder attached to my bed that I have, after subsequent procedures, been a less compliant patient than I might otherwise have been.

While the situation as regards my tonsils ended happily in my case (though I was not allowed to take my tonsils home with me; and, "happily" probably depends on your perspective, I'm sure I was a delightfully *ordinary* teenager); if a worse outcome had been realised, my mother and father were relatively physically close both to me and to each other. Forty two kilometres.

My understanding is that today such a procedure would not be available at West Wyalong District Hospital.

Forty two kilometres sounds like it's far away; as I'm writing this, there is a "health service" (which 30 years ago was a hospital) less than 500m from me. And can you imagine the reaction of Sydney siders told that their closest hospital is 40km from them. But forty two kilometres seems MUCH closer than the hundreds of kilometres it would be if I still lived in Ungarie.

We don't have a universal health care system. Actually, I suppose that's not quite true. We seem to have a system relatively close to universal health care … provided you live in Sydney.

Sure there are some (though increasingly few) doctors outside of Sydney which bulk bill General Practice services. But that depends on the community in which you live, the doctor themselves and sometimes even the Health Service. In the regions closest to the Australian Capital Territory finding a doctor willing to bulk bill is near impossible. Even those with Income Support and Pension Cards can struggle to find a General Practitioner willing to see patients with no gap. Though, the more chronic the health conditions of those with Pension Cards the more likely they will be to eventually be bulk billed. It has been like that for at least fifteen years and is unaided by similarly low levels of bulk billing in Canberra which seems attributable to the high levels of income with which a few very wealthy people are remunerated and the location of the bulk of the Commonwealth Senior Executive Service. That said this is an increasing experience across New South Welsh rural and regional communities – there are large areas of New South Wales where bulk billing is not a likely option most recently I was told that finding a bulk billing doctor is near impossible on the Mid-North Coast.

Then there are gap fees for specialists, if you can actually get in to see one. And there are a range of gaps when seeing a specialist. If you have to travel to because public patients are not always seen across the whole State, or specialists have dragged their heels and so it's quicker to have your health seen to if you travel; you *might* be eligible for "reimbursement" through IPTAAS – at this point I wish Microsoft adopted the eye roll emoji for Word. Then there's the gap between Medicare plus private health insurance coverage and what the relevant doctors' and health facilities' actually want to charge you. And if you're unable to foot that bill you then get pushed to the public system which means longer waiting times, longer dealing with the health issue and lower overall quality of life and productivity. So much for John Howard suggesting that by propping up his mates, like Mr Ramsay, in the private health insurance industry with tax dollars we would all see better and more timely access to the health services we require.

Then, of course, there's the reaction to a public health crisis, a possible second wave of a global pandemic afflicting New South Wales; and rather than protecting rural, regional and remote New South Wales from that possible second wave; the Berejiklian Government consciously chose to not stop travel from Greater Sydney to rural, regional and remote locations. Having been re-exposed to Covid 19 because of the arrogance of Sydney residents unwilling to fund plausibly helpful health services outside of Sydney; we are then worried that the virus may take hold in our communities which do not have health services of sufficient strength to deal with an outbreak of Covid 19 because of the arrogance of Sydney siders who simply won't be told that their travel is dangerous – or Sydney flipping us the bird. There are few situations where rural, regional and remote New South Wales will be made more overtly and acutely aware of our subservience to Sydney. And the luck of an outbreak seemingly not having taken hold in any of the recently exposed rural, regional and

remote communities is just that – luck. It was not good management. If Berejiklian was unwilling to cause rural, regional and remote communities to be off limits for Sydney siders; she should have immediately mandated mask wearing for anyone who has a Sydney postcode who was found anywhere in the rest of the State from no later than the second day of Northern Beaches notifications – doing so may have provided us with some, albeit limited, protection.

For the most part I think all Members of the New South Wales and Australian Parliament should be shouldering blame for the dreadful state of rural, regional and remote health service access; the National Party should be singled out for particular admonition because of their repeated and consistent failure to represent the interests of the communities comprising the electorates they hold. I also think the Colleges of medical professionals (rent seekers), the Australian Medical Association (rent seekers), insurance companies (rent seekers) and New South Wales Health (lazy and lacking problem solving skills) should shoulder a significant portion of blame as well.

I intend to cover a range of topics from data to cross-border health arrangements; primary health care; dialysis; allied health issues including aged care; and, maternity. There are more issues which I should cover, like access to reproductive health options; there are more topics which I should cover, including general commentary on staffing and/or facilities and fitness for purpose. But this submission is already likely to be lengthy.

At the end of my submission I hope you feel uncomfortable about the system you supposedly oversee. I hope you feel appalled at and about some of the analogies and examples I have offered. And I hope you realise that, currently, there is not balance between patient and community interest against the interests of the Colleges (rent seekers) and other peak body fat cats (rent seekers). Far from it. Unlike in literally every other part of public policy where regardless of their experience and/or knowledge of how the services should and do operate, what those systems do and what those systems are supposed to do every man, his dog and his political representatives will assume that their knowledge is superior to professionals in the field; the whole of the health system seems to be a sacred cow where politicians seem to refuse to want to listen to anyone who is not a medical doctor undermining not only other health professionals and community members but patients and quality of care.

Data and Population

Fascinatingly, the World Bank and the World Health Organisation not only seem to hold considerably more data than New South Wales Health, but they seem to be interested in people actually being able to easily access the data they hold – through browsing, through searching and exporting.

I spent a considerable amount of time trying to find out the infant mortality rates across New South Wales. As a Closing the Gap target, it would seem an obvious thing to make that data (both aggregated for the State as a whole and in, at least, regions or Local Government Areas) available for all to see.

Arguably the Agency with the best and easiest to find information relating to mortality should be New South Wales Health. Arguably, we should be able to access that type of deidentified data… easily… via multiple methods.

I browsed some of the Open Data holdings that New South Wales Health made available; and I found the average hospital stay for giving birth (much higher in private hospitals, just so you know; which, presumably health insurance companies wouldn't allow if it weren't strictly necessary – Greg Hunt (noted private hospital champion) wouldn't leave private health insurers to make anything less than the profits required to fund organisations like the Ramsay Centre which warrants the question – **how is it that public hospitals cause shorter stays for women who are giving or have just given birth?**). I found the number of infants who died in one year; split across urban, suburban, rural and very remote (classifications which, in and of themselves raise more than a question or two). But I couldn't find the infant mortality rate by browsing the Open Data.

After being unable to find the data I was looking for by browsing I searched and managed to find (some) of the data I was looking for. Fascinatingly the Far West of New South Wales seems to have been distinguished from Western New South Wales (which, hilariously, barely cracks the centre of the State let alone the West of it) in most of the Local Health District level data … but not in infant mortality.

In compiling my submission I spoke with a number of people including health professionals. Some of which expressed concern that of the infant mortality statistics they had seen; parts of the State were considered to have such low populations that statistical information would be unlikely to be available in regional form. What that doesn't tell me is that what data there is sounds like it reflects outcomes aligning with targets. Far from it. It suggests to me that what data there is probably reflects declining likelihood that New South Wales is achieving targets to reduce infant mortality … but only in some parts of New South Wales … probably those big bits where health services are less services than outposts. On the other hand, if those targets are actually being achieved, why wouldn't New South Wales Health want that information to be made available?

Stars quant (which would be the colloquial expression for some of the costings offered in Federal Budget Papers) covers all manner of sins. Statistical insignificance merely reduces transparency, reduces accountability and allows us to assume that New South Wales Health and the Colleges are sacrificing the health outcomes of some populations rather than promoting and improving health outcomes. Release the data … so we can see which New South Wales Health and the Colleges have been doing.

How can we effectively compare the health outcomes of Local Health Districts if we are sometimes including data about all of them, sometimes including data about some of them and generally cherry picking what we are prepared to make public and not?

As I mentioned earlier, when I was a kid in rural New South Wales it was possible to actually receive health services relatively close to home. I managed to get my tonsils extracted within 50km of home, for example. Highly specialised procedures like repairing holes in hearts were centralised in Sydney; but then there were very few of those types procedures conducted in the whole of Australia in any one year; and those procedures were relatively new. Tonsils and adenoids, though, are removed with relative regularity.

A couple of years after my tonsils were removed, the health system was slashed, particularly in rural, regional and remote New South Wales. Hospitals and their functions were severely downgraded, curtailed or cancelled. Many rural hospital facilities were downgraded to the point of really only providing care to chronic aged patients … or being the facility out of which an out of town General Practitioner would practice.

Can the following information be made available to the Inquiry (in real terms against the inflation rate and in nominal terms):

- **Per capita costs of the public health system from 1950 – present**
- **Actual funding by New South Wales Health facilities (and equivalent) from 1950 – present**
- **Actual funding by New South Wales Health facilities (and equivalent) by immediate population serviced from 1950 – present**
- **Procedures and number thereof performed in all New South Wales Health facilities (and equivalent) from 1950 – present**
- **Health worker populations and types of health workers affiliated to New South Wales Health by New South Wales Health facilities (and equivalent) from 1950 – present**
- **Infant mortality rates, by Local Health District (or equivalent) from 1950 – present**
- **Number of New South Welsh people residing within 50km of a District Hospital (or more highly rated facility), by Local Health District (or equivalent) from 1950 – present [alternatively, the reverse – ie. people not residing within 50km of a District Hospital]**
- **Number and type of specialist services available in New South Wales by Local Health District (or equivalent) from 1950 – present**
- **Number and type of specialist Visiting Medical Officers (for example, local General Practitioner with a specialty or dedicated speciality) accredited by New South Wales Health facilities (and equivalent) by Local Health District (or equivalent) from 1950 – present**
- **By procedure the number, type and location (New South Wales Health facilities or equivalent) from 1950 – present**

Yes, I have asked for rather a lot of data. Yes, it will take New South Wales Health some time to compile these numbers (fair to acknowledge the appalling state of Records in New South Wales in this space as well). But if New South Wales Health start doing this now, we might one day be able to see a clear picture of the extent to which the New South Wales Government, the Australian

Government and/or other institutions have been responsible for poorer health outcomes. Conversely we might actually see that New South Wales Health has not done the dreadful job they seem to have done or that the New South Wales Government hasn't failed spectacularly in health care provision.

And how can we effectively seek to analyse the impact of funding health services on population without access to such data?

On that point, can we also receive data relating to how accurate the demographic projections Miller Street (and equivalents) force onto Health Ministers are? Preferably, this data should be by health facility (or the local population around each health facility) and by analysis produced by Miller Street (and equivalents) from 1950 – present. In other words, for every single demographic prediction made by Miller Street and equivalents can we receive a rating (scale to be determined by the Inquiry Committee) for the level of accuracy Miller Street (and equivalents) have achieved with each analyses they've undertaken (probably by year covered in each analysis).

At this moment, organisations assert that they haven't caused problems. But, I'd indicate that it's impossible to know that without the numbers. And, realistically, the longer NSW Health refuses to make long-run data available, the harder it is to believe that New South Wales Health doesn't do an appalling job daily.

The significant reduction in health services made available to rural, regional and remote New South Welsh people in the late 1980s-early 1990s accompanied a significant reduction in population.

Has Miller Street given any thought to the impact of the significant reduction in health service expenditure and the increasing centralisation of medicine on not only the populations serviced; but also the size of the populations serviced?

Has Miller Street given any thought to how much the reduction in health services available in rural, regional and remote New South Wales negatively impacted local population sizes; resulting in fewer teachers being allocated to local schools; resulting in businesses (like banks) vacating rural, regional and remote communities; resulting in further reductions in health service availability and teachers and so on and so forth?

Did Miller Street consider the overall health impact on populations shifting to larger centres when, particularly, social and cultural networks for managing care (of children, the elderly, the disabled and other groups) were significantly disrupted by this significant population shift?

And what is Miller Street's response to the suggestion that it was Miller Street and the, then, Department of Health's policy implementation which started the vicious cycle of population decline for rural, regional and remote New South Wales?

The cost of living in rural, regional and remote New South Wales seems to be often incomparable with living in Newcastle, Sydney, Wollongong and the Blue Mountains because of the variations in what costs less, what costs more and what costs considerably more.

It is broadly true to say that expenses other than accommodation in remote New South Wales are significantly higher than, say, in Sydney because of the distance the product or service must travel to be available. That said, in many remote areas, if you are renting, your accommodation costs are not necessarily significantly lower than in Sydney; partly because the rental accommodation you occupy can be half or more of the cost of accommodation in Sydney; and, partly, because of poor maintenance and upgrading of accommodation and/or the general climatic conditions causing significantly higher heating and cooling and environmental management costs, older networks where you might see greater energy leakage.

However, if you purchase property in rural, regional or remote New South Wales; that property will generally be cheaper than similar property in Sydney.

That said, if you decide to sell up to move somewhere bigger (or, to a more centralised population with better access to services like health care); it may take a significantly longer period than it would in Newcastle, Sydney, Wollongong and the Blue Mountains to sell property you own; and, the amount you receive for sale will generally not be sufficient to purchase similar property in a larger centre without significant additional contribution and will often derive a sale price lower than your initial purchase price, even with intervening maintenance and even upgrades of the property.

That is, perhaps it's worth noting that Stamp Duty isn't the real barrier to labour mobility; there are a number of factors including wealth transferability, cultural and social networks and other barriers which also contribute to labour mobility.

Has Miller Street considered the overall health impact on populations shifting to larger centres in light of the stress of the lack of transferability of wealth?

Has Miller Street considered the overall health impact on populations aware that shifting to larger centres has been forced on them by service reductions?

In some situations, like National Disability Insurance Scheme service provision, health care workers (specialists, allied health workers, carers, others) might be sent to communities to provide some level of service or care to individuals or groups within rural, regional or remote communities.

There has been much discussion of the social and cultural issues caused by Fly In Fly Out and Drive In Drive Out workforces employed by the mining sector. Has Miller Street considered the social and cultural impact of their own Fly In Fly Out and Drive In Drive Out workforces?

Have New South Wales Health, the Colleges, the AMA and/or the politicians considered the social, cultural and political impact of Fly In Fly Out and Drive In Drive Out health workforces?

Have New South Wales Health, the Colleges, the AMA and/or the politicians considered the impact on the broader health care workforce of increasing numbers of Fly In Fly Out and Drive In Drive Out health workforces; both from the perspective of the health workforce which is permanently located in community and in terms of the transient workers?

Do New South Wales Health, the Colleges, the AMA and/or the politicians bother to speak with the peak bodies of allied health professionals and/or other interested Government bodies like

police, fire crews, teachers and/or Local Government when making decisions about permanent service and staffing allocation versus allocating transient Fly In Fly Out or Drive In Drive Out positions?

Or do the Institutions view the inviolability of the health system sufficient to avoid scrutiny of workforce planning, distribution and impact on treated populations?

What level of responsibility do New South Wales Health, the Colleges, the AMA and/or the politicians take for the relationships they build with other, particularly, health peak bodies and organisations?

Among the range of justifications given for reducing or minimising both the refugee and broader immigration intake is the capacity of the basins on which our metropolitan and highly urban populations sit.

Has New South Wales Health either considered or been lobbied to consider how decentralising health care (or generally just increasing health service availability and/or improving health services in rural, regional and remote areas) might be a useful tool to encourage populations to - remain in and/or shift to rural, regional and remote New South Wales?

The Colleges, the AMA, the universities, insurance and New South Wales Health: the Institutional Blockages

Before I commence this section I want to be very clear. I am not implying that these institutions are, among other things, racist. I am explicitly saying that I think the conduct of these institutions and other contributing institutions like Federal Agencies and other State Agencies of Government shows VERY strong signs of endemic racism.

I am not implying that these institutions are, among other things, engaged in poverty porn. I am explicitly saying that I think the conduct of these institutions and other contributing institutions like Federal Agencies and other State Agencies of Government shows VERY strong signs of systemic addiction to engaging in poverty porn.

Finally, I am not implying that I don't think these institutions have the best interests of people at heart. I am explicitly saying that I think of the conduct of these institutions and other contributing institutions like Federal Agencies and other State Agencies of Government shows VERY strong signs of not only not having the best interests of people, communities and patients at heart; but that these institutions and actors therein are archetypal seekers of rent in the interests of the self at the exclusion of all others and often to the detriment of others.

All of that said, I am no expert in this space. So, I would like a series of questions posed to the representatives of these institutions.

When developing submissions to State and Federal Governments on issues pertaining to their specialties how much international comparison and consideration do the Colleges and the AMA undertake?

When undertaking international comparisons, do the Colleges and the AMA only consider comparison with the OECD? Or do the Colleges and the AMA cast their nets more widely?

When the Colleges and the AMA offer submissions to State and Federal Governments on issues pertaining to rural, regional and remote health services and issues, do the Colleges and the AMA consider interstate and/or international comparisons of communities and/or populations which are broadly equivalent to or are even remotely similar to the populations we might see in rural, regional and remote New South Wales? If so, which other jurisdictions do the Colleges and the AMA favour for comparison when considering health issues impacting or health service availability for rural, regional and remote New South Wales?

Do the Colleges actively encourage General Practitioners to develop specialty practices to sit along side their General Practice?

Why are New South Wales Health and the Colleges overwhelmingly more likely to approve of or recommend GP Anaesthetists gaining Visiting Medical Officer accreditation to New South Wales Health facilities than any other GP specialty?

Are the Colleges happy with their reputation of being far more concerned with their access to the Opera House than to patients? Are the Colleges bothering to do anything to overcome this reputation?

What is the process of determining how many and which Visiting Medical Officers will be accredited with New South Wales Health facilities?

Why does the distribution of Visiting Medical Officer accreditation seem to be almost absent outside of Base and District Hospitals, in spite of significant and recent upgrades to, particularly, maternity but also other health facilities across a large swathe of New South Wales Health facilities in rural and remote areas?

Noting that Local Health Districts do not align with Aboriginal nations, is there any particular reason that the institutions have chosen to not find a path to acknowledge the importance of connection to country in the provision of medical services? Is it just all too inconvenient for the institutions to bother factoring Aboriginal people into their thinking?

Have the institutions given any thought to the distinct ways in which various cultures react to and/or deal with having to interact with the health system and/or hospitals?

To what extent have the institutions encouraged shifting the costs of health care on to patients from Government?

To what extent have the institutions dissuaded Governments from shifting the costs of health care on to patients?

Why are the institutions reluctant to engage with other Government service providers to improve health service provision, for example schools?

I acknowledge that the universities have engaged in communities which has ensured the exposure of many of their students to the health care needs of rural, regional and remote communities.

However, to what extent are universities involved in the reduction in services available to rural, regional and remote communities?

To what extent are these university outreach programs simply about funnelling money from health into the coffers of bloated university administrations?

What is the *actual* cost of providing services like the Broken Hill University health service, the Three Rivers Health service and the other services (all of which seem to be broadly attributable to either the University of Sydney, Charles Sturt University or Newcastle University) to rural, regional and remote communities?

How much of any grant moneys received from Government for providing these services to rural, regional and remote communities is on cost?

When attending local facilities, to what extent are students participating in these programs encouraged to experience the communities they are visiting? Given sufficient blocks of time in

community to actually get to know communities such as to attempt to understand the broader context in which they are learning? Or encouraged to attend the local health service, perhaps eat a meal out and then return to health service accommodation in favour of rejecting the community and, thus, not even observing it let alone experiencing it?

When setting accreditation and other requirements which will ultimately impact the cost and/or availability of insurance for Visiting Medical Officers, what level of consideration do the Colleges give to rural, regional and remote health care needs?

When setting accreditation and other requirements which would ultimately impact the cost and/or availability of insurance for Visiting Medical Officers, do the Colleges develop any flexible paths to maintaining accreditation? Or are all of the paths to developing and maintaining accreditation rigid and fixed?

To what extent is protecting income for existing College and specialty members the driving force behind restricting the number of specialty practitioners?

To what extent is providing holistic patient care and meeting the need for health care the driving force behind restricting the number of specialty practitioners?

To be clear I am saying that, at this point in proceedings, on the face of it the overwhelming driving force is protecting income for existing College and specialty members and that that is the antithesis of providing holistic patient care (which seems largely absent from the Colleges regardless of where members are practicing) and meeting health care needs.

Do insurers exert any influence over required standards to meet specialty accreditation?

Do insurers exert any influence over the extent to which General Practitioners with an additional specialty can receive Visiting Medical Officer status in New South Wales Health facilities?

To what extent do insurers exert this influence (donations, overt lobbying, other forms of pressure)?

Has New South Wales Health considered the irony of funding upgrades to physical facilities in rural, regional and remote New South Wales; when they seemingly had absolutely no intention of allowing these facilities to be used (for example, maternity care facilities)?

Given, also, that most of the upgrades furnishing those New South Wales Health facilities were performed by external or centrally contracted labour and firms; and that many of the facilities upgraded are rarely, if ever, used; what actual benefit of that expenditure to the communities in which those facilities were upgraded can New South Wales Health point to?

Has New South Wales Health considered actually employing doctors with specialties for rural, regional and remote health care provision; rather than leaving patients to the mercy of the Colleges and the, apparently, quite hit and miss Visiting Medical Officer system?

What actions are the Colleges and the AMA taking to:

- **Stamp out misogyny in the medical professions?**
- **Encourage more women to join specialist and General Practices?**
- **Stamp out racism in the medical profession?**
- **Encourage more people of Aboriginal and Torres Strait Islander heritage to join the medical and allied health professions (and not merely as Aboriginal Health Officers, but as mainstream qualified professionals)?**
- **Research health care needs, issues and symptoms experienced by rural, regional and remote women?**
- **Research the differences in symptoms of acute and/or chronic conditions experienced by women against those experienced by men (for example, heart attacks)?**
- **Research the differences in symptoms of acute and/or chronic conditions which might be experienced by groups which are not white middle class and men (for example, different reactions to pharmaceuticals)?**
- **Improve diagnoses offered in hospital settings?**
- **Promote the provision of primary health care locally?**
- **Prevent the holistic, the general and/or the chronic being crowded out by the acute, urgent and immediate?**
- **Promote whole-of-family and/or whole-of-community roles in each health care decision?**
- **Research the differences in health care needs, issues and symptoms experienced by culturally and linguistically diverse communities?**
- **Educate women and culturally and linguistically diverse communities about the symptoms of health conditions which might differ from white men?**
- **Meet the needs of people that aren't medical professionals concerned about their golf handicaps and access to the Opera House?**
- **Consult with, rather than dictate to, communities and patients?**

I have to apologise for sounding hostile. It's not my intention. But our health system is infuriating.

IPTAAS

Not only does the IPTAAS system not compensate patients for the real cost of their out of pocket treatment; the nominal costs leading to an IPTAAS claim are not necessarily all included in repayment to the patient.

Outside of expressions of frustration and anger, it is difficult to get people to talk about IPTAAS and its forms.

But, overwhelmingly, people do not like these forms; often find these forms complex, confusing and difficult to complete; require support to complete and lodge these forms.

When was IPTAAS and its hurdles last reviewed?

In what way does IPTAAS not represent a significant cost shift onto an unsuspecting community? Noting the significant individual costs incurred by patients leading to fulfilling the requirements of an IPTAAS reimbursement,

Can New South Wales Health provide an estimate of the amount of money New South Wales and/or the Federal Government make (through interest – or, conversely, save in interest) by people feeling confronted and daunted by the IPTAAS form and either not submitting or delaying the submission of the forms?

Can New South Wales Health provide an estimate as to the volume of patients who delay or refuse diagnoses or treatment because of the difficulty with and complexity of IPTAAS forms, the range of bureaucratic hoops though which they anticipate they will be forced to jump and because their health just seems too hard? Can New South Wales Health also provide an estimate as to what this might have looked like over time?

Could we reform this form, please?

Cross-Border Health Arrangements

The Liberals and Labor have officially driven and concluded a range of cross border health agreements. Communities are oftentimes not happy with the arrangements that are brokered.

And during the Covid pandemic the New South Wales Government failed to deal with problems relating to these cross border health arrangements as borders closed. Evidently it was not obvious to New South Wales that they were going to be unable to enforce contracts and would have to subsequently take action for breaches in contract along borders while biting the bullet and filling the service gaps rather than cut off health services to border communities. Tenterfield and Broken Hill were stark examples of communities which all but lost access to health services simply because New South Wales refused to take their constitutional responsibilities for the provision of health care seriously causing significant and unnecessary delays to treatment and recovery from injuries and illnesses for many people.

What consultation with communities occurs prior to the conclusion of either cross-border health agreements or renewal or alteration of cross border health agreements? Rather, does any? And if there is consultation with affected communities is it done in person or is it more a gazettal process inviting comment; wherein residents would have to know to look out for the Gazette in order to find out that there was an invitation to be consulted on local health care needs?

In the case that real consultations have taken place, are there any instances where community preferences have swayed from which side of the border services are provided to communities? If so, which communities have managed to influence the health system in which they are looked after?

How frequently are cross-border arrangements reviewed and re-negotiated?

What assurances have the New South Wales Government extracted from the Commonwealth and ACT Governments leading to the closure of the Yass Maternity Ward?

Why does New South Wales Health seem to enjoy appearing to hate women? Reducing choice and services to women in rural, regional and remote New South Wales is, surely, not helpful to appearing to care for populations?

Anecdotally, I would submit that where a rural, regional or remote New South Wales Health facility retains procedural capacity, that waiting lists for those procedures are often far more favourable for patient health outcomes than is often the case in a range of other facilities.

What are the surgical waiting lists, by procedure type, across all New South Wales Health facilities (individually) in comparison to facilities used as part of cross-border health arrangements in Victoria, Queensland, South Australia and the ACT?

If that anecdotal information bears out across the data; congratulations to the GP specialists, GP anaesthetists and the hospital and health district boards which have fought to maintain their accreditation in the relevant specialties such as to be engaged in positive promotion of health outcomes for their local communities.

General practice

The rising costs of general practice and a general lack of commitment from the Federal Government to provide actual people with actual health care is resulting in gaps between the Medicare Schedule amount and what the a GP might like to charge.

In a range of areas across rural and regional New South Wales there has been a significant reduction in bulk billing and a significant uptick in compulsion to pay gap fees. Additionally, the gap amount sought by general practice is increasing.

The areas around the Australian Capital Territory and coastal communities both north and south are increasingly unlikely to qualify for bulk billed services.

I am very concerned that not only does this represent significant costs shifted onto communities, many of which can't afford those costs; but that this represents increasing attempts by Coalition Governments to push to allow health insurance companies to create rather an American system of health care.

General practitioners who have chosen to live and work in rural, regional and remote communities who are willing to obtain and maintain accreditation in specialties should be encouraged to do so.

The Colleges should not be preventing general practitioners from obtaining specialities, particularly those which are in extraordinary demand in rural, regional and remote communities.

Gynaecology and Obstetrics specialties are particularly in demand. Colleges should not prevent obtaining accreditation and should be facilitating rotation systems to ensure that practitioners can maintain accreditation in order that general practitioners with an obstetrics and/or gynaecology specialty can gain access to Visiting Medical Officer privileges in New South Wales Health facilities.

That New South Wales Health and the Colleges seem to regularly ignore local health professionals (including GPs) is extremely problematic.

Bureaucratic silos

Then, of course, there seems to be a significant lack of interest in New South Wales Health engaging with other Departments of State and influencing decisions which have the potential to impact the health and wellbeing of New South Wales populations. Some of which I discuss below in the environment section.

It's unclear whether this clear separation of New South Wales Health from other agencies of Government is because of an unearned snobbery or patches being guarded or, indeed, just a lack of interest in the way that life is complex and multi-layered. But it would seem to be important that in such a complex environment, where it is clear that a multi-disciplinary approach to people, community and economy is beneficial, that New South Wales Health should be working hard to engage with all other Departments, Ministries and Agencies.

How is it that New South Wales Health and the Department of Education seem to actively fail to talk to each other?

Does the School Dentist program still exist? In all of the time I lived in Wilcannia there was never any mention of the School Dentist travelling to Wilcannia.

Rural, regional and remote New South Wales has an horrific problem with suicide, particularly in young male populations. It would seem sensible to ensure that School Counsellors are available in schools to be identifying at risk populations and helping to make them aware of supports which might be available during school or, perhaps, even after school. But where are the School Counsellors? And why is the time allocated for access to School Counsellors so restricted, when School Counsellors are actually funded and provided to schools?

It's getting to the point that teachers will have to gain both counselling and social work qualifications in addition to their education qualifications in order to successfully provide education in rural and remote communities, such is the lack of support communities receive from Government. Well, why not actually do that, attach some health services to schools, full time, for community use so that those health services actually exist in communities rather than those communities having to continue begging New South Wales Health to provide them with basic services?

It seems particularly pertinent to discuss the relationship between New South Wales Health and the Department of Education because of the level of liability that teachers face. Some how teachers and schools have become responsible for monitoring and reporting on the health and wellbeing of individual students and cohorts; being responsive to health and wellbeing needs; and without dedicated or even visible support from New South Wales Health.

Drugs

To go about getting Dan Howard to undertake an Inquiry and then literally do nothing.

Your former colleague, Peter Black former Member for Murray-Darling, urged me to include some commentary on drugs and to emphasise his recent message from the *Barrier Daily Truth* that we have lost the war on drugs (I mean, to the extent that there was a war and to the extent that Government was actually serious about it)[1].

I don't disagree with Mr Black's assessment that, in the case that we were ever waging a war on drugs, that we've lost.

I also don't disagree with his assessment that in spite of hearing hours of testimony and receiving a significant volume of submissions that Mr Howard has clearly put rather a lot of thought into the matter of drug law reform.

I regard drug addiction as a health issue rather than a legal issue; and it is my contention that by decriminalising drug abuse and encouraging the Federal Government to move to a policy of legalisation (or, at least trialling legalisation and taxation) we would best serve our communities.

Rural, regional and remote Australia don't merely suffer from people engaged in drug abuse, they suffer from a lack of access to rehabilitation and treatment facilities. Locating drug and alcohol rehabilitation and treatment services in communities with residential options within one or two hundred kilometres would be helpful to providing people with options to engage in behavioural change.

"Just say no" doesn't work. Fines don't work. Prison terms don't work.

And hiding behind Corona Virus, as though the New South Wales bureaucracy is incapable of doing more than one thing at once, is cheating people out of improving the health system.

[1] Black, "Drugs scourge above politics", *Barrier Daily Truth*, 21 November 2020.

Mental Health

I mentioned youth suicide rates earlier. But that is hardly the tip of the ice berg of mental health issues and mental health service gaps in rural, regional and remote New South Wales.

That said, while Headspace Offices are open in some regional communities, and that's great for some regional communities, I am left to wonder what happens in other communities.

The closest most rural, other regional and remote communities get to mental health services is School Counsellors … in the case that the Department of Education actually bothers employing School Counsellors and giving an appropriate volume of hours to each school rather than just some schools.

There are of course other mental health problems in rural, regional and remote communities which, while being less likely to result in suicide, still have significant impacts on families and communities. Drug and alcohol addiction and abuse fall into this category. But also stress and impact of work, reductions in economic and cultural activity, water and its absence, homelessness and precarious housing. The absence of services and the additional difficulties one faces simply by being resident in a community that is not offered any kind of priority by Government.

The stress of an IPTAAS form, the stress of having to travel to receive medical services … it could easily be said that in addition to not actually addressing the mental health issues experienced by rural, regional and remote New South Welsh people, that New South Wales Health actively increases mental health issues through their cost shifts on to patients and communities; failing to consider the whole person and the impact that the loss of that person for an extended period of time to engage in health treatment; and in a range of other ways.

Disability

The transition to the National Disability Insurance Scheme has been tough on disabled people. Ignoring, for a moment, the compliance requirements and the arduous nature of those compliance requirements (because they are Federal); it was disappointing to see that State Government services were, in effect, divested in favour of non-Government organisations.

I am concerned about the lack of accountability that exists in the non-Government sectors (private or community) of the provision of support services to a range of people; but particularly those with disabilities. I am concerned that the employment of these non-Government entities to provide services to people with disabilities is doing three things:

1. Causing significant profits to shareholders rather than providing services to those who need it;
2. That, particularly people with intellectual disabilities but also those with minimal experience of bureaucratic drama, people with disabilities are struggling to engage in the compliance required by Government and non-Government organisations; and,
3. That lines of responsibility are becoming increasingly less clear.

My concerns are based on my observations of the operation of the system; but I have only become interested in the operation of the system because of people contacting me to tell me how difficult they are finding the system.

It would be helpful to have named portfolios allocated for Disability Services (or similar) at both State and Federal levels so that it is clear to whom comments, concerns and complaints should be directed.

I mention this because while disability is not, strictly speaking, part of New South Wales Health; the provision of health care services for those with disabilities is part of the health care system.

Provision of services to disabled people is another area where Fly In Fly Out and Drive In Drive Out workforces are impacting local communities.

Aged Care

Not just aged care but also culturally appropriate aged care.

There is increasing disparity in the experience of aged care across New South Wales.

It seems odd to me that we have committed to Closing the Gap targets, one of which is extending the life expectancy of Aboriginal and Torres Strait Islanders… and aged care isn't a priority for Aboriginal Communities? In fact, I find this very intellectually challenging.

In this space I would like to see the New South Wales Government involved in consulting with communities and providing the Federal Government with details of required improvements.

I would also like to see the New South Wales Government encouraging the Colleges and the AMA to open more places for doctors, particularly rural and remote General Practitioners, to specialise in gerontology.

Domestic Violence

Domestic Violence is a scourge in our communities.

However, there are many communities where a path to assistance and protection doesn't exist.

At some Domestic Violence shelters I have observed safe women's spaces being established where workshops and activities are offered to women from the broader community. These are places and times where informal and formal discussion about a range of topics and issues might occur. These discussions will sometimes venture in to informal discussions about health care. There are occasions when local health care workers might be present which allows all participants to increase their knowledge about various parts of the health care system and to find the path to approaching formal institutions of State easier.

In a place like Condobolin, a town of close to 3000 people, there is no Domestic Violence Shelter, there is no Women's Shelter.

If anyone in Condobolin suffers Domestic Violence, the closest shelter to them is Forbes… which is usually full.

If a woman is bashed in Condobolin her options are:

- Put up with it;
- Develop the confidence to escape (which often has to come from inner strength because of networks broken down by the perpetrator of that violence) and do so when the perpetrator isn't home;
- Flee in the middle of an attack.

The choice itself becomes more complex when children are involved, I'm told.

But, if a woman chooses to leave mid-attack and actually manages to get far enough away from the perpetrator to attempt to go to a Shelter, she then has to find the money or the transport to get to Forbes – where she may or may not have find that the Shelter has space for her and/or her and her children.

There is no in community option for women.

Oh, but she could call the Police.

Well, I suppose there's a chance that she *could* call the Police; but Police are often reluctant to enter domestic disputes. And what are Police actually going to do? And what if her abuser is mates with the Coppers?

In essence, there is nothing stopping her abuser putting the car in neutral, sticking a brick on the accelerator and bashing the crap out of her; except the amount of petrol that happens to be in the car.

The Environment

Water

The absence of water through rural, regional and remote communities is causing significant health issues. Firstly there is the lack of ground cover because of restrictions on watering. Secondly, there are droughts generally causing significant issues of economy and society. Thirdly, there are the decisions made by Water Ministers upstream failing to balance the needs of downstream residents and communities with those of upstream residents and communities.

The lack of ground cover in places like Broken Hill is causing an increase in dust storms (as there is nothing holding on to the dirt to stop it from being picked up by the wind); and dust storms including lead content. Those dust storms are, generally, travelling east. These east travelling dust storms are impacting Newcastle, Sydney, Wollongong and the Blue Mountains. Allocating sufficient water downstream means that residents can ensure an uptick in the growth of ground cover, which will result in fewer dust storms and/or a reduction in the intensity of dust storms which happen.

The Darling River stopped flowing for the first time in living and dreaming memory this century.

The river had run low, previously, but never stopped.

It took this century's Water Ministers in Queensland and New South Wales to over-allocate water upstream.

New South Wales Health seems to have demonstrated a lack of interest in engaging in this space.

Mental health issues in Tilpa, Louth, Wilcannnia, Broken Hill, Menindee and Pooncarie which result from a lack of access to fresh water and/or recreational water and/or being forced to use the lower quality water supplies offered by bore water supplies (which are increasingly under pressure as the New South Wales Government dictates that communities the sizes of Dubbo and Tamworth are pushed on to Great Artesian Basin water supplies) remain unaddressed and uncompensated.

And the Darling River problems are a result of upstream water allocations; they are not to do with drought exclusively. Now, I'm not anti-irrigation or anti-upstream water use; I am, however, pro-balance. Balance in water use is not currently present and this is causing significant health impacts.

Housing

With a lack of reliable, suitable, well maintained, appropriately sized housing people lack safe and secure environs in which to sleep.

Reductions in health services has caused a lack of access to trades which merely perpetuates health problems.

The Government needs to engage in increasing public housing – not social housing, not divested housing, not asset recycling or cleansing … but public housing.

When choosing to supply housing to communities I find it fascinating that rather than bringing trades in to town, allowing local people to become labourers and/or apprentices; the New South Wales Government is opting for pre-fabrication of dwellings … in fact, the New South Wales Government is opting for pre-fabrication of dwellings in Corrections Facilities.

The message this sends to communities, where services have disappeared across the board, is that to get training and develop skills which might one day help get a job – you have to go to gaol.

Notwithstanding the appalling nature of this message; what does New South Wales Health think is the mental health outcome of such policies? Does New South Wales Health and/or the Health Minister offer commentary on these policies before they're adopted? Or do New South Wales Health and the Health Minister just stick their heads in the sand?

Recreation

Recreational activities have the ability to make up for some of the things New South Wales Health might not provide communities. Improving sport and recreational facilities across rural, regional and remote communities would be helpful to engaging young people and, of course, improving the health of populations.

This includes ensuring sufficient access to water to maintain grounds, swimming pools and other facilities.

I would like to see New South Wales Sport and Recreation undertaking some outreach programs in addition to running the facilities they maintain in a few different communities in New South Wales.

Population

It seems ridiculous to have to point this out but the significant shift in population since health services were defunded in the late 1980s increasing pressure has been placed on the basins of upsized populations. Newcastle, Wollongong and the Blue Mountains moved to Sydney; residents of large regional centres moved to Newcastle, Sydney, Wollongong and the Blue Mountains; residents of rural areas moved to large regional centres, Newcastle, Sydney, Wollongong and the Blue Mountains; residents of remote areas moved to rural areas, large regional centres, Newcastle, Sydney, Wollongong and the Blue Mountains.

As this shift started, smaller locations lost more and more services; meaning more and more people shifted to larger and larger centres; which caused further loss of services; and repeat.

We have been told that taking more migrants and refugees is difficult because the infrastructure of Sydney and Melbourne is insufficient to meet demand. The reality is that the points at which current infrastructure met demand in either Sydney or Melbourne are well and truly in the rear vision mirror.

In both cities Governments are barely designing infrastructure for demand ten years prior to the commencement of design; let alone anything that might be needed by the time the infrastructure is actually built.

Arguably, the last piece of infrastructure built in Australia that was built for the purpose of the future; and which was successfully adapted for changing needs; and which actually improved with age was the Sydney Harbour Bridge…

Various Governments have attempted to build longer lasting, comprehensive future serving infrastructure; but they've been unhelpfully scuppered by successive Governments.

So, 1923 was the last time that a serious, needed piece of long-run infrastructure was commissioned. 1932 was the last time that such a piece of infrastructure was delivered (in fact, it looks like it was 88 years and 361 days ago that the Sydney Harbour Bridge was completed).

Rather than pushing people into more centralised populations where infrastructure is already at breaking point; to the extent that it is now impacting our ability to meet our national and international obligations; perhaps we should revert to provision of health services closer to the populations that need them, rather than forcing those populations to travel to those health services.

… maybe that would make sense?

<u>Increasing privatisation of Government services</u>

It's like the Liberal Party don't realise that if people don't have work there will, ultimately, be social unrest. And that, in order to have workforces which are fit and sufficiently educated and trained to be able to offer products for which premium prices can be demanded that we need a strong Medicare (or, preferably, a single-employer universal health system) and a strong education system.

It is with some frustration that I see the increasing privatisation of the bits of Government which offer a return to the Government (the Lotteries, the Land Titles Office, public housing) so that Liberal Party donors can derive enormous financial benefit from broadly opaque transactions. Worse, that funds are then siphoned away from health and education services for the people who can least afford to make up the short-fall; which immediately relegates a significant portion of our labour market unhelpful for high-end value add, reducing the amount which can be charged for products produced.

In the health system, specifically, we see private hospitals and private health care facilities a gogo being built either by (and at the cost of) Government or with heavy Government subsidies. At a State level it's not like this is the only public policy area in which we see this conduct from Government, the new Serco prison in Grafton (replete with transferring prisoners further and further away from the familial support networks which will have to attempt to keep their former inmates on the straight and narrow) and the increasing prevalence of private schools because the State Government hasn't bothered funding public education sufficiently are also examples.

The single most ridiculous example of this ridiculous pursuit of pushing people out of being able to access health services that I can think of off the top of my head is an MRI machine. I realise that MRI machines and licences fall into the Federal policy space, sort of; but because it's health care and that's a State matter I can't imagine the Feds making a decision of this nature without consultation with the State Government.

Who was the bright spark who looked at Broken Hill and the broader area that Broken Hill services and decided that an area with an average income which is less than a quarter of the average incomes of Federal Electorates (and their commensurate State or Territory) of Wentworth, Canberra, Fenner, Higgins and Kooyong was the place to put a private MRI machine with a private MRI licence? I admit to having last looked at or for that demographic information over two years ago; but during that time economic conditions in Far West New South Wales haven't changed such that an increase in average income; if anything, the reverse is more likely. In an area where fresh food, at a minimum, costs an enormous amount of money; and where, in spite of living on a major river, water is only available because of bores and/or is trucked in – both functions which cause an extraordinary increase to the cost of water. And in an area where because of the combination of other costs, private health insurance is less likely to be held than in most other parts of Australia.

What support and/or advice did the Ministry for Health, or any other part of the New South Wales bureaucracy, or the Minister for Health, or any other Member of the Cabinet or the Legislative Assembly or Legislative Council, provide to the Federal Government and/or the Federal bureaucracy about Broken Hill needing an MRI machine and the level of suitability of a private licence and a private machine versus a public machine with a public licence?

The people who desperately need closer and ready access to an MRI machine? Well, if they've got private health insurance they *may* not face a gap fee. If they don't have private health insurance? Those people are still saddled with travelling to Mildura or Adelaide.

Idiots. Ridiculous.

Kidney Disease

We know that significant populations in rural, regional and remote areas experience kidney disease.

We know that, in particular, a significant portion of First Nations People suffer from kidney disease.

We also know that it is not just First Nations People who suffer from kidney disease in rural, regional and remote New South Wales.

To me it would make sense to ensure that communities which have demonstrated kidney disease prevalence and/or exhibit characteristics which correlate with kidney disease prevalence would be provided with the equipment required to treat kidney disease – like dialysis machines. It would then make sense to me to ensure that sufficient nursing or other allied health staff are educated and accredited to treat patients with the relevant machines and that those staff are distributed appropriately to meet the needs of communities suffering kidney disease. And that in being equipped and responsive New South Wales Health would be supporting a holistic person, family and community approach to the provision of treatment for potentially deadly chronic conditions.

Instead.

New South Wales Health often does not provide or have access to equipment to provide ready access to dialysis services throughout New South Wales. And, when they do occasionally happen to hit on providing the equipment and sometimes even sufficient staffing to manage treatment in community; they often don't maintain both equipment and staffing for sufficient time to actually treat the community for sufficient periods.

Condobolin, for example, has sufficiently significant populations of both white people and Aboriginal people with kidney disease to warrant both a machine and staffing. Yet a couple of years after being granted both a machine and staffing, they lost the treating nurse and that position wasn't replaced. Local residents suffering from kidney disease then had two options: 1. Travel to Orange, Dubbo or Wagga Wagga multiple times a week to receive treatment; 2. Move to a location which provides treatment.

In the case that you have to move to a larger centre for health care you leave behind your support network, particularly problematic if you have children who are impacted; you potentially leave behind the job that you had managed to hold down in spite of your kidney disease; you often leave behind family; and you often leave behind home ownership and the notion thereof.

In other words, there are real world impacts because New South Wales Health either can't be bothered providing access to health facilities or is incompetent in attracting, developing and managing staffing populations.

While kidney disease is not the only area in which such stark and potentially quite damaging choices are being made, it is one in which such decisions are made at critical and chronic times in a person's life. And there are real world impacts which politicians and bureaucrats are not interested in considering.

I don’t want you to think that Condobolin is the only place in which dialysis treatment is considered to be lacking by the community.

Residents of Gunnedah and surrounds have complained about their access to dialysis and the impact on their communities. And residents of some remote communities have also complained to me about their access to treatments for kidney and other chronic diseases – but don’t necessarily want their stories shared.

The Rona and respiratory issues

The mass exodus of people from Sydney on Boxing Day to rural, regional and remote New South Wales was embarrassing and generating fear. That our Premier had failed to lock down a Corona Virus hot spot (ie. Greater Sydney) and failed to cause the potentially infected population to employ any type of barrier controls (ie. mandated mask wearing) was atrocious. We deserve better than that.

Even our base hospitals would struggle to provide services if a significant outbreak occurred in that hospital's immediate community; let alone if such an outbreak were to be in a more outposted area of that base hospital's footprint.

If the New South Wales Government doesn't actually want to spend necessary funds on rural, regional and remote health care and hospital services, the New South Wales Government must attempt to shield communities from contagion with other means. In the case of many diseases, vaccination and/or barrier protection is promoted to protect rural, regional and remote populations from outbreaks of serious diseases which could cause enormous and catastrophic impacts.

So, when new diseases and/or pandemics are identified and determined to be highly contagious or communicable the New South Wales Government must do more to prevent populations from metropolitan areas travelling to and infecting local populations.

In relation to the current pandemic, it would be helpful to ensure that, particularly, the whole of remote New South Wales populations are targeted for vaccination as early as possible reducing both the overall cost of providing vaccinations (particularly New South Wales Health Staff and vaccine travel time) and the chances that populations will be exposed to intrusion from unvaccinated populations prior to being protected because of reducing adherence to Covid safe protocols like keeping a safe distance and using barrier protection like masks.

While the Corona Virus has not impacted rural, regional and remote New South Wales extensively, there have been cases in the population which have caused concern in communities; and which are, like other cases of Corona Virus globally, potential sources of life long respiratory and neurological issues. Along with the impact of Corona Virus, increasing frequency and severity of drought caused by climate change and the mismanagement of water allocations leaving downstream communities with insufficient water to have ground cover for lead and iron rich soils; rural, regional and remote communities are likely to be seeing increasing long-run and chronic respiratory issues.

There seems to have been little effort to date to research and/or abate causes, effects and broader community and societal impacts beyond hand washing programs to teach children to wash their hands to ensure they don't end up with lead ingestion diseases.

The lack of ground cover outside of Newcastle, Sydney, Wollongong and the Blue Mountains is clearly impacting Newcastle, Sydney, Wollongong and the Blue Mountains with increasing frequency, duration and severity of dust storms from the West, in particular, plaguing air ports and

general populations. Another eye roll emoji could be used for the mainstream media which doesn't seem to think something is either a problem or worth reporting on until it impacts Sydney Harbour Bridge visibility – but I guess those are the breaks.

Notwithstanding the broader mental and physical health issues caused by the absence of water and/or bureaucratic or Government failure to apportion water reserves in a fair and equitable manner, we see immediate problems with increasing ear nose and throat problems in, particularly, rural and remote children. When it comes to the ear nose and throat difficulties, New South Wales Health does seem capable of handling issues through education and health programs. But when it comes to the increased risk of respiratory problems and other related problems New South Wales seems less capable and responsive to community needs. And, as I mentioned earlier, when it comes to phenomena which significantly impact Newcastle, Sydney, Wollongong and the Blue Mountains New South Wales Health seems to exert limited, if any, influence; or it is abrogating its responsibilities to the whole of the State population by refusing the emphasise the health impacts both in rural, regional and remote locations as well as the metropolitan, urban and suburban environments under its control.

Dental Services

We really need to stop assuming that the mouth has nothing to do with health and wellbeing; or that, to the extent that the mouth has something to do with health and wellbeing, the mouth is insufficient for coverage through the health system.

Back in the 1980s Gundagai Shire Council put together sufficient funds to acquire a well located property and equipment for a dentist; advertised to attract a dentist; and then provided support and assistance to that dentist to establish a practice in Gundagai. My understanding is that there was a repayment agreement made with the successful dentist. And that dentist and that practice has been located in Gundagai since they were attracted by Council almost 40 years ago. Dr Bob McDonald was my first dentist. And Dr McDonald has extensively contributed to the Gundagai community and surrounds for the decades since his arrival.

If Gundagai Shire Council understood the importance of the mouth to the overall health and wellbeing of a person, and they understood it in the 1980s, why does it seem impossible for the New South Wales and Australian Governments to understand the importance of the mouth to overall health and wellbeing of a person?

When living and working in Lightning Ridge, my sister was diagnosed as needing to have her four wisdom teeth extracted. The closest practice which would perform this procedure was in Dubbo. Thankfully my parents were capable of accompanying her to have this procedure performed. And thankfully my parents were able to afford to stay in Dubbo overnight as the treating dentist required my sister to present the day after the procedure as well. Not having lived in Dubbo my parents found it challenging to obtain the ice prescribed by the dentist in an appropriate volume to soothe my sister's pain (thank you Dubbo McDonalds), as well as food my sister could consume without regular cooking facilities in a motel room.

Public dentists seem to be few and far between with insufficient appointments available to meet demand. And the services offered to, particularly, rural and remote patients seem to be fewer and fewer with more and more travel creeping into paths to treatment. This is a concerning development in health care and must be a trend reversed.

Maternity

To the men on the Inquiry.

Can you imagine having just passed a kidney stone the size of a peppercorn? Then you receive stitches at the base of your scrotum (or, anywhere between the base of your scrotum and your anus). Soon after you are forced to have both nipples pierced.

And for the first of these procedures you are not given all of the drugs. Far from it. At most you are given a vague numbing agent to dull the pain. And then there are no drugs for the remainder of the procedures... Or perhaps some cream to soothe those nipples, but not much and probably not with any type of numbing agent... At best maybe anticeptic, but probably not even that.

Then a couple of hours later you are forced to sit down (not lie down, not stand up, but sit down) for anything up to ten hours straight. With a seat belt on. And, even though you didn't receive pain relief as much as a mild numbing agent, you are not allowed to drive. So, whilst you are sitting down for all of that time you have no control over the vehicle you are travelling in.

Imagine every single turn where that seat belt will run against your nipples and cause your body to shift to absorb the turn and that shift causing your stitches to rub against your pants and the seat on which you sit.

Then imagine the curvature of the road, the flood dips, the pot holes.

Then imagine that while you are doing this there is a baby sitting next to you. Brand new. So much so that it still has that new baby smell. And think about the limited communication skills that baby has. It can't tell you what it wants or needs. And it doesn't understand your attempts to find out what it wants or needs and/or to soothe it in spite of being unable to determine or to gift that thing to it.

In that type of situation what do babies do? Well, often they'll cry. And as time goes on with failure after failure to receive what it wants or needs, it becomes ever more desperate... And when babies become desperate, what do they do? Scream. A scream which can be sustained for what feels like an eon. A scream which has a frightening pitch. And, in spite of only having been pushed out mere hours ago, with an extraordinary lung capacity causing an intolerable volume.

...

And who knows how much longer you will be sitting there, unable to deal with this child. And who knows how long it will be until the child runs out of energy and falls asleep. And who knows how far you are from your support network (mother, partner, sisters, community health workers).

And, Gents, that's just the version where nothing goes seriously wrong. Where you don't need an emergency hysterectomy and your brand new baby doesn't need some kind of emergency painful intervention or, indeed, isn't identified as needing something similar.

I've consulted widely on that analogy. I've been told that it's a little bit student politics. I've also been told that no woman would choose to sit on a bus for ten hours within a couple of days of giving birth let alone a couple of hours.

And that's the point.

Men regularly dismiss the health issues of women purely because they are the health issues of women. Research into pharmaceuticals and other health treatments as well as diseases, symptoms and other elements of health is often done on white men at the exclusion of women and people of colour; because of some desperate desire to restrict women's bodies purely for procreational purposes and because, evidently, people of colour are inconvenient.

So, it's about time we start breaking some of those barriers and explaining what things are like to give people some idea as to the experiences of others.

That said, that analogy is still only a relatively limited version of what actually happens, because that's pretty well a best case scenario.

To lean on that analogy a little further, though, let's then think about giving birth on country; or, the desire of the very white Colleges and New South Wales Health to cause gaps at birth for Indigenous Australians rather than acting to attempt to close those gaps across the board … and the closest I can get to helping you understand is:

And then, imagine you are Irish Catholic in the 1970s and living in Northern Ireland but that you were forced to go to London to pass that kidney stone. That kidney stone then has an English Birth Certificate. And is sent home with you to Northern Ireland to live with you in your Irish Catholic community... And literally everyone knows that your kidney stone is English. All the kids at school know, all the mothers and fathers of those kids know. All of the church elders know that your kidney stone is English.

I have also consulted widely on that analogy with Aboriginal people, many of whom learned far more about the Northern Irish conflict than they did their own history. I've been told that while it is imperfect, it's one of the closest approximations that can be offered to being forced to move to another country (for example, from Gamileroi country to Wiradjuri country; or Boona country to Wiradjuri country) to give birth.

Infant mortality is often given as a justification for the atrocious lack of maternity options available to rural, regional and remote pregnant people. We need to minimise the infant mortality rate therefore we over classify risk in pregnancy and likely births. Therefore we force pregnant people to travel further and further to more and more centralised services. We force pregnant people to spend longer and longer away from the family unit and their personal and health care networks of support. We emphasise this need by reducing the number of weeks a person can be pregnant and

still allowed to use various forms of transport aeroplanes … or, slightly more relevantly for this matter, buses.

… we also then turn around and turf people almost immediately post-natal with an hours old baby to find their way home; often with no or limited support. In spite of the average length of stay for women who have birthed in private hospitals being five days; the public option seems to be a stay of two to three days. Insurance companies aren't really known for throwing money around … presumably five days must be in some way necessary or they wouldn't be allowing their customers five days recovery prior to leaving their health facility. **So, why are public birthing stays around half the duration, on average, of private birthing stays?**

If there are problems, the Government forces that brand new parent to dip into their own pocket to fund accommodation and other services to allow them to remain close to their newborn. Though, if the problem is with the mother, the accommodation may not be as much a problem but care for the newborn in such a situation might not be readily offered … because there often isn't a second parent or a grandmother or other obvious members of a support network present … because sometimes people are too busy or poor to be able to arrange their employment and/or transport availability to be able to travel several hundred kilometres with limited notice … and, more often, people are busy trying to hold the rest of the existing family together in the absence of the parent who is most likely ordinarily responsible for ensuring the safety and welfare of pre-existing children or the care of elderly relatives …

… sometimes people in rural, regional and remote New South Wales don't actually live in Newcastle, Sydney, Wollongong or the Blue Mountains and public transport networks are just not as effective or prevalent.

… sometimes people in rural, regional and remote New South Wales don't actually live in the place they are required to birth their child (Bourke, Lightning Ridge, Coonabarabran, Yass, Narrabri and Wilcannia residents have all complained to me; and I imagine that the situations in Brewarrina, Walgett, Coonamble, Warren, Hay and myriad other parts of New South Wales – for example).

… often, in spite of midwives and other medical professionals living in towns with refurbished and upgraded maternity care facilities in New South Wales Health facilities, women are still forced to travel to far off places to have their babies – because New South Wales Health won't provide a path to accreditation of medical and allied health professionals; nor to maintaining accreditation.

… in fact, often people in rural, regional and remote New South Wales have to travel extensive distances to engage in a necessary precondition for life. And, arguably,

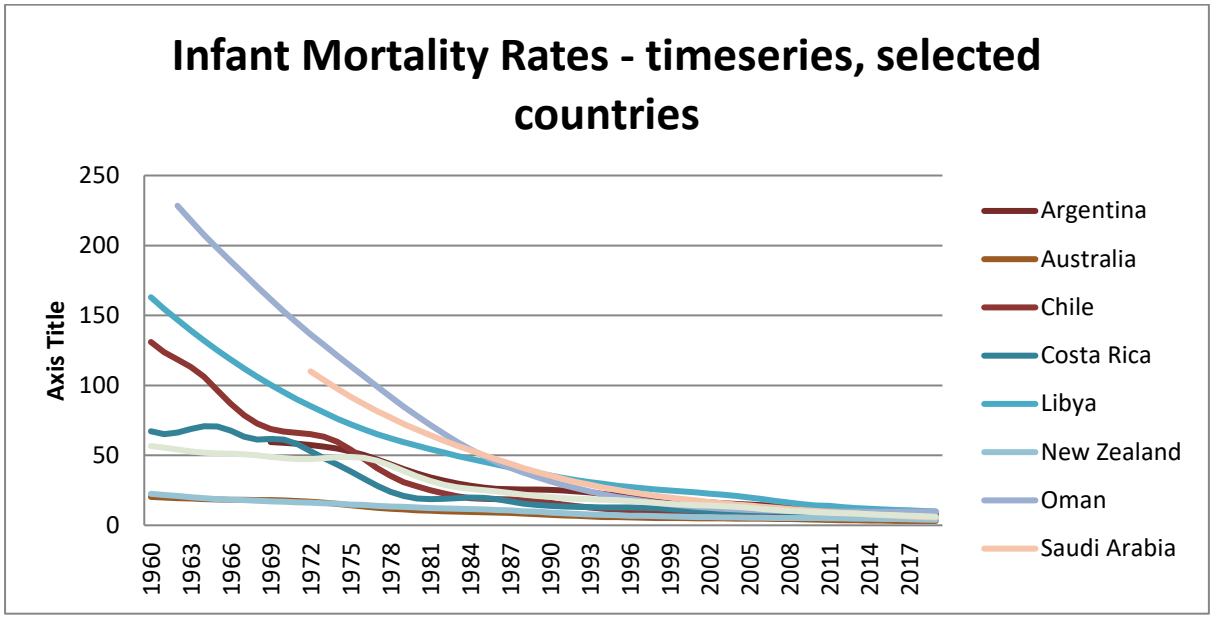
And yet in the Northern Territory it is possible to allow and assist people to give birth in isolated areas. In large swathes of the rest of the world it is also possible to allow and assist people to give birth in isolated areas. And to do these things successfully. And if it is possible to do these things successfully in isolated areas, surely it is also possible to give rural and remote women options for birthing in their own communities rather than forcing them to travel significant distances?

Lack of data, research and/or publicly available anecdotal information pertaining to infant mortality rates pre-white settlement. Though, given there was no evidence to suggest that individuals in First Nations communities were 99,750 years or older, we can assert that the infant mortality rate was not 100%.

Noting that we lack quality data about the practices of First Nations people, perhaps it would be a good idea to be encouraging more Aboriginal women into health services, particularly midwifery.

And I am wondering about international comparisons. I have cherry picked some data from the World Bank, via the World Health Organisation, a timeseries of infant mortality rates across several countries, most of them not white, not rich and not as urbanised as New South Wales.

That these countries seem to be able to facilitate infant mortality rates which are not hugely dissimilar from our own, whilst their populations are in many cases significantly less urban than our own and often in far more inhospitable conditions than those in which we reside; I am left wondering whether, perhaps, New South Wales Health and the Colleges have it wrong. Perhaps it is possible to give birth closer to home where the pregnant person can continue to maintain their role in the family and community, where the father can be an early greeter of the new addition to the family and where the child being born might actually have a chance of survival.



Source: World Bank, https://data.worldbank.org/indicator/SP.DYN.IMRT.IN?view=chart, last accessed: 15 January 2021.

As you can see, while many of these countries struggled with infant mortality prior to 1990, concerted efforts subsequently have brought infant mortality rates down to very close to the rates recorded by Australia and New Zealand.

Perhaps it would be useful for New South Wales Health and/or the Colleges to find out what they do to ensure that even in rural, regional and remote areas of their countries people are still able to give birth safely and with prospects of their children living through infancy.

I think Chile would be a particularly interesting comparison given that a significant portion of their population is isolated, by Australian standards. I also think that post-Gaddafi-Libya would be an interesting study.

Blackbooking

As I understand it, blackbooking is a process where early identification of targets for removal occurs during the course of or as a result of patient conferences for pregnant people … Aboriginal targets.

I have heard credible anecdotes suggesting that this process is occurring. It is particularly prevalent in places where local hospitals have been disaccredited, forcing women to travel long distances to birth; where women are vulnerable without their support networks and families; and where women become increasingly vulnerable throughout their stay at their required birthing centre.

This is not a little bit racist. This is overtly racist.

It doesn't matter whether New South Wales Health or the Colleges or the other institutions directly engage in, sanction or are merely on the periphery of this conduct; but that it occurs most overtly in communities which are disenfranchised by New South Wales Health and the other institutions. And whether or not the institutions engage in or sanction this conduct, that the conduct is possible merely reflects the endemic racism which exists in the institutions.

This conduct MUST be stopped immediately.

There must urgently be a review of the levels of racism that exist in the institutions; but this conduct must be outlawed prior to even engaging in such a review.

If the institutions fail to address this problem, this time. The Legislative Assembly and the Legislative Council must legislate penalty units for any person found to be engaging in this conduct.

Primary Health Care

The World Health Organisation tells us that the fundamental premise of primary health care is that: All people, everywhere, deserve the right care, right in their community.[2]

Further, the World Health Organisation tells us that "primary health care addresses the majority of a person's health needs throughout their life"[3].

I find it difficult to believe that this would mean something other than that the World Health Organisation is committed to encouraging all health systems globally to provide access to relevant health care for the things which are likely to be encountered by populations in their communities: cradle to grave.

I also find it difficult to believe that anyone would be able to mount a case which would suggest that New South Wales offers those services in communities from cradle to grave.

Rural and remote health services seem to no longer include maternity, chronic health condition treatments and/or even minor and straightforward fracture setting; all of which would seem to form the types of basic health service provision which should be expected in community. New South Wales Health seems, now, to prefer the sexier acute, immediate and urgent strains of medicine at the exclusion of the stuff that happens.

"Meeting people's health needs … addressing broader determinants of health … and empowering individuals, families and communities"[4] are the components of primary health care according to the World Health Organisation.

It is clear that New South Wales Health and successive New South Wales Health Ministers fail to take these responsibilities seriously, particularly when it comes to the provision of health and hospital services to rural, regional and remote New South Welsh communities.

[2] World Health Organisation, "Primary Health Care", World Health Organisation web site, https://www.who.int/health-topics/primary-health-care#tab=tab_1, last accessed: 15 January 2021.
[3] See above.
[4] See above.

Some Good Things

I don't want you to mistake me for someone who has nothing but negative things to say about our Health System. In spite of the decrepit and declining nature of our health system there are some good bits… or were.

A friend who was diagnosed with gallstones found that the waiting list for removing her gallbladder in Canberra was considerably longer than returning to her familial home in Cootamundra and having it extracted there. Though, that was ten years ago. And the only reason Cootamundra managed to retain that specialty was because the GP Specialist was accredited as a Visiting Medical Officer years ago.

That said, to be treated in Cootamundra meant that keyhole surgery was not an option for her; and, as such, her recovery time was considerably longer than it otherwise might have been.

Also in the negative, I presented at Queanbeyan Health Service at around 1am on Good Friday a few years ago. I was diagnosed with exploding ovarian cysts. I looked the condition up and discovered that until after menopause nothing could be done. However, two and a half years later after regularly experiencing excruciating pain which impacted my work and workplace I discovered that I had been misdiagnosed and that I actually had gallstone issues and required a gallbladder extraction. At that point I was lucky to have health insurance and was lucky enough to be slotted in to a cancelled operation timeslot meaning my extraction was within four months of my final diagnosis. If it weren't for that cancellation, the operation would have been delayed by three months. And if I had not have had private health insurance the operation would have been approximately two years later.

In Coonabarabran maternity care might be a nonsensical mess; but aged care and the interaction of New South Wales Health with aged care facilities is viewed very favourably with residents of care facilities and community residents expressing good things about those facilities.

First Nations People are open to discussions across the whole of New South Wales, to talk about their needs and the needs of their people. This might be viewed as a start point, but discussions even as a start is good news.

Another friend who lives on a property around 100km from Dubbo that has given birth to two children; one prior to the 2016 refurbishment and upgrade of the maternity unit; and, one during the immediate period after the refurbishment and upgrade of the facility. She tells me that her experience was excellent (in as much as birth can be described that way) and that the staff and facilities were outstanding.

This shouldn't detract from the concerns of other users of this facility who are shipped in from Lightning Ridge, Bourke and other places which are hundreds of kilometres from where they live and where their support networks exist (and, in the cases of many, their countries) who have to return quite quickly after birthing.

Outside of some very specific incidents, I'm not raising concern about individual staff members; I am raising concerns about the institutions and their actions against patients in rural, regional and remote New South Wales. Overwhelmingly, I hear compliments about health workers, particularly allied professionals and nurses… less so specialists and Visiting Medical Officers who are not locally based.

Suggestions

The Colleges and the AMA must be removed from the market determining admission to training and granting of specialties. The time has come for these unions to be busted and it is infuriating that this is one of four sets of unions the Liberal and National Parties are unwilling to bust.

The Colleges and the AMA must be removed from New South Wales Health decision making relating to the accreditation of Visiting Medical Officers.

New South Wales Health must actively support and facilitate General Practitioners developing and maintaining specialty practices to sit along side their General Practice including providing assistance with maintaining accreditation.

The New South Wales Government must pass legislation for the benefit of New South Welsh people whether or not such legislation has an impact on the income of members of the Colleges and the AMA.

At least one full set of birthing options must be made available in each Aboriginal Nation in order to minimise the chances that New South Wales Health and the Colleges are actually increasing the gap. And the Colleges MUST support these facilities and staff developing and maintaining accreditation.

Elder groups within the First Nations must be consulted, by New South Wales Health and the Colleges, about processes to identify community members who might be targeted to become health professionals (including midwives) (and beyond Aboriginal Health Officers) and to provide a multidisciplinary approach to supporting identified community members to move into health service provision and, hopefully, to causing New South Wales Health facilities with local options of treating physicians, nurses, midwives, social workers and other allied health professionals. Such a multidisciplinary approach would include working with local schools and health services, the Department of Education and the Ministry of Health to assist the Elders and community members to see the path from school or from post-school to becoming health professionals. Perhaps such support could involve scholarships to obtain certifications, early career exposure during high school and providing Elders with support to talk about how these careers are within the reach of their communities and listening to Elders talk about what cultural support might be required to help community members to achieve such professional options.

Capacity to offer dialysis services (that is, provision of a dialysis machine) must be made available in each Local Government Area. New South Wales Health must then work with communities to

determine when trained health professionals must be provided to provide dialysis services to communities. And where dialysis is needed by community members who have developed kidney disease, New South Wales Health must ensure that at least one trained nurse is supplied permanently to that community within one month of a single diagnosis; and, until that nurse is supplied permanently, New South Wales Health must cause a nurse to travel to the community to ensure that dialysis can be supplied locally and when that permanent nurse is taking recreation or other types of leave, it is the responsibility of New South Wales Health to ensure that no interruption of treatment is incurred.

In the case of the unincorporated area or of demand for dialysis which is greater than a single machine, New South Wales Health must develop a solution for those communities whether they be kidney buses or the acquisition of additional machines and/or staffing to meet community need.

At least one domestic violence shelter must be established in every rural, regional and remote Local Government Area. This might involve all or more than one level of Government; but the prevention and/or cessation of domestic violence absolutely must be at the top of every Governments' agendum.

Though domestic violence shelters, dedicated women's spaces where a range of activities can be performed in information settings must be allocated. Such spaces could be used for a range of workshops and other activities and will ultimately provide a safe space for women to talk about their experiences giving any local health service employees who are female and attending such activities an opportunity to talk about or answer questions about health issues in informal and non-confronting settings.

The institutions must open themselves to creative thinking to solve problems. For example, using rotation processes to obtain and maintain specialty accreditation and therefore Visiting Medical Officer access rights to New South Wales Health for, particularly, remote and rural General Practitioners.

All emergency department doctors must be trained in the setting of minor fractures. All emergency departments must be equipped to set minor fractures. If this requires doctors obtaining some sort of orthopaedic specialty, New South Wales Health must firstly pay for this specialty to be acquired by the relevant doctors; and must work with Colleges to ensure that this capacity can be met. And the Colleges must support such training and services being offered to communities… New South Wales Health should be embarrassed to admit that patients presenting in Lithgow have to be transferred to Nepean to have bones set. I am embarrassed for New South Wales Health. That's

humiliating … and one has to wonder whether it's the quality of doctors hired by New South Wales Health or the quality of New South Wales Health which is at fault in this space.

New South Wales Health must regularly engage with local communities and Local Health Districts (and must listen to communities) to determine what actual community health needs are present.

New South Wales Health must actively work to provide communities with the health services identified through consultation processes.

New South Wales Health must employ at least three social workers in every Local Government Area; whose role is to engage community. This might involve working with schools or other organisations in town to promote safe health and safe work practices. It will involve attending cultural activities like going to the pub on a Friday night to get to know communities and to increase the information New South Wales Health has about what is actually going on in communities.

Given that New South Wales Health has shown insufficient interest in communities and multidisciplinary health sufficient that the above suggestion is a pipe dream, the Department of Education and Training must hire at least one social worker in each public school (whether primary, secondary or central) in the State. The role of that social worker will be to engage with and within communities and to observe and provide support to communities; including the school community (teachers, children, parents, potential future employers).

It is my hope that by providing a social worker to live and work in communities throughout New South Wales that social workers will be able to manage and/or assist to direct those in need to services relevant to their circumstances when people are having difficulty. And that a social worker presence might be able to organise early intervention to people who need help and, ultimately, might save lives – particularly those of young rural men who are committing suicide at an extraordinary rate.

Failing the above, immediately when drought is declared for any and every Local Government Area in New South Wales, New South Wales Health will: embed a minimum of three social workers in each affected Local Government Area; ensure that social workers are engaging with social and professional activities in communities; provide the beginnings of relationships which might result in a reduction in the rural youth suicide rate.

The New South Wales Department of Education MUST provide School Counsellors and sufficient hours in school for those Counsellors to support schools and school communities. In the case that

the Department is unable to attract appropriately qualified people, the Department must embark on a development program to train existing staff in the qualifications required to become School Counsellors. Current hours attached to schools are insufficient for School Counsellors to have either a positive impact or sufficient time to observe and engage with the broader communities in which schools sit.

Dental facilities must be available and routinely maintained and upgraded in rural and remote health facilities where no commercial dental practice is available for local members of the community to visit. These facilities must also be staffed for a period determined by the dental health unit but left vacant for no more than three months prior to the next attendance by a dentist and qualified dental assistant.

The School Dentist program must be revived; and, if it does still exist, it must be extended to remote schools in addition to other schools.

The New South Wales Government must, immediately, undertake a review of New South Wales Health with a view to identifying racist conduct, procedures and processes and access to services: and counselling or sacking racists working for or affiliated with New South Wales Health; abolishing procedures and processes which exhibit racism; and, improving service availability and accessibility for people of colour throughout New South Wales.

New South Wales Health should trial providing culturally appropriate care in two or three rural, regional or remote Local Health Districts. Culturally appropriate care would include having facilities of sufficient size to ensure that immediate and extended family members can visit patients to improve continued access to community and culture during any period of hospitalisation or other institutionalisation. Such care options might be taken advantage of by First Nations People, communities of Mediterranean background, devoutly Catholic families and people of other cultures for whom entry into hospital and other Government institutions has meant that that family member is never seen again; or for whom health care is a holistic and communal family and societal thing. Places like Moree, Woodburn and Griffith or Leeton might be appropriate for such trials where communities are culturally diverse and land is cheaper than in metropolitan New South Wales. Such facilities should be purely public but built by local builders employing local and culturally diverse labour, including apprentices. These facilities should not be built before the end of an extensive consultation and research period where the needs of communities are thoroughly considered as well as the requirements of medical and allied health professionals. And the consultation process should consider all issues raised and all ideas offered; including bigger rooms to give extended families space to support patients in culturally sensitive ways.

New South Wales Health and the New South Wales Government, in conjunction with the universities and the Colleges and/or the Federal Government, should engage in programs of research:

- Developing a rural and remote health specialty for doctors, nurses and other allied health professionals
- Respiratory diseases
- Women's health
    - Reproductive health
    - Endocrinological health (like Poly Cystic Ovarian Syndrome)
    - Chronic diseases
    - Treatments of chronic diseases
    - Best education methods
- First Nations People health
    - Reproductive health
    - Chronic diseases
    - Endocrinological health
    - Best education methods

Given that the Federal Government is refusing to acknowledge the cost of General Practice and other Health Services, surely it is the role of the New South Wales Government to either pick up the slack and help General Practitioners to bulk bill patients; or to lobby the Federal Government to ensure that General Practitioners are funded sufficiently to provide primary health care services.

I call on the Federal Government and Federal Parties to move to a single-employer actual Universal Healthcare System.

I would also like to see a Roland Wilson Scholarship recipient (or any PhD student) study the cost of our current health system and the likely changes to that cost based on shifting to a wholly public model of health care provision.

Ambulance officers on arterial highways must be trained in at least basic elements of paramedicine. Serious accidents occur on these highways; and while the RFDS will often arrive quickly, sometimes the urgency of medical treatment needs means that a First Aid Certificate isn't actually sufficient.

Conclusion

A couple of years ago I was sitting at the kitchen table of family friends. I have known and respected this family for almost all of my life. We were talking about kidney disease in Condobolin and how disappointed, but not surprised, I was to learn that in spite of an oddly high population of kidney disease sufferers that residents had to travel to Dubbo, Orange or Wagga several times a week to receive treatment; or to move one of those locations. Why? Because, while Condobolin had been granted a dialysis machine and staff trained to use it, they had subsequently lost the nurse.

The patriarch of the family looked at me and said, "we make the choice to live here" as if to suggest that choosing to live in a rural area means that you choose to give up rights to health care.

I looked at him and said:

You may choose to live here, but that's not the actual choice you are making. The choice you are actually making is to grow or otherwise produce our food and fibre or to extract or exploit our resources or, indeed, to support the growth and production of our food and fibre or the extraction and exploitation of our resources. Food, fibre and resources which are then sent elsewhere to generate enormous amounts of wealth for people that live in Sydney, Melbourne, Canberra and overseas destinations. And the contribution you make to that wealth is far more labour intensive, physical and potentially physically damaging than anything the people who benefit from the wealth you generate for them are likely to do – either for that wealth or more generally.

You may choose to live here, you don't choose substandard health care… and nor should you have to.

What I didn't say, but could have, is that because of, particularly, conservative governments systematically shutting down our manufacturing sector and other secondary industries; Australia's wealth overwhelmingly depends on primary and tertiary production. And even though commodities markets are notoriously variable and Australia's climate is notoriously harsh; the Mineral's Council of Australia will point to the significant contribution to the national wealth made by mining, historically Australia has relied on the sheep's back and Moree Plains Shire Council, for example, is consistently in the top three production and export Local Government Areas in Australia – off the back of primary production.

Newcastle, Sydney, Wollongong and the Blue Mountains derive significant benefits from the sacrifices made by all New South Welsh rural, regional and remote residents. But in an advanced country with, what it likes to think of as, one of the best health systems in the world; we should not have to ask for even basic services to be available within a reasonable distance.

… then again, you can't even get a the bone from a minor, textbook and straightforward fracture set in Lithgow. No no, you've got to go to Nepean.

… shame on all of you.

I recognise that trade offs have to be made when distributing taxation dollars. I recognise that there are trade offs which have to be made to provide the greatest benefit to the greatest number. I recognise that choosing between the suite of options available to Government is a complex process.

But that should not mean that New South Welsh people should be subjected to substandard access to health care simply because of their postcodes. It should not mean that New South Welsh people ignore symptoms or delay seeking diagnoses because they are subjected to substandard access to health care simply because of their postcodes.

At this moment, it seems that the acute and immediate is usurping the importance of the holistic and chronic. It seems that New South Wales Health either doesn't realise or it doesn't care about the impact that it has on not only the patient but also the lives of people around the patient, the people that rely on that patient, the families of those patients, the workplaces and volunteering of those patients.

As the growers, producers, extractors and exploiters and the people who support growth, production, extraction and exploitation of our wealth for the benefit of all; we should not be left with systems, in this case health, which fail to support us to generate that wealth.

And I hope that when you are voting on State Budgets or, should you move to the Federal area, Federal Budgets that you reflect on this and other submissions; and you think about the real costs of the decisions that you make.