REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

CORRECTED

At Macquarie Room, Parliament House, Sydney on Friday, 19 March 2021

The Committee met at 9:05 am

PRESENT

The Hon. Greg Donnelly (Chair)

The Hon. Lou Amato
Ms Cate Faehrmann
The Hon. Wes Fang
The Hon. Emma Hurst (Deputy Chair)
The Hon. Natasha Maclaren-Jones
The Hon. Walt Secord

The CHAIR: Welcome to the first hearing of the Portfolio Committee No. 2 inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. The inquiry is examining health outcomes, access to services, patient experience, planning and capital expenditure in rural, regional and remote New South Wales. Before I commence, I acknowledge the Gadigal people who are the traditional custodians of this land and I also pay my respects to Elders past, present and emerging of the Eora nation and extend that respect to other First Nations people present.

Today we will be hearing from a number of stakeholders including NSW Health, peak health and medical organisations and unions. While we have some witnesses with us in person, some will be appearing via videoconference. I thank everybody for making the time to give evidence to this important inquiry. Before we commence, I will make some brief comments about the procedures for today's hearing. Today's hearing is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcasting guidelines, media representatives are reminded that they must take responsibility for what they publish about the Committee's proceedings.

While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the hearing, whether they are here in person or remotely. I therefore urge witnesses to be careful about comments they may make to the media or to others after they complete their evidence today. Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard it is important that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily. All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. If witnesses are unable to answer a question and want more time to respond, they can take a question on notice. Written answers to questions taken on notice are to be provided to the secretariat within 21 days. If witnesses wish to hand up documents, they should do so through the Committee secretariat.

In regard to the audibility of today's hearing, I remind Committee members and witnesses to speak into the microphone; you may need to pull them forward. As we have a number of witnesses in person and via videoconference, it will be helpful for members to identify who they are directing their question to and for witnesses to say who they are when they are responding. It will be helpful for Hansard to have a clear exchange of names. For those with hearing difficulties who are present in the room today, please note that the room is fitted with induction loops compatible with hearing aid systems that have telecoil receivers. Finally, please turn your mobile phones to silent for the duration of the hearing.

LUKE SARTOR, Policy and Research Officer, National Rural Health Alliance, before the Committee via videoconference, sworn and examined

COLETTE COLMAN, Director, Policy and Strategy Development, National Rural Health Alliance, before the Committee via videoconference, affirmed and examined

SHEHNARZ SALINDERA, Councillor, Australian Medical Association, affirmed and examined

The CHAIR: I welcome our first witnesses. Dr Salindera, would you like to make an opening statement?

Dr SALINDERA: Certainly. The Australian Medical Association [AMA] (NSW) thanks you for the opportunity to provide a submission and to appear before the parliamentary inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. The AMA (NSW) supports the aims of this inquiry to examine health outcomes, patient experiences, wait times and quality of care for people who live in rural, regional and remote New South Wales.

We acknowledge the range of issues that will be addressed over the coming months and we place importance on each aspect of the service issues that have been identified and will be examined and placed under scrutiny. We are aware of the shortcomings of health services, particularly in some of the more rural and remote communities, as well as the inadequate or absent service delivery that has resulted in some very poor outcomes and very sad circumstances for some individuals and their families. Our place in this inquiry, we believe, is to focus on what improvements can be made to prevent these scenarios from occurring and, as the peak representative organisation for medical professionals in New South Wales, what can be done to ensure that regional, rural, and remote communities of New South Wales have access to adequate and reliable medical services.

We have prepared our written submissions with the input of our members who have experience working in these communities. The input has covered experiences from doctors in training to senior practitioners. We have relied upon anecdotal evidence and their feedback as well as observations as we are of the view that this is invaluable when it comes to improving health services in our regions. We believe this is the most reliable and contemporaneous evidence of the status of the provision of medical services available. By collating that feedback together with work we undertake on a day-to-day basis, we formed the view that there are initiatives that could be developed to improve services. We acknowledge that those improvements may require collaboration with many organisations and will also require coordination with Federal organisations—private and government—as healthcare in New South Wales is delivered as a collaborative service that relies upon various funding, training and education facility models.

In our submission we set out a summary of recommendations. These cover recommendations going primarily to recruiting and retaining a well-trained, well-resourced and supported medical workforce. I summarise these recommendations as follows. For doctors in training: firstly, the provision of allowances of incentives for doctors in training to rotate to regional hospitals; secondly, provision of allowances and incentives to allow those doctors in training who are based in regional areas to return to the city to undertake necessary rotations; next, require colleges to support regional training or explain why regional training is not appropriate; and, further, to review the accreditation of rural and regional hospitals to allow for further college training programs across more specialties.

Next, visiting medical officers [VMOs]: Firstly, we need greater flexibility in relation to on-call commitments. Next, access to professional support payments to VMOs in regional areas in accordance with the terms of the determination and to give effect to the policy behind the payment, namely, to attract and retain VMOs in regional communities. Next, greater flexibility with the recruitment process so that local health districts [LHDs] can commit to doctors who are interested in working in regional and rural centres in a timely fashion. Next, to ensure doctors are offered appropriate contracts, which will also encourage the doctor to establish and maintain a private service to support the community.

Next, career medical officers [CMOs]: An increase in CMO roles to attract those medical practitioners who are seeking to establish themselves and their families in regional and rural areas but not seeking to practise as a specialist. Remuneration: An increase for locum rates; a review of the VMO fee-for-service rates and allowances to access additional payments, such as claiming sessional rates in circumstances where the Commonwealth Medical Benefits Schedule [CMBS] prevents payment for a service. Finally, with the Commonwealth Government, review the CMBS for general practice item numbers for rural and regional GPs.

Relocation grants: An extension of relocation grants to specialists for those specialities in shortage, including, but not limited to, psychiatry, cardiology, neurology and oncology. Finally, for oncology:

Decentralisation of radiotherapy and chemotherapy services to reduce travel time for cancer patients, particularly in the Western NSW and North Coast NSW local health districts. Thank you.

The CHAIR: Thank you very much, Dr Salindera; that was a very comprehensive overview with particular reference to the summary of key points. I invite either Ms Colman or Mr Sartor to make an opening statement.

Ms COLMAN: Thank you very much. The National Rural Health Alliance thanks the Committee for the invitation to attend this Committee hearing and welcomes the opportunity to speak to you today. The alliance is the peak national body for rural and remote health in Australia. The alliance comprises 44 member organisations and is committed to improving the health and wellbeing of the seven million people living in rural, regional and remote Australia. Our vision is for healthy and sustainable rural, regional and remote communities. The alliance's membership is diverse and geographically dispersed. This reflects the complex nature of rural health. Our members include consumer groups such as the Country Women's Association of Australia and the Isolated Children's Parents' Association of Australia; the Indigenous health sector, such as the National Aboriginal Community Controlled Health Organisation and the Australian Indigenous Doctors' Association; professional organisations representing medical practitioners, nurses, midwives, allied health professionals, dentists, pharmacists, optometrists and others; and service providers such as the Royal Flying Doctor Service and Royal Far West.

The alliance is a national organisation and as such is best placed to discuss overarching evidence and strategies. Other witnesses will be better placed to provide detailed commentary on circumstances for programs specific to New South Wales. The evidence in our submission shows that there are significant disparities in current and expected health outcomes and access for patients in rural, regional and remote New South Wales. People in rural New South Wales have shorter lives, higher levels of disease and injury and poorer access and use of health services compared with people in the metropolitan part of the State's east coast. The burden of disease from cancers and diseases of the cardiovascular, respiratory and endocrine systems generally increase with remoteness, as does the risk of suicide.

Coinciding with the disease burden across New South Wales, the risk factors of disease and injury generally also increase with remoteness. That is because of special determinants of health, particularly income, education and employment pathways. They also include smoking, alcohol and illicit drug use, domestic violence and occupational and physical risks, such as agricultural accidents and road injuries. Waiting times for medical treatment and care are generally longer and Medicare services become less readily available as remoteness increases. The health workforce is less able to meet demand for services in rural New South Wales both inside and outside the public hospital system.

These issues are persistent in that they are not improving over time generally. The alliance believes this situation is unacceptable and we believe it is important for all levels of government to work together to address this inequity. Fundamental to these issues is the systemic problem. The New South Wales and Commonwealth governments need to collaborate more in the design, funding and management of services across the whole health system. The separation of powers and funding responsibility for hospital services, primary healthcare services and public health activities leads to gaps, duplication and fragmentation in service delivery. Joint planning and funding for health services would help in providing coordinated patient-centred care from a wide breadth of health professionals to address patients' health needs over time. Primary health networks and local hospital districts are an excellent point of reference for this collaboration. There are several trials working to overcome these issues. We would be happy to discuss with the Committee any issues raised in the alliance's submission. Thank you.

The CHAIR: Thank you very much, Ms Colman, for that very clear and specific opening statement, which I am sure will stimulate a number of questions. We will commence with the opening of questions. I would like to keep it free flowing, as I indicated. We typically start with Opposition, crossbench and Government and we will start in that sequence, but we will move that around over the course of the day so it is shared around. Once again, I invite honourable members to indicate specifically who you are addressing a question to so that the questionee is aware that the question is being directed to them. We will commence with the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you for participating today. Dr Salindera, you mentioned in your opening statement that you concentrate on VMOs, visiting medical officers. You said there were concerns about on-call commitments. What were you referring to when you referred to that?

Dr SALINDERA: With the on-call arrangements in a rural area there is less of us, so we need to do more on-call. As our regional areas get busier, and even in our rural hospitals, you have less people to cover the load, so you are doing a more frequent on-call and then you are still required to deliver a service daily; so you are less likely to be in a position where you can have the next day off after being up all night. I personally do double the on-call that some of my friends in the city do and I do not have the backup or support to change that, we just

have to get by with what we have got. So that is what we mean. When we look at on-call arrangements we have to look at how frequent they are, what are the safe working hours and look at the ways that we can create more flexible on-call arrangements.

The Hon. WALT SECORD: For those who do not have experience with medicine, when you are on-call in a rural area or a regional area or a remote area what does that actually mean?

Dr SALINDERA: It can mean different things in different hospitals and it depends who you are. If you are speaking about the VMO specifically, that would imply a consultant specialist usually or a non-GP specialist. It can mean in some instances that you are physically in the hospital until a certain hour and then you are called on from home after that. Other times it can mean that you are not required to necessarily be in the building but to be within 20 minutes, for example. And then it depends on your specialty. As a surgeon, for me that means that I need to be within 20 minutes and available for trauma surgery, for emergency work. So in reality, in a busy regional hospital, that means you spend most of that day in the hospital doing emergency cases and then you are available at night as well and you do need to come in because the backup you have got on the ground tends to be more junior; so your support on the ground is less and you need to be there to lead care.

The Hon. WALT SECORD: Just to give a bit of context, have you had situations where you have in fact been on-call and worked, say, 48 hours without sleep? Have things like that occurred?

Dr SALINDERA: To me personally?

The Hon. WALT SECORD: Yes.

Dr SALINDERA: Yes. That was my on-call last week. Absolutely. I do a 24/7—I do a week on-call and I have to be available, and if you are up in the night you are up in the night. That happens.

The Hon. WALT SECORD: This is not a personal best or a personal worst, but what is the longest stretch that you have had to undertake because of accidents, emergencies, being on call or a lack of staff support?

Dr SALINDERA: I am definitely not alone in this and we can look at the AMA surveys in safe hours and provide those documentations for you because we would have that data and also college surgeons will have that more broad data, but yes—

The CHAIR: To interrupt, that would be a valuable piece of information and if, on notice, we could make that request—

Dr SALINDERA: Yes. We could provide that.

The Hon. WALT SECORD: I would also like to know your personal experience.

Dr SALINDERA: Yes. If you want to talk about last week, I was on call in that week for four days straight. I provided care during the day. I had elective operating lists—clinics—in the mornings and emergency operating in the afternoon. I was required to attend the hospital. I was called at 11.00 p.m. and then 12.00 p.m. and then we prepared the operating theatre. I operated on an emergency surgery at 2.00 a.m. That surgery took me through until 5.00 a.m.

The Hon. WALT SECORD: What?

Dr SALINDERA: Yes. I went home. I had breakfast and I was back at 8.30 a.m.

The Hon. WALT SECORD: Not a reflection on you, but you would not be operating or performing at your absolute top.

Dr SALINDERA: I think that we prepare for this, we train for this and we are ready for this. Then I take my break when I can get it, but certainly you have to deliver care. That is what on-call surgery is and, as I said, as the senior consultant you have to be there. It is not an operation that can be done without you being there. So you need to be there. You need to be available to supervise and this is what we train for.

The Hon. WALT SECORD: You are from Coffs Harbour. You live in Coffs Harbour. The situation in Coffs Harbour which you describe would be even worse in far western New South Wales or in the north-west.

Dr SALINDERA: Our AMA data—again you could look to that to gain experience from that. As I said, it depends on your specialty and service. I have given you an example for general surgery, but there would also be orthopaedics on call, the emergency department and the work that they do, the on-call physicians and then our GP specialists who run our smaller hospitals and what they are required to attend and return and work for. Definitely when you have got less numbers, you cannot just assume that it is less busy there. It is not. It is busy, and when you have got less numbers to distribute that work, then that does make it difficult. Having more junior

staff that you are then responsible for means that you are carrying more of the load in terms of being the consultant surgeon than when, for example, I am on call where I have trained in Sydney.

The CHAIR: Can I just invite honourable members to bear in mind that we do have witnesses remotely. It is easily done when people are not in the room. To those remotely, we can see you there. The questions will flow in due course.

Ms CATE FAEHRMANN: Just with that line of questioning, is that similar in, for example, Sydney hospitals with doctors on call, or are we talking about on call particularly remotely or regionally because there actually are no other doctors. For example, the operation going from 2.00 a.m. to 5.00 a.m.—could this happen in Sydney hospitals as well where somebody goes and has breakfast and comes back at 7.00 a.m. or 8.00 a.m. or is this pretty unique to regional areas?

Dr SALINDERA: As I was mentioning, it depends on the team you have available and the problems we face in rural and regional areas is that you are often the only doctor. In a regional area, yes, I have some junior trainees who are available to work with me but their level of skill and experience is different compared to when I have been on call in the urban centres. Our urban centres have a bigger team. There are more people available and there is more capacity to ask other people to step in to help you or to finish the work so that you can go home or maybe look after your clinic the next day. In our case, we do not have anybody else to step in to take that up.

Ms CATE FAEHRMANN: Would it be the situation therefore that, in those hospitals that do have the staff there, they would say, "No, there is no way that you come back at eight o'clock. That is unsafe." They can bring other people in. Would there be any protocols, for example, around that in terms of safe work practices—that if somebody has worked straight for 12 hours and then has to come back, that there is something that can be referred to in terms of saying, "You have worked this number of hours. You must take a break now," and that you do not have the luxury of doing that?

Dr SALINDERA: The AMA does provide, again in that framework on safe work hours, ideal hours and then the adoption of that within the health service I think is perhaps—I will have to clarify and get back to you but—more individual, and certainly for junior doctors and nursing staff there are more clear regulations than there are for us at a VMO level.

Ms CATE FAEHRMANN: I have one more question, which I will throw to the National Rural Health Alliance. Thank you for your excellent submission. It is in relation to the integration that you have recommended of the Commonwealth and State health planning and funding, and you use the example of the HealthOne NSW model which is being funded with $146 million. I was wondering for the Committee if you could just expand upon what that looks like in practice in terms of the integration of State and Federal and how that HealthOne NSW model works?

Mr SARTOR: Thank you very much for the opportunity to speak, and I just acknowledge the somewhat harrowing story of the experiences like for our doctor and her hours. In regard to the HealthOne NSW initiative, that is an example of an initiative where, for the purposes of our submission, we raised it as an example of, in general terms and relative to the expenditure on hospital services in New South Wales, where, as a preventative activity and as a population health measure, it is a very minute proportion of total funding that goes towards hospitals. Where the hospital system is overloaded, there needs to be more of a focus on avoiding hospitalisation where possible and decreasing potentially preventable hospitalisations with greater investment in primary health care. On the ground that would look like more collaboration and more co-commissioning for services that are locally informed and community led. Those would be with the primary health networks of the Australian Government as well as the local hospital districts in New South Wales.

The Hon. WES FANG: I will direct my questioning to you first, Dr Salindera. I probably have a greater advantage than some of the other members here because for a long time I was married to a VMO in a rural area and she certainly experienced on-call situations like you as well. That has become the norm for me. When she looked to go regional, one of the considerations that she took was the fact that she had junior staff under her at a training hospital. You spoke about the same. How much does that take the load off for you and how much are you able to divert to the registrars, or fellows if you have one, within your team?

Dr SALINDERA: That is a great question and if you look into our submission, we actually explain that we have a problem in rural and regional health in that unfortunately we are often left understaffed because of the metropolitan hospitals prioritising their staffing over the staffing of our regional centres. In our submission we have outlined that this is a serious problem and I think if you look to the medical colleges, other colleges are now making recommendations to that effect as well—that we actually need to staff the regional areas first. Because when they are left short, there is no-one to fill the gap.

It is something that you look for but it can change—when you sign up maybe there was an accredited trainee, maybe the hospital does not maintain the trainee position, maybe the post goes unfilled. Certainly we have experienced that at my hospital. After all, these guys are there to train. We are still there to do the work, to supervise, to deliver consultant-led care. So, yes, it does help but certainly you are there to teach and train them, not for them to be the primary clinician. I think we can also work to improve the safe hours for those junior doctors. In regional hospitals, there are often less of them. We do not always have the luxury of having a separate night doctor, for example, versus the day doctors. Then they also do a 24-hour or 72-hour on-call. So even if you do have junior staff they are often working in quite a challenging environment as well. If we can look to our submission and how we could aim to develop policies around working to staff those regional centres as a priority, that would be a wonderful change—a welcome change.

The Hon. WES FANG: You have started to answer my second question, which is where I was leading with my original one. One way to alleviate the workload that the VMO doctors would face would be to have more VMOs. The other way that we might be able to look at that would be to have more training positions in rural and regional areas and have those positions filled. That would then flow on and possibly produce more trained specialists into the future. Do you see that as a comparable solution to some of the issues that you have faced, as opposed to just having more specialists in rural and regional areas?

Dr SALINDERA: Your insight is excellent. If you look at our submission, it is about the whole rural training pipeline. If we want to have more rural doctors, we need to encourage them to do more of their training in a rural area. If you look at data from where we start off, we have to select for rural, train for rural, recruit for rural and then retain for rural. If you look at the beginning we are doing a good job now. The medical schools are getting rural origin students in. In addition to that, we have got students of non-rural origin who say they want to work rural. Those numbers—again you will have to look into the detail of it but I believe it is around 25 to 30 per cent. But something happens along the training pipeline where they then spend most of their training time in a metropolitan area. If that whole 30 per cent actually turned out to work rural it would be great; we would be at parity. But that is not what happens because their training is mostly metropolitan based and the experience they see is of sub-specialist medicine rather than generalist medicine.

If you look at the document here—and I am sure other college submissions will also say this—we need to train for generalism and generalist experience by increasing the training positions, not only in the junior years but in the advanced years. For example, advanced training in the specialties as well as fellowships in rural areas, using such things such as the Specialist Training Program [STP] that is listed here in the submission— they are the ways that we can then continue to keep people in rural areas, and even have rural-based training as the majority and then travel to metro as needed. Again, that needs to be funded and supported, and that was mentioned in our doctors and training section. This is how we see to grow the future, absolutely.

The Hon. WES FANG: Where do you see the backlog occurring? Is it an issue with the colleges, or is it an issue with the base training hospitals, or the tertiary centres in Sydney filling their rosters first? Where is the backlog?

Dr SALINDERA: It is a complex problem because the training and college programs in collaboration with how our selection and allocation works on a State-based level and how the State hospitals fund and allow these positions—so it requires quite a bit of collaboration between all of those to get the position identified in the local hospital. That needs the local health district to know that we need a position here. That then needs to follow on with the funding from the State or any national programs where that can be accessed, and accreditation by the college to create those posts. So it is a complex issue. There are problems with, as you said, the metro hospitals potentially prioritising their rostering, but then it so much more than that too.

You need to have a well-supported, positive work environment for these junior doctors to come to—or even senior trainees—so we need to have the allowances that allow them to go. We need the relocation allowance, for example—we need to support their partners and families. What we have seen in COVID is this amazing ability to work from home suddenly, and I maintain great hope that this will help us recruit more people to rural areas because often partners cannot leave the city, or kids need to be in school in the city. So the problems are complex but they are not insurmountable. If we take a closer look at how we offer packages that address these issues, we should be able to recruit those positions, certainly.

The CHAIR: We are going to deal with the timing issue after this tranche of witnesses because there are so many questions and, may I say, we will be requesting to send some supplementary questions to you. You have so much relevant information that we want to try and extract, but it is very hard to do so in the time available. We will do our very best but there will be questions forwarded to you.

The Hon. WALT SECORD: What is your response to telehealth? Many people have said that the way to overcome the lack of doctors, nurses, medical support and specialists is telehealth. What is your response to the push for that? I will go to the National Rural Health Alliance first.

Ms COLMAN: Telehealth is a valuable addition to the suite of services in overcoming some of the access difficulties, but we would certainly see it as a supplement, not a substitute. I think it is a very important point to make—and the increase in access to telehealth that has been made available and recently extended again up till the end of June as a result of the pandemic has certainly been a great leap forward. It is important to note, though, that it does lend itself to some particular practices over others. For psychologists, for speech pathology, for some occupational therapy, telehealth can be excellent and it has certainly been a great way, particularly during the pandemic, for people in more remote areas and areas where there is a significant mal-distribution of health workforce to be able to access mental health services in particular. But we would be very concerned if it was seen as an opportunity to replace those on-the-ground services that are critical for rural health services.

Mr SARTOR: It is also imperative that telehealth services be delivered by the health professional who has an ability to have an established relationship with the patient in the first place. I think that it is valuable that there be some level of continuity of care, meaning that the patient has visited their doctor or their health professional before to support the ongoing telehealth services so that it is not, as my colleague Ms Colman has said, a replacement for services. Rather, it is a supplement or an additional means of being able to access services from their healthcare professional.

Dr SALINDERA: I believe the AMA has a position statement on this. If it is okay I will take on notice that we provide the policy statement, but I do concur with the comments already made by my colleagues.

Ms CATE FAEHRMANN: In relation to the National Rural Health Alliance's submission, you refer to the Government's *NSW Rural Health Plan: Towards 2021*. Of course, we are in 2021 now and I am just having a look at the plan that was released in 2014. One of the goals was halving the gap between Aboriginal and non-Aboriginal infant mortality by 2018. Firstly, have many of these goals been met? Secondly, what is one of the key things that you think the Government needs to do differently in its next plan so that it can reach more goals? It seems that you have basically said in your submission that the reality is that there is no evidence that these disparities are improving over time. It is a big question, but see how you go.

Ms COLMAN: I think across Australia for an extended period of time there has been little movement in the key indicators for health for Australians living in rural Australia. It is not a New South Wales specific issue and it is something that has been happening for decades. It always comes back to workforce. It is interesting that most of the conversation this morning has been focused on workforce. I think many of the things that we have discussed today have covered strategies for improving the number and the retention of the rural workforce. I think the fact that funding is between the Commonwealth and States, and local government in some instances—private providers are also in the mix—which really makes the situation very complex. Certainly the National Rural Health Alliance is very strong on local-based solutions. With the best will in the world we talk about trying to coordinate at a national, State and local health district network level. Trying to coordinate and pool funding at the local level we see as probably one of the best ways forward. That way solutions are community owned and managed. It does mean that some of the barriers to attracting and retaining a range of health professionals can be overcome.

If you can set up services that can provide multidisciplinary teams you get that professional support and overcome that sense of professional isolation together with pooling funding to provide health professionals, including allied health professionals, with some financial security before they make the leap to move into a rural area. At the moment for a standalone physiotherapist to decide to set up a rural practice, as well as professional barriers there are significant financial challenges in knowing whether you have a population base there that is going to be able to support you, that you are going to have a regular income stream. Establishing locally based community solutions to overcome those sorts of professional and financial barriers to attracting and retaining staff we think will be a critical way going forward. There are certainly trials underway. Some of your witnesses later in the day will be able to speak to some of those trials that are going on in New South Wales, for example, the Rural Doctors Network.

The CHAIR: I have a quick question if I could jump in as the Chair.

The Hon. WES FANG: You have the prerogative; you are the Chair.

The CHAIR: I direct it to both organisations and there may be a need to take it on notice if you need to provide more detail. My specific question goes to the provision of palliative medicine, nursing and care in regional, rural and remote New South Wales. Specifically, my question is in two parts. First is an overview of the situation as it currently is, as you understand it as thoroughly as you may do or may not do as the case may be, but I am sure you have some rich insights. Secondly, in your view as organisations, what needs to be done to

improve the provision of palliative medicine, nursing and care in regional, rural and remote New South Wales? We will start with the National Rural Health Alliance.

Ms COLMAN: Yes, certainly that has been identified as an issue. It is interesting. I do not want to speak for doctors but certainly there is an expectation for doctors to step into those roles rurally where perhaps there would be a specialist available in city areas. One of the big initiatives coming forward is the rural generalist program and certainly palliative care is one of those areas where a rural GP can pick up an area of specialty and that seems to me to be one of the great potential areas to overcome that particular issue.

Mr SARTOR: I will also make an additional comment to Ms Colman's. At last review Australia's end- of- life care was ranked second in the world. It is acknowledged that there are a number of programs and initiatives both Australia-wide and in New South Wales more specifically to address and support palliative care and end-of-life care. We believe it is important for these programs to continue to be reviewed and evaluated for their effectiveness and that the lessons learned from such evaluations are brought forward and put in place to modify such programs.

The CHAIR: Thank you, Mr Sartor.

Dr SALINDERA: I concur with the comments of both my colleagues. In our submission we did provide insights into the palliative care problem. In some places where we would have a specialist provide that care we have not been able to or where the specialist exists they do not have admitting rights and that is a complex issue.

The CHAIR: I am sorry, they do not have what?

Dr SALINDERA: Admitting rights.

The CHAIR: What does that mean?

Dr SALINDERA: It means that they may be a palliative service but they cannot admit the patient under that specialist bed card, for example. It means that patient might come under surgery or oncology or a different specialist team and that team consults to provide the care rather than being able to be admitted under that specialist name. It is a complex problem and we absolutely agree that it is an area where we may need to consider, as suggested, new models of care where you collaborate with local GPs on the ground. The key is that each LHD actually thinks about what is our palliative health care plan for our LHD? What are our needs and what can we deliver under our circumstances? As we said, and as Ms Colman has put so well, every LHD is different.

New South Wales rural and regional communities are very diverse. What happens on the coast to what happens out west is so different. What their needs are is so different. What areas are growing and what areas may not be or are changing in different ways requires local solutions. Having local solutions and prompting each LHD to actually have a palliative care plan and how they deliver that care and whether it meets the standards that we frame from best practice medicine as well as what patient expectations are and community expectations are should be in collaboration with the hospital network to provide that, whether it is palliative in the community or within hospital services.

The CHAIR: This is my last question. With respect to such plans and the work done at the senior level of the LHDs to interrogate that issue for the production and maintenance of that plan over time, is that going on at the moment?

Dr SALINDERA: I would have to take that on notice. Every LHD is probably a little bit different.

The CHAIR: That is fine.

The Hon. WES FANG: I have a question for the National Rural Health Alliance. I apologise as I have my back to you but it is because of the microphone and the arrangement of the tables. I noted the discussion around telehealth and I have a concern that telehealth is getting a bad rap. Some fantastic programs are being rolled out across the State with telehealth, for example, the telestroke pilot that is being trialled in New South Wales. Is the use of technology and the use of real-time imagery from rural and remote areas back to tertiary centres able to provide health care or advice which is of benefit to those patients that are out there?

Ms COLMAN: I possibly undersold the benefits of our telehealth a little bit previously, too, because I think there is a tremendous amount of potential for telehealth for rural and remote Australia. I will restate that having someone at the patient end is also incredibly important. It also has the potential for professional development. For example, if there is a patient who is recovering from a stroke, if they can have a physiotherapist with them in the room while they are receiving a telehealth service from a specialist in a city area then you are not only getting the benefit for the patient, but you are also getting the professional learnings for the physiotherapist, the GP or the exercise physiologist who can be with them while they are getting the treatment. I think that is an

important thing. That is certainly something that we need to look at in terms of funding reform to make sure that there is funding available to support those patient-end services for telehealth as well.

The Hon. WES FANG: I guess the advantage of telehealth, though, is that—I note your answer was certainly based around a consultation on telehealth with somebody who is recovering from a stroke. For example, the telestroke program is around the initial response and immediacy of that advice from a stroke specialist, which has led to some fantastic outcomes for people that are having a stroke in a rural and regional area that has a stroke specialist beaming in. Do you see that the immediacy of specialist intervention in an area that would not normally get it can be of benefit to the communities?

Mr SARTOR: Thank you very much for the question. I certainly agree with the premise that telehealth has a very important role for that; it would be a first line of care response. The first response for stroke or with other emergencies and other crises more generally—it is the period from the moment the event occurs to the moment that there is an ambulance on site. That duration itself is not based simply on the ambulance response time, but also the response time for the nearest members, or for the member who is having the stroke or other adverse event, to be able to get on the phone and to be able to get the paramedics on board. It then highlights the importance of having telehealth as a way to provide more advice and more support for that immediate response. Also, it hints at the importance of having some of those acute specialists, such as paramedics, working in the community itself, in the primary health care setting, in order to be able to respond more quickly to that first line of response.

Dr SALINDERA: I think I would comment on the stroke issue.

The CHAIR: Please, doctor.

Dr SALINDERA: I think it is wonderful to have the telehealth service for the acute care in emergency, and we have to remember that it comes with those emergency doctors being trained to then deliver that thrombolysis or whatever the treatment is that is needed. But I think we need to set the bar higher. I do not understand why our regional hospitals do not have stroke units. The fact that we have a regional hospital that has to ring a tertiary hospital for stroke, which is a very common presentation and a seriously debilitating disease—I think we need to set the bar that our regional hospitals in New South Wales should have stroke units and that it is the rural and remote hospital that then rings that regional hospital for that expertise.

Yes, this is a good measure in between to get us there. It is going to take time to set up those units. It is going to take time to recruit those specialists. But I foresee that we need to be planning—what do we expect our regional hospitals to be doing if we are not doing stroke? It is so common in our aging populations in rural and regional areas. They need to be doing that. We need to be enhancing the care that we deliver in our regional hospitals. I do not think we can say that stroke is a quaternary or tertiary specialty anymore.

The Hon. WES FANG: From my area, we certainly have that. We have some of the specialists that are providing their support through telestroke, which is a fantastic program.

The CHAIR: It has gone 10 o'clock. I thank all our witnesses for thoughtful and insightful answers. I am sorry it was such a rapid pace. I indicate that we only got through a relatively small percentage of the questions we would have liked to have got through. If it is okay with yourselves, I am sure there will be some questions on notice provided, if you are agreeable to receive them. Our Committee secretariat will liaise with you with respect to the turnaround of those, which is normally a 21-day period. On behalf of the Committee, I thank you all very much for participating today. Thank you for coming and participating virtually. I thank both organisations for the outstanding work that you do in the area of health for our citizens in regional, rural and remote New South Wales. Thank you very much.

Dr SALINDERA: Thank you.

Ms COLMAN: Thank you.

Mr SARTOR: Thank you.

(The witnesses withdrew.)

DIANNE KITCHER, CEO, South Eastern NSW Primary Health Network, NSW Rural Primary Health Networks, before the Committee via videoconference, affirmed and examined

RICHARD NANKERVIS, CEO, Hunter, New England and Central Coast Primary Health Network, NSW Rural Primary Health Networks, before the Committee via videoconference, affirmed and examined

MICHAEL CLEMENTS, Chair – Rural, The Royal Australian College of General Practitioners, before the Committee via videoconference, sworn and examined

CHARLOTTE HESPE, Chair – NSW and ACT, The Royal Australian College of General Practitioners, before the Committee via videoconference, affirmed and examined

The CHAIR: Welcome to the second session of our inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. With that done, I indicate that with respect to submissions from respective pairs of witnesses and organisations, Ms Kitcher and Mr Nankervis, your organisation's submission is submission No. 452. It was received by the Committee. Thank you very much. It has been processed, it stands as a submission to this inquiry and it is on the Committee's webpage. With respect to the next pair of witnesses, Dr Clements and Dr Hespe, your organisation's submission is submission No. 629. It has been processed by the Committee secretariat, it stands as a submission to this inquiry and it is on the Committee website. Of course, they are both publicly available.

Now, unfortunately we have a limited amount of time with such expert witnesses. To enable us to maximise the questioning, if it is agreeable I will invite one representative from each group to make an opening statement. Keep it to a couple of minutes if you can. If it is a longer opening statement, we are happy to have it incorporated as part of your opening statement, but we want to keep the opening statements as short as we can to maximise the questioning opportunity amongst the members. If you have a long opening statement, I apologise for truncating it but it can still be received as evidence. Then we can open up, share the questioning and maximise the opportunity from Committee members to interrogate you on a range of issues from your respective submissions and other matters that they may wish to raise. Starting with Ms Kitcher and Mr Nankervis, who will make an opening statement?

Ms KITCHER: Dianne Kitcher.

The CHAIR: Thank you very much. I invite you to make your opening statement.

Ms KITCHER: Okay, but three minutes is too long I assume?

The CHAIR: I will give you the grace of 60 seconds. Go for it.

Ms KITCHER: Thanks for the invitation to address the Portfolio Committee. Today Richard Nankervis and I are speaking on behalf of the five primary health networks that are based in regional, rural and remote New South Wales. Primary health networks [PHNs] were established by the Federal Government in 2015 to serve as independent regional commissioning organisations with a key role to support general practice and to partner with local health districts [LHDs] to integrate health services and systems. In our submission to this inquiry we propose that any examination of the health system, such as the hospital sector, must also include consideration of primary care. A failure of one component of the health system will have serious flow-on effects to other sectors of the system. As many of our colleagues and peak bodies have submitted to the inquiry, one of the factors causing pressure on our rural hospitals is the declining GP workforce.

The lack of access to GPs has serious impacts on hospitals and emergency care. A survey of Western and Far West New South Wales has identified that there are 41 towns that are at risk of not having a practising GP within the next 10 years. There is general acceptance that the fee-for-service MBS system is unsustainable and not viable in rural areas. Alternative funding models that pool Commonwealth and State funding to co-design new workforce approaches are urgently required. We support the various proposals put forward by the peak bodies to boost the supply of GPs by increasing training programs and by providing more financial supports to ensure that their businesses are viable. However, from our vantage point as PHNs, any improvement in health outcomes and access will only be achieved by working together across the Federal and State boundaries and by including local clinicians from both primary and secondary settings as well as the community members themselves to design and implement new ways of working to integrate services and systems.

Importantly, there is no one-size-fits-all solution; each town or region will require a different solution tailored to their unique needs. Policy frameworks do exist. The National Health Reform Agreement includes a commitment to exploring innovative approaches and outlines how governments can work together to provide high-quality services that are planned and delivered at a local level. The New South Wales joint statement, about

to be signed, is between the 15 LHDs and the 10 PHNs in New South Wales. It states our shared vision to have one health system mindset, it promotes working together and it encourages us all to act beyond the current structures and boundaries in health care, with the patient at the centre. There are many excellent examples of LHDs and PHNs working together to achieve better care in the community, including using virtual care models to access specialist care and to support GPs; developing digital enablers to support best practice, such as the Health Pathways portal; secure messaging; and shared care planning across the primary and secondary care setting.

However, in practice implementing health reform is patchy across the regions as both LHDs and PHNs are generally under-resourced and faced with many competing priorities. We ask that the Committee highlight the importance of these collaborative ways of working that cross State and Federal boundaries, and that appropriately resourced innovative models of joined-up care both across the primary and secondary care setting are trialled with the intention of being scaled up from the outset—many pilots just stop after they have been a pilot. Thank you.

The CHAIR: Thank you, Ms Kitcher. That is a model opening statement that covered all of the key details. It was excellent, so thank you very much. I will pass now to a representative from the Royal Australian College of General Practitioners for an opening statement.

Dr HESPE: It is Dr Charlotte Hespe who will give it. That is a bit hard, Dianne Kitcher. Thank you for providing that challenge.

The CHAIR: Set the bar pretty high, hasn't she?

Dr HESPE: Dr Clemens and I are here today on behalf of the Royal Australian College of General Practitioners. The RACGP is Australia's largest professional general practice organisation representing over 40,000 members who are working in or towards a career in general practice. Almost 10,000 of these members work in rural, regional and remote communities across Australia. We would like to thank the Committee for the opportunity to give evidence in relation to the inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. The inquiry has broad terms of reference, so in our submission we chose to provide an overview of the key points along with 10 specific recommendations that we feel would help address some of these issues.

Nationally we know that patients in rural communities have poorer health outcomes than those living in major cities. They are more likely to have higher mortality rates, lower life expectancy, higher death rates from chronic disease, higher prevalence of mental health problems and poorer dental health. They are also likely to have poorer access to health services than patients in metropolitan areas and with less availability of local specialist services. But a national picture is reflected in patient experiences in New South Wales. The Bureau of Health Information published a report in late 2016 documenting the challenges faced by patients in rural, regional and remote New South Wales. This report found the same trends in rural health outcomes and access to health as was reported nationally.

GPs do have a key, central role in delivering health care to patients. They are usually a patient's first contact and access point to the healthcare system. GPs help patients access the most appropriate professionals and services to meet their needs. In our rural communities, GPs are relied upon to deliver a broad scope of services with less support from other specialist doctors or allied health professionals than their metro counterparts, and GPs often need to take on additional skills to meet their community's needs. Addressing the current maldistribution of GPs would be a significant step toward addressing poorer health outcomes and poorer access to health services in rural areas. In our submission we made 10 recommendations to help tackle these challenges. The solutions can be broken down into three main areas: supporting GP trainees, attracting GPs who are working in more urban areas and supporting GPs who are already working in rural communities. Thank you again for the opportunity to appear before you. We are looking forward to answering your questions.

The CHAIR: Thank you very much, doctor. This Committee is well known for not playing favourites so I would like to acknowledge the salience of your submission and the specific details, which once again I am sure will stimulate a number of questions. We are going to move to questioning now. Representatives on this Committee comprise Opposition, crossbench and Government members. What we will do is divide the time, that is the time left between now and 11 o'clock, between the three groups. That is effectively 13 minutes. That sounds almost like an absurdly short period. There will be the desire, no doubt, to ask questions on notice beyond 11 o'clock. We are not going to short-change anyone but we have to control the time as best we can. I will ask members to indicate who they are directing the question to, so there is no doubt about who is receiving the question. We will start with the Hon. Walt Secord from the Opposition.

The Hon. WALT SECORD: Thank you for your time and your submissions. My question is to a representative from the Royal Australian College of General Practitioners. We heard evidence from previous witnesses about VMOs lack of flexibility and incentives to get them to rotate through rural and regional areas.

I have looked at your 10 recommendations. Are there any comparable jurisdictions to New South Wales that support or encourage general practitioners to rural and regional areas? I am looking to Canada, Alaska, New Zealand. Are there other models that we should look at?

Dr HESPE: Dr Clements, do you want to start with that, because I think Queensland actually has a different model, which has advantages and disadvantages?

The Hon. WALT SECORD: Could highlight the advantages and disadvantages?

Dr CLEMENTS: Thank you very much. It is an important question. We know that a thriving community will benefit most when there are community GPs practicing in the community providing the bulk of comprehensive chronic disease and mental health care, supported by a well-staffed hospital. Certainly your VMO model in New South Wales is similar to elsewhere, but that engagement model can have difficulties. I am based in Townsville. I am a GP in Townsville and we have got different models of care, including the medical officer with right of private practice, up here where for example a GP can be given a retaining salary for being on call for the hospital, but then can continue to work in their private practice and bill patients accordingly.

Queensland certainly does have a number of models where we do not call them VMOs, we call them Senior Medical Officers [SMOs] and medical officers with right of private practice, which is a way of essentially the State Government subsidising or being able to fund these rural GPs in the services. I cannot speak for Canada. I know there are different funding models in different areas. We do know that our members have expressed to us that the VMO model used in some of those rural New South Wales areas can be a little bit of a barrier. It is a fee-for-service type arrangement frequently and it relies on a good, trusting relationship between the LHD and the private practitioners, and those trusting relationships are not always there because there are sometimes competing interests.

Dr HESPE: Can I quickly just do a Canadian model one, if that is okay?

The Hon. WALT SECORD: Thank you.

Dr HESPE: In Canada, I love their rural-remote models where it is similar to the Aboriginal Medical Service concept where it is set up within the community with a different funding model. But there are a couple which are basically community controlled. They are funded from Canada itself. What is really interesting is that community has very much control over what services and how access to the health care is provided. What is really interesting is that they actually end up with much better health outcomes than a normal health service with cheaper access costs because it actually has a very strong community voice around what services and clinician input is required. The clinician enjoyment of that particular service is also much better because they actually are made to be part of the community, rather than being seen to be, I suppose more bureaucratic and administrative in the way in which they provide services. Happy to provide more information.

The Hon. WALT SECORD: I was going to ask a quick follow-up question on that. Can you give me an example of what you mean by that? A community would say that they would like a doctor with these skills. What happens?

Dr HESPE: It is more around the funding of services. The community identifies what gaps that they might need in terms of improving health. A lot of the time we know that might actually be around access to education and social services, which has a direct link to improving health. The community identified that, for instance, there might be an issue with domestic violence and how are they going to solve that. That might well be in terms of health literacy education, et cetera, around how to improve that, but the doctors and the GPs are involved in being able to also actively identify and assist people in psychological services, et cetera. The funding of the services around that problem is able to be more flexibly moved, which is where the Primary Health Networks [PHNs], can I say, are really very key in how we can mould into more flexible healthcare systems, as long as they are given the flexibility. Currently, my issue with a lot of the PHNs is they are told what to do rather than actually being able to go in and help the community themselves identify the services that they need.

The Hon. WALT SECORD: Earlier today we heard evidence about the pros and cons of telehealth, then concerns that, yes, it can be a supplement but it should not replace medical staff. What was the experience of rural GPs in areas of New South Wales during the height of COVID where face-to-face consultations did not occur? I have seen data here that 20 per cent of homes in rural and regional areas do not have a computer and do not have the internet. What did GPs do at the height of COVID when they could not do face-to-face consultations?

Dr HESPE: The access for consultation that was Medicare-funded through telephone as well as video consultation really opened up the ability to provide better care. It has actually been a fantastic option for health care in rural-remote communities. I heard some fantastic stories from GPs around the ability to actually provide much more accessible care for their patient population. I think you put your finger on the nub. The key issue from

my perspective is that in fact we know that better health care is provided through it actually being video, rather than just phone. We do need to address the access to better internet and smart phones, et cetera. But that aside, just being able to do phone call access that was actually funded for GPs has been a significant improvement and I can only hope that it is an ongoing funded thing under Medicare.

Ms CATE FAEHRMANN: This is a question for both witness organisations. In the submission from the NSW Rural Primary Health Networks you talk about the fact that, under our healthcare model, GPs are privately owned businesses. You have statistics as well in the Deloittes study which shows that 41 small towns are at risk of having no GP workforce in 10 years. Is there something here about the Government stepping in? I know there is a lot of discussion around relocation incentives and a lot of other things, but is there something more than that around government-funded and assisted primary health services such as GPs, local government-funded medical clinics, actually upping the level of investment and government intervention, if you like, particularly in regional and remote communities? Has that been actively canvassed or considered amongst your networks? Perhaps we should hear first from a representative from the PHN.

Ms KITCHER: Mr Nankervis, do you want to go first, and I will add, if there is anything to add?

Mr NANKERVIS: Yes, certainly. This has been a key issue in parts of our region, particularly small, rural towns where the MBS-based, session-based rebates for GPs does not always adequately support the small business requirements of the general practice. What we are hearing from some GPs is that there is a strong opportunity to trial different types of contracting GPs or non-MBS models, that also better support visiting medical officer [VMO] coverage in some of those small-town hospitals. There is an example of that that is about to be piloted in Murrumbidgee and the State is working with the Commonwealth around that.

We think there are some good opportunities to support general practices and GPs more in piloting different models that include different payment models, also noting that general practice includes other staff as well, including practice nurses and a range of staff. We are seeing some key deficits in those staff in rural towns and we think there is an opportunity to work on some multidisciplinary models that might better meet the needs of rural general practices and the local communities. So we think there are some opportunities around those. When it comes to telehealth we also think there are some really strong models and we are seeing that between GPs working in rural areas and specialists who are located remotely to those general practices. There are some other types of models that can be looked at as well.

Ms CATE FAEHRMANN: Thank you, that was an extremely useful response. I would not mind hearing a little bit more about—you said there was potentially a trial happening in Murrumbidgee in terms of a different type, an alternative to the MBS model for GP services. Could you expand on what that is and how that works?

Mr NANKERVIS: I can expand to some extent; however, it is a key agreement between NSW Health and the Commonwealth so they will have the most content around it. It is the idea of piloting approaches where a GP is not necessarily employed by the general practice itself but employed by the local health district. There are different approaches to that type of model. You can have those models where a portion of their work is MBS and MBS funded and a portion supports VMO coverage, or small local rural hospitals coverage, and allows for leave, leave coverage and some of those other arrangements that support a rural GP to be able to take some time off or to bring in some alternate cover as needed, particularly after-hours or weekends. My understanding is that those are some of the aspects that are being piloted in Murrumbidgee.

Ms CATE FAEHRMANN: I hear that and it is extraordinary that that is not happening already. It is extraordinary that that is just something that is being piloted now. It is surprising to hear that that is just being thought of now as a potential solution, given this has been going on for decades. These numbers have been getting worse for rural and remote health outcomes.

Dr HESPE: For some of these things it is not that they have not been thought of, it is that we are unable to garner funding to do—there are a lot of really good innovative models out there that are very difficult to get funding for. Because of the dislocation between Medicare funding for general practice, which is otherwise a private business, and the funding through NSW Health or otherwise for hospital and community services, we will continue to have an issue between how we do really, truly innovative models in our rural settings because of that dislocated funding. What we need is an ability to bring together the two streams of funding in a way that is not stymied by the very rigid nature of our Medicare system for GPs to really be able to deliver a quality-care, value-based service, rather than a volume flow through that does not actually truly cover the healthcare needs of the community that they are in.

We know that Medicare does not enable communities that are poor and socio-demographically challenged to have a high quality healthcare service because the funding model does not really cover the ability

to cover that service. I think Mr Nankervis has already noted that part of that is because you need the other allied health—nursing services et cetera. They are really poorly funded under Medicare—really poorly funded. So for a general practice to have a really comprehensive, multi-team approach—which is the best model—is incredibly challenging.

Ms CATE FAEHRMANN: Yes. Just to clarify, my previous question was not in any way directed at the lack of innovation and your advocacy in this. It was pretty pointed in that it was probably funding, as you pointed out.

The Hon. WALT SECORD: I go back to the opening statement when you said that within 10 years there is a possibility that 41 communities will be without a GP. I was shadow Minister for Health for five years and I remember talking to GPs in communities where they were the only GP. They were usually men in their mid-to-late 60s who, in fact, had no prospect of handing over their practice to anyone because they were paper-based: they did not have computers; they were old-school country doctors. What can the Government do or this Committee recommend to support GPs who are in that scenario?

Dr CLEMENTS: I have two general practices in Townsville and six months ago I was invited to a meeting about a failed general practice on an island in a MMM5 area called Magnetic Island. They had a single doctor trying to cover 24/7 emergency services, as well as being a GP. I was called in and I ended up buying the place. When I bought the place, I said, "We need help." So I had the State Government take the head lease out on the big practice and I subleased at a market rate that I was willing to accept. I guaranteed tenancy, where they would pay rent to me for use of parts of those rooms and they allowed me to operate my business from there at a very secure and stable rate. The [RTO] was able to fund an increase in my IT because it was a failed practice and needed a big upgrade to be able to take trainees. So the RTO came in and gave me a cash investment to upgrade the IT. They guaranteed me registrars to come to that practice because I was already a supervisor—

The CHAIR: Sorry, Dr Clements, for Hansard, what is an RTO?

Dr CLEMENTS: Regional Training Organisations. They are the organisations responsible for administering GP training. We had them come in and provide support to recruit. Once we developed a partnership with the hospital and health service, we turned it into—there are six doctors at that practice now, and the State Government provides a retainer to some of those doctors under what is called a medical officer with right of private practice model, which we are still finalising. They get paid an allowance for being available on the island and they share the on-call roster. They can continue to work in my private practice. The other thing we were able to achieve was—the community expected bulk billing but we had a very clear public relations campaign saying that we can just not afford to do that anymore under MBS, so we have moved to a mixed billing model. I now have a waiting list of doctors to come and join the island, and I have a good community service, well underpinned by the State Government and the other organisations, such as RTOs.

The Hon. NATASHA MACLAREN-JONES: What you implemented obviously required a lot of self-motivation.

Dr CLEMENTS: Yes.

The Hon. NATASHA MACLAREN-JONES: What advice would you give to other doctors, or even communities, that would be looking at that type of model? Secondly, are you aware of that type of model being rolled out or piloted in other areas?

Dr CLEMENTS: Yes. What it took was a crisis and Magnetic Island has got a very popular, very politically driven community of 2,500 people, so we had all the agencies that you can imagine, including the PHN and State and Federal representatives, saying that we need to solve this. They came with their wallets open, ready to say, "Yes, we are willing to do what is needed." That made the difference, because when I went to them as a private business owner, I was able to say, "In this community these are my needs." So if you get these roundtables—and the community was there, of course. It was a community-led meeting there and they were saying, "This is what we need." We are doing a similar discussion at the moment in the town of Julia Creek where we are trying to understand what the community needs. The private practice—remember, small business owners are very efficient at running private practices. If you give them the right key enablers, they are willing to take that on.

Now sometimes that might be providing them with or actually paying for the lease on their general practice. It might be actually just having doctors' accommodation available. I have been talking to one town where they just cannot get accommodation for the doctors. Maybe the State Government can find accommodation for the doctors. It might be that the practice is having real trouble recruiting nurses and maybe the State Government is quite happy to fund a nurse practitioner or a nurse to work out of a private general practice and actually augment that model of care. I would be very interested in that myself if we had a State government willing to, I guess,

underwrite some of my business expenses. There are plenty of people out in rural New South Wales willing to do this but they do not know what to ask for. If you start holding these conversations and say, "Listen, we are here as the State Government and we are willing to listen to what you need to make this work", then you will find that there will be business owners willing to take that on.

The Hon. WALT SECORD: Dr Hespe, is the 10 years and 41 towns a new phenomenon or is it that every five or 10 years there is a cycle of 41 or 50 towns where the doctor is on the verge of retirement? Is this something that has just happened recently—if you understand the context of my question?

Dr HESPE: Yes, I think I understand the context of your question. I think it is a cyclical thing, but the problem has been that there is less incentive for a sort of continuity plan for GPs to be able to be replaced. A part of that is really that general practice is seen as being financially unattractive in comparison to other specialties and unsupported in terms of actually getting you out there. What we know is that doctors—careerwise your training happens at the same time that you are putting roots down for your family. It is very difficult to uproot a family of young children into a rural community when they have been settled for five to 10 years of their training in the city. That is really part of what our application goes to say. We really need to have more flexible training models that guarantee doctors will be able to stay in a local community, put down roots and become part of it so that they can establish better continuity and flow-through.

Again, I think some of the towns where they have been able to very much link in with making their junior doctors feel part of the community—there are some really good models where that is actually demonstrated. Then you actually are able to do continuity. I was part of a project in Victoria which showed a concerted effort of really engaging with the GP registrar—a bit like what Dr Clements was talking about—where you actually make them feel like part of the furniture, so to speak, and your spouse and children are accommodated as well. Then you are much more likely to be able to keep them on long term than one where you are just seen as being very temporary. That has been one of the problems with our International Medical Graduate [IMG] models, where we have made overseas doctors come and take the burden of our rural communities, but they do not actually embed themselves. They plant their family in a city and they only operate for the hours that they are running the clinic and then they will go back to the city. I understand why they are doing that, but while we have that as a model of how we are providing our rural workforce, then it is never going to become a long-term implementation solution.

The Hon. WALT SECORD: Is there a role for nurse practitioners in rural and regional areas? I think there is quite a small pool of them.

The Hon. NATASHA MACLAREN-JONES: We need more.

The Hon. WALT SECORD: Do we need more?

The Hon. NATASHA MACLAREN-JONES: No, we do need more.

Dr HESPE: Absolutely. Nurses are fantastic.

The Hon. WALT SECORD: Nurse practitioners particularly.

Dr HESPE: Yes, nurse practitioners—whatever. I mean, practice nurses from general practice—nurse practitioners tend to have a specialty. You have to be careful that you do not end up with somebody being too specialised that they are not as helpful in a general practice setting, but a general practice nurse who can pretty much assist in triaging and care planning, et cetera, is fantastic. Again, it is really a funding model. You do get better funding in rural than you do in urban to do that but it is still not enough.

Dr CLEMENTS: I might jump in on the nurse practitioner question. We support a model of care where there is a nurse practitioner in a township called Karumba, which has 500 people. That is not enough to support a GP so we have a collaborative arrangement with a nurse practitioner. They live there and they are there five days a week. They provide scripts and chronic disease management. We support them, train them and then we fly into that town once every fortnight and back them up. In between those times we are able to do telehealth support to the nurse practitioner and the community. This is a massive enabler for small communities where they do not have enough workforce to support a full-time equivalent GP—so very supportive of what we call GP-led care, which is where a GP is leading the care delivery by multiple allied health professionals. But, as Dr Hespe said, it has got to be the right nurse practitioner. Many of them find themselves moving into hospital specialised paths. We would like to see an increase or a support of the generalist nurse practitioner who is actually enabled to work in the communities. You would find that would be a massive enabler for your rural communities in New South Wales.

The Hon. WALT SECORD: What about cancer treatment and oncology particularly in remote areas? How does that fit in with telehealth? Dr Clements, could you address that?

Dr CLEMENTS: If you google oncology telehealth, North Queensland has been a pioneer. The Townsville University Hospital basically trains a lot of the rural and remote sites in administering the chemotherapy. Then the person would be sitting in the chair in their home community with the oncologist and the oncology nurse back in the city actually consulting them while they are having it done. That is in a supported and trained framework. That is a real community enabler as well. There are good models and it is a good one to follow.

The Hon. WES FANG: Dr Clements, I will just start following on from the last answer that you gave around telehealth. We had some evidence previously from the witnesses who appeared before you around telehealth. As I said to them, we have had a bit of a bad rap around the telehealth issue, but you have just indicated that there are some fantastic initiatives that are happening with telehealth. Are you able to expand on any other programs that you have seen rolled out in those rural and remote communities where telehealth was able to provide an immediate and advantageous support to those communities through the provision of health care and advice?

Dr CLEMENTS: Yes. Thank you for the opportunity. RACGP fiercely defends the benefits of telehealth and video telehealth to our communities both in the cities and the rural and remote communities. I will give you an example. My practices run outreach clinics. Julia Creek recently fell over in terms of doctor support. I make myself available three afternoons a week for telehealth support. I am managing palliative care patients. Sadly I managed a miscarriage over the phone. I had a chat with a guy who wants to die in Julia Creek and we are doing our best to support him. So I just chatted to him about his symptoms. He said, "Actually, Doc, I need a bit more of OxyContin for my pain relief." I knew him. I had actually flown out there so I already met him last month, so I said, "Sure." Because of e-script functionality, which is widespread now, as I was talking to him I texted him the script for his OxyContin and then he popped down to the pharmacy, which I have a relationship with as well, as they call me with any of the patient problems.

Clermont is a town where there is a lovely practitioner called Sarah who runs a practice, and she lost the only other GP who worked with her. She put a call out for help and she has actually partnered with some GPs from Brisbane. These GPs from Brisbane cannot get there to Clermont because of their own family reasons, but now they are providing daily telehealth support to the town of Clermont in collaboration with the GP practice over in that rural and remote site. COVID has really brought this massive enabler for us. If the Federal Government decided to take that away we would certainly be keen to offer it still, but we would be charging. Then you are going to have a case of some rural communities that can afford the service doing better than those that cannot.

The Hon. WES FANG: Did any of the other witnesses want to make a contribution on that? I am just conscious that—

Ms KITCHER: I can, I suppose. In South Eastern New South Wales we have done a very similar type of model for chronic pain patients with particularly bad back pain. Most of our flow of patients goes into the ACT and there were terrible waitlists to get in to see specialists in the ACT from down south. We established an alternative program through the Primary Health Network [PHN] with St Vincent's Hospital and with its multidisciplinary chronic pain team there. They came down and did some training with some multidisciplinary people in the southern part of our region and the GPs were trained in their particular model of care as well.

They are now seeing patients through telemedicine between St Vincent's, where they get direct access to the specialist team, and then the local teams that have been trained in that particular model of care so that they are all speaking the same language and they all understand what their objectives are and what they are trying to do. It has had an amazing impact on those communities and those members who were experiencing chronic pain and just sitting on a long waitlist to get into ACT. Those sorts of programs do exist and we would love to be in a position where we could scale them up more. I know many of our city counterparts, as Dr Clements mentioned, look at that program with envy because they could have a very similar approach in the city that would be equally beneficial.

The Hon. LOU AMATO: Ms Kitcher, I will just follow up on chronic pain. What can you tell me about the palliative care in rural and regional areas? How is that being administered, and what are the shortfalls there?

Ms KITCHER: That particular program was not about palliative care; that was about chronic back pain.

The Hon. LOU AMATO: Yes, but while we are talking about pain, how is palliative care?

Ms KITCHER: Palliative care can be supported as well in smaller communities and does get supported in smaller communities. It depends on the service. We do not particularly have a commissioned service that we do that. Mr Nankervis, do you know if any of the other PHNs—I know some of them do—

Dr HESPE: I am happy to—

The CHAIR: Yes, jump in.

The Hon. LOU AMATO: Jump in, Dr Hespe. I do not mind who answers the questions.

Dr HESPE: I do not know about any specific commissioned services, but I certainly know about collaborations of GPs who are in a palliative care network who are basically collaborating with their local palliative care service. That is where telehealth has been absolutely fantastic: where the GP is the prescriber and the overall carer, so to speak, for the patient, most of which is provided via telehealth, and the palliative care service actually assists in making sure that the nurses will touch base on a regular basis and let the GP know what recommendations they might have for what needs to be prescribed and otherwise done from a medical model of care for those patients.

Again, they are able to care much more rapidly and have easier what we call "touch points" via using telehealth for that. It actually means a patient can be at home in a very rural setting and have the same level of care through a telehealth service than has ever been able to be provided before—which, can I say, is absolutely fabulous. But it is just a matter of coordinating and making sure that the GP who has always looked after that patient can then also be upskilled and supported through the palliative care network, so that they do not feel like they are prescribing outside their comfort zone as well.

The Hon. LOU AMATO: We are talking about pain management, but—sorry, Ms Kitcher?

Ms KITCHER: If we can go back to the funding model that supports that, all that coordination that you are hearing be described by our two wonderful doctors with us is what is not funded under the fee-for-service Medicare Benefits Schedule [MBS] billing framework. That is the really critical piece for GPs anywhere, but particularly in rural areas, that all of that coordination and all that extra work to make all those multidisciplinary connections and get the video all set-up, et cetera, is not funded.

The Hon. LOU AMATO: If I can just interject for a moment, what about the mental health aspect of it? We are talking about the pain relief side of it, but what about the mental part of it? What sort of help is there?

Ms KITCHER: I will answer quickly and then pass to Dr Hespe. In our chronic pain program that we have down south psychologists are part of that multidisciplinary team. Typically you would have a physio, a GP and a psychologist as the core team, depending on what else that person might need. In that particular instance, it is very much a critical component of that team.

Dr HESPE: From my perspective as the GP, again, the GP can vary—using telehealth has been a really good way of being able to link in with patients, get appropriate mental healthcare planning done and then refer to psychologists. Psychologists have been using telehealth as well. There are some really good opportunities for doing that, but again it goes back to the funding model for the access to the counselling. For some of these people it needs to be completely free or a minimal-fee service. Although we have access for anyone who qualifies for GP mental healthcare plans for 10 visits per year, the PHNs do provide a psychological support service that is much more what I call "stepped care", so it is appropriate to that patient as to what they need, but that actually has to be funded separately. There is a requirement for the psychologist to be funded outside of Medicare, really, to be able to have the patient access to appropriate services. Again, that is where we can link in with PHNs and GPs providing that, but it can be done remotely. It is just about being able to link in better and have that funded.

The Hon. WES FANG: I know we are running out of time. Briefly, I just wanted to ask a question of the doctors that we have on the panel, given they have got so much experience in this area. Say you are a graduating GP and you want to hang your shingle somewhere. You have got the opportunity to potentially go to a regional place and join an established practice, or you can look to go to a rural or remote area that potentially does not have a practice and you look to start one. Is it possible you might be able to provide some feedback to the Committee as to how hard it is for a graduating doctor to go to one of these rural or regional towns where they do not have a service already? What is required in order to establish a practice, and how might we be able to actually assist with that?

Dr HESPE: I will just start and then hand over to Dr Clements for that. Basically, it is hard. You have to be highly motivated and want to do it. Having said that, there are lots of services and support available. Certainly the RACGP has all of the support that any GP wanting to become a practice owner might need in terms of how to set up a business. That want aside, you have got to be willing to set up a business.

In terms of then accessing an appropriate mentor—because really you need someone who can assist you if you are young—that needs to be happening, which is where I will hand over to Dr Clements, because we have got some programs that the college is running and some possibilities as to what that might look like. But you also need the local community to be highly supportive and really be able to help in doing it. That then goes back to the Canadian model that I was talking about, where you almost need to be part of—this is a community that wants somebody. Sometimes you need the right person in the right place at the right time, rather than anything else. But I think there is a lot of support that can be provided. Michael, do you want to—

Dr CLEMENTS: Thanks, Dr Hespe. I will be brief. The evidence is absolutely clear that the likelihood of converting a medical student or junior doctor to rural service depends on the breadth and the length of time that they spend training in that rural environment and the quality of that experience. To enhance the quality of the training experience, you need to support the general practitioners and the general practice owners. You need to have direct conversations. The LHDs need to be talking to the practices and saying, "What do you need and how can we help you?" There are often some legislative or funding barriers to the LHDs supporting private practices. It is often thought of as not being their business.

There are exemplar primary health networks that do very well at engaging with private practices and there are PHNs that do not do such exemplary work. I think if you can build into your State-based processes that your expectations and their KPIs are to work with the general practices—whether that is supporting them financially in terms of bricks-and-mortar or houses, training, travel and accommodation expenses or whether it is that the LHD pays for training to be done in that area and all the GPs are invited—you need to make it the LHDs' business to work with the general practices. If you have a thriving general practice with good supervision and a good, positive experience then the doctors will come.

The CHAIR: Time has sadly beaten us. I can guarantee there will be some questions on notice that honourable members will be looking to have forwarded to yourselves through the secretariat, if you would be good enough to consider answering those and returning them back. There is a 21-day turnaround cycle for that. On behalf of the whole Committee, I thank you all for the excellent work that you are all doing enhancing and improving the availability and the quality of health services outside large metropolitan areas. It has been particularly valuable and insightful to get perspectives from outside the State of New South Wales, particularly from sunny Queensland. Right across the board, the answering of the questions has been very good in terms of its standard and its specificity and detail. We thank you all very much for participating in our inquiry.

(The witnesses withdrew.)

(Short adjournment)

JOHN KRAMER, Chair, NSW Rural Doctors Network, before the Committee via videoconference, sworn and examined

ROD MARTIN, Rural Generalist, Australian College of Rural and Remote Medicine, before the Committee via videoconference, affirmed and examined

RICHARD COLBRAN, Chief Executive Officer, NSW Rural Doctors Network, sworn and examined

CHARLES EVILL, President, Rural Doctors Association (NSW), sworn and examined

The CHAIR: Welcome to the third session for the first day of this important inquiry. I ask each of the respective organisations to have one of their representatives provide an opening statement, hopefully just two or three minutes. If it is quite a long one then so be it, but we would ask you to perhaps provide a precis of it and then provide us with a copy of the longer opening statement. That will maximise our opportunity for questioning. If that is agreeable to you, gentlemen, we will proceed that way. We will start with the Rural Doctors Association (NSW).

Dr EVILL: I will make this as brief as I can because most of what we want to say is already contained in our submission, which I have also tried to keep fairly brief. The Rural Doctors Association (NSW) is a member-funded organisation that exists to take care of the interests of rural doctors, mostly those working as visiting medical officers [VMOs] in rural hospitals at the moment but we are also interested to support any rural doctors. As I said, we are member funded so there is no other organisation to which we are beholden. We take very seriously our commitment to the health of rural communities as well. Supporting everything that is available to make that work also helps our members to support their families and to make their workplaces interesting, satisfying and sustainable.

I will say something about myself. I have been a rural generalist, which is something that I am sure you will hear more about from Dr Martin. To date I have worked in 28 rural New South Wales towns, providing general practice relief and small hospital emergency department relief across everything from base hospitals to solo-doctor towns. I think it gives me a unique perspective on rural medicine. I have a previous background in medical research and working in a large teaching hospital. I think that is all I would like to say in my preparatory statements and we will let the questions and answers deal with the other things.

The CHAIR: Thank you very much, Dr Evill. Just to clarify this, your submission has been provided to the inquiry. It has been received, processed and published and stands as submission 446 to this inquiry. We are grateful for that. I will move to Dr Martin from the Australian College of Rural and Remote Medicine, with a confirmation that once again your submission has been received. It stands as submission 403 to this inquiry. It has been duly processed and published and is available to the public on the Committee's website. Dr Martin, would you like to make a statement to augment what Dr Evill has already said?

Dr MARTIN: Yes, Chair. Thank you for the opportunity. Just to let you know, we will send a full opening statement via email at the conclusion of the meeting.

The CHAIR: Thank you very much.

Dr MARTIN: On that basis I will just precis what we are talking about. Our strong belief is that the College of Rural and Remote Medicine is able to provide rural generalist doctors that are trained and assessed to high standards. This provides a cornerstone for improvement in health outcomes for our patients by delivery of the broadest range of healthcare locally. Three key points were drawn out from our submission, the first being that too often we make drastic changes to rural and remote health service provision on the basis of a single adverse outcome. That can often come at the subsequent cost of other cumulative adverse outcomes over time. The second point, which was certainly borne out by the advice that we got from the New South Wales college members, was that we are concerned that there is an increasing chopper mentality with respect to emergency care in rural and remote areas. We now have it that our rural patients who are subject to rural trauma are not managed in an initial rural trauma centre, that being the local rural hospital. We certainly believe now that some of the outcomes for those patients are worse because of the necessity of expecting a helicopter to come and retrieve those patients, rather than going back to their local district hospital.

My third key point is that rural and remote health services need rebuilding and rejuvenation. We believe that the rural generalist is key to the process of rebuilding and rejuvenating those services. While we appreciate the fact that there is increasing lean on telehealth services, we would contend that in-person care cannot be replaced by on-camera care. Again, that is more detailed in both submissions we have got there. I guess my final paragraph from the summary is that, in summary, we believe that a well-supported rural generalist can provide much of the solution to the challenges that face rural and remote communities and for NSW Health as well.

Our college trains and assesses our doctors to very high standards of primary, secondary and emergency care. They have been trained in and for the communities that are beset by myriad challenges of living outside urban areas. They are adapted to the nature of the clinical exposure and their training and we deliberately examine these capabilities. Many possess the leadership qualities so needed in a low resource and low experience sense. These qualities, in addition to enhanced clinical capacity, is what we believe is a key component in solving the health deficits for the rural and remote inhabitants of New South Wales.

The CHAIR: Doctor, thank you very much for a very clear and precise opening statement. May I invite Mr Colbran or Dr Kramer to make an opening statement? You may well have prepared one each. Given the great experience of both of you, if you wish to do so I will give you some leniency to share, if you wish, but I will leave it to you gentlemen to make the decision on how we do this.

Mr COLBRAN: Thank you, Chair. I will be speaking on behalf of the NSW Rural Doctors Network [RDN] and Dr Kramer will chime in with some questions later on, I think.

The CHAIR: Wonderful. Thank you.

Mr COLBRAN: I am Richard Colbran, the chief executive of the NSW Rural Doctors Network and our chair, Dr Kramer, is in Coffs Harbour today. He is a longstanding GP and practice owner for the North Coast of New South Wales. We feel very privileged today to be able to represent RDN, our members, our staff and also the communities that we serve. We do have a longer statement which we will submit properly, as you have suggested, and I will try to give you a quick summary of the key points.

The CHAIR: Please. Take your time.

Mr COLBRAN: Before we start, in the Rural Doctors Network we always look to pay respects to the lands on which we meet and also that the lands across all of New South Wales, Aboriginal lands, that our health system supports and works in. We truly believe that considerations of health and health outcomes need to require thinking and consultation and listening to the Aboriginal communities and the Aboriginal Health Services, and we work in close partnership with the Aboriginal medical team. We see great value from their work and their support. We trust and expect that they will also have the chance to be consulted through an inquiry like this.

The Rural Doctors Network was established in 1987 and 1998. We are an independent non-Government charity organisation that works in partnership with community. It was set up with the primary purpose to build and support access to quality health care in rural New South Wales. We are funded through a whole host of different streams that include State and Federal Government funding and we look to try to use that funding and the other independent sources of our income to develop programs and work in partnership with local communities and the sector more generally to support the attraction, recruitment and retention, not just of doctors, as our name might suggest, but also the broader health system and that could include nurses and midwives, allied health workers, Aboriginal health practitioners, practice managers and health administrators. We look at the whole of the team and look at what is required in a local and subregional level in supporting local communities.

Our submission was number 394. It includes five themes and 26 different recommendations. We would be happy to explore those further in any questions that come up. Probably the two or three really critical points that we would like to raise before we start the discussion include the fact that we have great concern at the moment around the wellbeing and welfare of the New South Wales rural health workforce—so the people delivering service—on the back of drought, COVID, fires, a little bit of flood, mices—is it mice or micee?— and now locusts.

The Hon. WALT SECORD: Meeses.

Mr COLBRAN: We are seeing a significant challenge here in terms of welfare and capability for our workforce. They are very committed. They work tirelessly to support rural community but on the back of those natural disasters and emergencies they face their own challenges both in their personal lives and their professional lives. We have some concerns in relation to not just these conversations but the media and all that sort of thing. We would really like to call out the fact that we need to see the positives as well and also the wellbeing and their welfare because, if we start to lose them, it goes from an attraction and recruitment conversation to being a retention or preservation conversation, and we think that that is very real for us at the moment.

The second point we would like to make will give you some attention to the lens or the focus that we have used in our submission and it is the definition of the term "rural". In New South Wales and in relation to health delivery, we think it is very important to segment that up into three very distinct geographic thinkings, the first being remote, the second being rural, and the third being regional. We think as you dive deeper into your considerations you will start to see the difference between those three definitive areas and how each of those areas is necessary but require a different type of solution in each of those areas. For the purposes of the Rural Doctors

Network submission, we have particularly focused on remote and rural as opposed to regional and that is explained further in our submission.

In our work in community, the Rural Doctors Network looks at an access or workforce solution approach, which looks at the whole of the team. We use the phrase "deliberate team-based care" where we think about the appropriate solution for that local community. In many respects that may not today actually be a GP-led solution and we think that that is very important to acknowledge the value of all the different cohorts and workforce disciplines and allowing them to work at their top of scope and supporting and encouraging them to work in a cooperative and collaborative manner. However, the primary recommendation that we have made today in using and thinking about the challenges faced by rural New South Wales relates to one specific workforce, and that is what we call the GP proceduralist or the GP VMO. You will hear that cohort referenced today and through the inquiry as the rural generalist and so we will be using that phrase as well moving forward, but the reality is that without that cohort our State faces a significant crisis. This crisis is well acknowledged by everybody involved, particularly in remote and rural settings.

Ten years ago there were over 800 rural generalists working in remote and rural New South Wales. Today there are fewer than 200 and over 50 per cent of those are aged over 55 and are starting to prepare for retirement planning. If that population, that workforce cohort, is not supported and sustained—not just those who are currently practising but also the pipeline for the new rural generalists—we are in serious trouble. I have a couple of more points, if that is okay.

The CHAIR: No, no. Continue. You have got our attention.

Mr COLBRAN: Yes. And then the final couple of points, if I may raise also, is we think it is really important and interesting to also talk about the positives. Rural health is often maligned by the deficit conversation and we are very hard on ourselves as well. For me, that is an admirable quality because rural health looks to improve itself always. However, what it does tend to do is take the discussion to the negative and there are so many positives that can be seen in rural health, not just in New South Wales but Australia alone. We actually lead in many instances around innovation and solution development, and we would like to call that out as well. I would be very comfortable in sharing with you today or in further writing some of the opportunities and positives that we see.

And just to finish, we are privileged to actually have support and partnerships with community and our partner agencies, so many of whom you have called through the inquiry. Just to finish on behalf of Dr Kramer we would like to continue to offer RDN support for Government and communities into the next 10 to 15 years. We think that we are at an important intersection now with rural health and rural communities and we believe that healthy rural communities will support and sustain thriving rural communities for New South Wales and Australia. Thank you.

The CHAIR: Thank you, Mr Colbran, and thank you very much for the submission, as you alluded to, provided by the NSW Rural Doctors Network, which is a quality submission, particularly with respect to the very thorough and detailed enunciation of recommendations, from which I am sure some questions will arise from some of the Committee members.

Mr COLBRAN: Thank you.

The CHAIR: And it is being processed and stands as submission No. 394 to this inquiry, which has been processed by the Committee secretariat, published, and available to the public. Now we will commence with the questioning. Believe it or not, there are 13 minutes for Opposition, crossbench and Government but I would like to say up-front that I know that gives no justice to really the scope of matters we need to cover, so I am foreshadowing that no doubt there will be some questions on notice that honourable members will wish to provide and indeed there may be supplementary questions relating to questions that we discuss today. There is a process that we will deal with at the end about the way in which we will deal with providing you with time to deal with those questions. Once again, I appreciate that 30 minutes is a very short time but we will get through as much as we can in that period followed up by further opportunities. To commence with the Opposition, questions from the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you, and thank you for your time. Dr Evill, you mentioned that you have worked in 28 different towns. What is the longest stretch that you have completed in a town or a community?

Dr EVILL: Probably six weeks, I think,

The Hon. WALT SECORD: Is that the longest stretch?

Dr EVILL: It depends. Could I just seek the indulgence of the Chair?

The Hon. WALT SECORD: Will you give me a bit of context?

The CHAIR: Yes, please proceed.

Dr EVILL: I seek the indulgence of the Chair for a moment. One of the things that I did mean to say in my opening statement is to recognise that Australia and New South Wales have one of the best health systems in the world. I do not want to take anything away from that but, as has been remarked many times, the price of liberty is eternal vigilance and we should not be complacent at all about how we are doing. I think this inquiry is addressing some of the areas that we really need to pay attention to. I work as a locum and relieving doctor. I have worked in some practices for several years on a part-time basis. In Alstonville I have worked there for probably about three or four years but not continuously. I still provide locum services very regularly in Evans Head. I worked for a year in Lismore Base Hospital doing obstetrics, so that when I said six weeks I am thinking about my recent locum experiences.

The CHAIR: Yes.

Dr EVILL: But across the years I have spent relatively long periods of time. I should also mention I have worked in another 20-odd towns across Queensland and south-east Queensland. That is just to back up that level of experience.

The Hon. WALT SECORD: You have extensive experience in small, remote communities?

Dr EVILL: Everything from a town where there is only one doctor looking after the hospital and a nursing home and 24/7 on call.

The Hon. WALT SECORD: And you have been in those situations?

Dr EVILL: Absolutely.

The Hon. WALT SECORD: What is the best way to support a health professional who is in a community like that?

Dr EVILL: One of the first things to do is to enable. Too many of the places that I work in, particularly as I come in as a locum, are there because the local doctor has found it too difficult or left. One of the common themes is that the local health districts, or even the local administration, has not been supportive when asked for help. When deficiencies are identified, it is too long for there to be a response. I think NSW Health is at a critical point now of paying very close attention to putting support into small rural hospitals, not creating problems. There are some serious issues, I think, with NSW Health administration which does not feed down to clear policy for local managers and clear policy for local healthcare workers.

The Hon. WALT SECORD: For instance?

Dr EVILL: Just recently I have been told—and this is a larger hospital issue—that the Lismore Base Hospital had a brand-new intensive care unit built. Nurses identified that they could not see all of the beds properly in order to provide proper intensive care and when they asked for extra staff this was not forthcoming. The intensive care unit has been closed and is currently being used as a COVID vaccination clinic. I think that is a glaring example of poor administration and poor thought about it.

The Hon. WALT SECORD: Just so we have this in context, an intensive care unit—

Dr EVILL: Yes, it is new 14-bed—

The Hon. WALT SECORD: What kind of ailments or treatments would occur in an intensive care unit?

Dr EVILL: These are people who require basically life-support to stay alive. That is probably that in a nutshell but the sort of people who end up there are people who have had critical incidents in surgery or who have come in with severe system failure. So they may be cardiac patients, they may be respiratory, but they are on life support.

The Hon. WALT SECORD: And they have closed this?

Dr EVILL: They have gone back to the old one.

The Hon. WALT SECORD: So there is a brand new one—

Dr EVILL: The brand new one does not have any patients in it. I could refer to other issues. Again this is a Lismore one but it exactly parallels the evidence that you heard from the doctor from Coffs Harbour AMA surgeon about ridiculous demands being put on junior doctors and senior doctors for time. I am aware that there have been complaints in Lismore, at least, where people have not been paid overtime for coming back on-call.

These things are not addressed so when a complaint is made it takes forever to get a response. This contributes to that ongoing grind where people look at that and say, "Why would I want to do that?"

The Hon. WALT SECORD: I was going to say does that then, in fact, drive people back to the city?

Dr EVILL: It certainly makes it look difficult. In Bellingen hospital at the moment, which is run by general practitioner visiting medical officers who provide both inpatient and emergency care, they have recently been told by the LHD that they are not allowed to continue to work in the hospital if they only cover emergency. The contract says, which I do not believe it does, that they are supposed to do both ward cover and emergency or they cannot do anything at all. This is leading to a considerable amount of angst amongst the local doctors, some of whom are excellent rural generalists with excellent general skills and emergency skills.

This kind of thing, if it were unique, it would be fine, but in the Rural Doctors Association what we hear is constantly this level of complaint in one place or another. It is very commonly where the administration has not been responsive, has made what appear to be arbitrary decisions, and very often persecute the person that has complained. It is a very toxic sort of a thing and you could attribute some of those statistics that Mr Colbran referred to about the reduction in the number of rural generalists who have just thrown up their hands and said, "I can't do this."

A rural generalist in a small hospital does not have junior medical staff so a lot of the things that come down assume that you have got a registrar, a junior doctor or somebody to do the leg work, the note keeping and all of that sort of stuff. So every imposition that comes in takes away time that that doctor has. A rural generalist in a small town has a general practice which, as has been alluded to, is Medicare funded. They will be on-call for emergency and will have to do ward rounds on admitted patients at some point. As a solo doctor that is an incredible imposition. I have worked in some places where it is completely unsustainable. I have worked in Casino hospital, which is a busy hospital, which has alienated all of the local GP VMOs. So there are capable doctors in the community who will not come to work in the hospital, in the emergency department and, to a certain extent, the wards are dependent on locums and rotating persons from Lismore.

The Hon. WALT SECORD: So what happens to the patients? Who is giving them treatment if the local doctors will not work there?

Dr EVILL: Locums, of which I have been one. I have spent a weekend in Casino on my own looking after the wards and the departments. I saw 105 emergency patients through the emergency department.

The Hon. WALT SECORD: One doctor for 105 emergency patients?

Dr EVILL: Yes, over two days.

The Hon. WALT SECORD: You must be running from person to person.

Dr EVILL: What happens is you sit in the emergency department and just keep seeing them as they come in and they are triaged by the nurse and you sort them out and see the urgent ones as quickly as you can. But I could not leave the department for 32 hours out of 48.

The Hon. WALT SECORD: So you worked 32 hours continuously.

Dr EVILL: Physically in the department.

The Hon. WALT SECORD: Let me say that again: You worked 32 hours continuously by yourself? You had nurses?

Dr EVILL: I will just give a call out to nurses here. One of the issues is that some of this applies equally well to nurses. We are running out of nurses. We are running out of nurses who have that good general experience that support the doctor, and I absolutely cannot work without them, and we are running out of them. Had I not had some excellent emergency nurses who, by the way, also did obstetrics when they were not doing emergency, worked as scrub nurses and worked on the wards. So you need nurses that have all that range of skills. If you are going to run the small rural hospital you cannot run it with specialty nurses.

The Hon. WALT SECORD: Why would you put yourself in a situation where you are the only doctor working for 32 hours?

Dr EVILL: Well, I was not quite expecting it to be quite like that, but it happens, that is the point. Things are a little better in Casino at the moment because they now have locums who work 12 hours on and 12 hour off. The same applies to Inverell hospital where I was recently.

The CHAIR: We are sticking to the times.

The Hon. WES FANG: I just wanted to ask when this was.

The Hon. WALT SECORD: When you say locums, just for people to understand, that is a doctor who comes in.

Dr EVILL: Yes, that is me, a gun for hire for small rural towns. So I will come in and cover whatever services are required. Sometimes it is a bit ridiculous. I have been in situations where I have been in Wellington 24/7 on call for a week. I cannot do that for two weeks in a row. I have got to take some time out so I come in and do it for a week. Sometimes it is okay; sometimes it is ridiculously busy. But it is a bit the same as what you were hearing from the surgeon this morning. You just keep going until you get it done; that is the only way.

The Hon. WALT SECORD: How would you feel at the end of a full week being on call in a small community like Wellington? You must be just completely—

Dr EVILL: Very tired.

The Hon. WALT SECORD: Very tired, but you cannot stop because you would obviously feel an obligation.

Dr EVILL: Yes. If they call, I come.

The Hon. WALT SECORD: That is extraordinary.

The Hon. WES FANG: Dr Evill, can I just ask quickly—

The Hon. WALT SECORD: Wesley.

The Hon. WES FANG: —and then I will be done.

Ms CATE FAEHRMANN: He is just asking when.

The Hon. WES FANG: I just want to find out, when was the incident in Casino that you mentioned?

Dr EVILL: That particular instance was probably of the sort of six- or seven-years-ago range. Things have changed now. They are not employing a locum to cover 24 hours straight or indeed an entire weekend. In Inverell, where I was recently doing the fast-track clinic to take the pressure off the emergency department, they are working locums 12 hours on and12 hours off. These people come for a reasonable length of time.

The Hon. WES FANG: I just did not want to have—

The CHAIR: Wes.

The Hon. WALT SECORD: Mr Colbran, is he an outlier or are there doctors across the State in the same situation? He is not just one man this is happening to. It is happening to other doctors, is it not?

Mr COLBRAN: There are situations definitely that Dr Evill speaks to that we are familiar with across New South Wales. What is interesting, though, is that things have peaks and troughs—

The Hon. WALT SECORD: I understand that.

Mr COLBRAN: —depending on resourcing and administration support; that type of thing. But it is a common story for us and that is one of the reasons I mentioned the welfare of the doctors is so important and also one of the reasons we talk about this remote, rural and regional perspective because it is presented in different ways in different parts of the State at different times.

The Hon. WALT SECORD: You must get a doctor, like Dr Evill, who will call you up to say, "I have been out here for seven days now without a break." What do you tell them?

Mr COLBRAN: Yes. We do take those phone calls and we—

The Hon. WALT SECORD: What do you say to them?

Mr COLBRAN: Most placements would not go longer than a week if it is a locum place or a relieving doctor place. We tend to work with a core group of doctors who might be participating in that relieving roster, like Dr Evill, and we would look to make sure that they have got respite time and that they are prepared to manage their diary so that they are not doing weeks back to back. It does take a lot of navigation and a lot of targeted planning. I think you will find that in instances where there is very strong planning and good cooperation, the situation is manageable. Most of the doctors we speak to enjoy the challenge that their work brings. A rural doctor enjoys the challenge that they face. However, I think the things that we hear from the Rural Doctors Association shows more needs to be done.

The Hon. WALT SECORD: I think you are understating it. I think it is a bit more than a challenge.

Mr COLBRAN: Yes.

Dr EVILL: Just to clarify a bit, I do take breaks between doing locums; I cannot do it continuously. But most of the locums that I do are for those places where the doctors have given up and the hospital cannot find anyone to cover. So it is not everywhere but it is common.

The CHAIR: It is common. Is that the word you would use?

Dr EVILL: Yes. But having said all that, I would like to also say that I have just recently done a tour of southern New South Wales in the name of the Rural Doctors Association and spoken to rural generalists who absolutely love what they are doing and who are having a fantastic time and would not do anything else. I do not want to paint a picture of disaster. Like I said, we have a great healthcare system; there is a lot of good things.

The Hon. WES FANG: That point is really important because we need to focus on the good as well as—

The Hon. WALT SECORD: Wes.

The CHAIR: We have worked out what the terms of engagement are in terms of questioning. We may return to the Hon. Walt Secord if there is any time but it is the Hon. Emma Hurst's time for questions and then Ms Cate Faehrmann.

The Hon. WALT SECORD: I just want to say, I did not want to give the impression that I was critical. No, I am supportive and I think the work that you do is extraordinary.

The CHAIR: Thank you for clarifying. I did not mean to cut you off in that respect.

The Hon. EMMA HURST: I have a couple of follow-up questions for Dr Evill. We are going to speak with the NSW Nurses and Midwives' Association later but I want to talk about the comment you made that we are running out of nurses. Could you expand a bit more on that? The other thing that you said that really stood out to me is that doctors have given up in some of these areas. I am assuming that those two things are quite correlated. Can you tell us a bit more about what is happening there?

Dr EVILL: First to nurses, and I said that I work with some fantastic people who are nursing out there. There is a common theme though that the generalist rural nurse—and I use generalist advisedly because we are now starting to give specialised training to our nurses—is an aging breed. A good many of the nurses that I work with are over 40, and some into their sixties, who do it because they love it. That is a thing that probably is true to everybody that does this work; we love it. But the nurses are getting worn out. They also see that they are not being replaced. We still need that generalist—what used to be called the triple certificate nurse—if we are going to staff the rural hospitals with people that can give that support.

The CHAIR: I remind honourable members that we do have two very good experts who have got lots to say remotely. I am sure some questions will come but I want to make sure that everyone is aware that we have got two in the room and two via videoconference.

The Hon. EMMA HURST: Dr Evill, do you think that this situation is just starting to build up and get worse and worse? It sounds like there is a lot of stress and pressure at the moment.

Dr EVILL: I think you have already heard evidence from other people—I have been sitting here since nine o'clock and listened to some very good evidence—that there is a declining trend in the number of doctors and nurses available to work in these interesting positions. In the Rural Doctors Association we support people who are having difficulty in their workplace or negotiating with NSW Health, so we do tend to hear a lot of that stuff. But that is a common story that people have found themselves in a particular situation, not felt supported, battled and battled to try and get what they feel needs to be done and eventually said it is too hard and given up. I can give you endless stories, which is probably not very helpful. I would still like to say again, there are lots of places that are working really well.

There are a couple of things I would like to mention before I forget. I would like to unpick the question of telehealth. Telehealth is a term that is used and it means different things in different people's minds. The telehealth that most people think about is the video consult for which doctors are paid by Medicare, both the specialist at one end and the GP on the other end, and that involves having the patient and the specialist and their support, be that allied health or GP, together on a teleconference and sorting out a particular medical problem. That is the original one.

Telehealth is also often used to talk about making telephone consultations. I would like to support at least in part what Dr Charlotte Hespe said about the availability of being able to bill for telephone consults. The last one is the over-the-camera bed remote thing. What happens is, if somebody comes into a rural emergency department in New South Wales, there is a great deal of money being spent to provide fantastic cameras that can look at one of the beds in the emergency department and you can call in any sort of specialist, that is usually

supported by another emergency doctor somewhere, to advise you on what to do or help you through something that you might not be completely familiar with or to assist in the assessment of a patient. That is an absolutely fabulous service. I would like to particularly congratulate all of the doctors that provide the other end of that.

As I was going through southern New South Wales I heard some great stories from people who said that the support and education that they had had helped them build their confidence and enabled them to stay in the community. So that sort of telehealth is a fabulous service and we should recognise NSW Health for providing that. It usually is very timely; you usually get people quickly and you usually get the right person. So that version of telehealth we fully support, but it is too expensive to roll out outside of hospitals and it is extraordinarily useful. I just wanted to say that. So when people talk to you about telehealth they may be meaning a number of different things and you may need to be a little bit clearer about what that is.

The CHAIR: The Hon. Cate Faehrmann.

Ms CATE FAEHRMANN: Thank you, Chair. I might just throw to the Australian College of Rural and Remote Medicine [ACRRM] now because I note in your submission you also talk about telehealth and the unintended perverse telehealth outcomes. I wondered if you could expand a bit upon what that is, recognising the benefits of course as well, some of the benefits that have arisen during COVID particularly.

Dr MARTIN: Thanks for the question. ACRRM is certainly one of the early proponents of using telehealth as a support and assistance device for remote practice. The way that Charles describes it is certainly a very clear outline of the levels. One of the challenges and one of the things that we progressively observe is that means that the patient no longer gets physically seen sometimes by a specialist when they probably every now and again need to be seen face-to-face and examined by that specialist. There are ways around it. Certainly we are always guarded and very careful about how far and wide telehealth can be applied in some settings.

Charles is exactly right, it is a great relief to be able to switch on the doc in the box, as we often call it, if we are away from a place where there are plenty of doctors to be able to get a second opinion on or get someone to look at. The great peril is that you cannot substitute a high-definition camera and a good microphone set-up for being able to physically look at a patient from the end of the bed and lay hands on. Similarly, it helps assist diagnostic decisions but it does not help with management; it does not allow you to try to teach someone how to cannulate if there is no doctor in town or if the doctor does not have enough experience in town—that certainly is not helpful. But that comes from me; we built an entire remote patient monitoring system here to be able to deploy in Armidale, but it is a tool, not a complete solution.

Ms CATE FAEHRMANN: Thank you. Mr Colbran, the figure you quoted in the opening statement of the 800 generalists being reduced to 200 now, did you say? That is an extraordinary figure. Have you undertaken surveys of the doctors who have left in that time? What are the key reasons? You are nodding.

Mr COLBRAN: We are very familiar with this. Everyone in the sector is very familiar with this situation. The numbers sound drastic but there are reasons for it and some of the reasons are that the system is changing and evolving. Ten years ago the health system was different to what it is today and the nature of medicine and the nature of healthcare delivery is different. So I would not so much focus on the change as opposed to talking about the fact there is now less than 200. What we are realising is that—and this is across the country—if you look at the National Rural Generalist program and the rural health commissioner's work in terms of the discussions about the importance of the rural generalist doctor, this is a conversation that is happening across the country.

Where I think we have got to in New South Wales is that you get to a point where you say we must now focus on this because these are the doctors, as we have heard this morning, that do keep our remote and rural public facilities open. They often are engaged in contract-type relationships or as visiting medical officers into these facilities, and this is this very important intersection of the Federal Government health system—the primary healthcare system—and the State Government system, which is the hospital system, and the intersection is at this point where the rural generalists need to be engaged, embraced, encouraged and supported to sustain themselves. Whether they are permanently placed or locum placements—it actually can be either; it is does not necessarily need to be a permanent placement—we like the idea, we want to see doctors putting down their roots in their local communities, but the idea of one town, one doctor for 40 years does not exist anymore and that is unrealistic.

So much of the work that we all do now is to work with our local communities in the rural and remote regions to have them understand and appreciate and actually buy-in to this idea of the rotating model of the medical practitioners. We think if we can get three to five years out of a doctor putting their roots down with their families, that is a superb outcome because, as we know, across all sectors at the moment younger people transition their way through a life of different careers. So we look to really celebrate and appreciate the contemporary social experiences that people are looking for.

The Hon. WALT SECORD: Dr Evill, I am trying to get a picture of what you do. What you do is you go around the State, 28 different towns, and if you are called upon to do a last-minute—to use a baseball analogy—pinch hit, you come in and pick up when a doctor is unable to do so. Do you improve your skills or do your skills drop? Do you find that because you are doing different situations in a rural town, your skill set becomes enhanced or does it become diminished? I have met dentists in the Northern Territory in remote communities and they said that their skills go down because all they do is deal with extractions and emergency things. What is your experience of the treatment?

Dr EVILL: I would say skill sets remain about the same. There is very little opportunity to enhance your skill set while you are doing this sort of thing. However, certainly consultations with the camera in the box thing have helped; I find that useful. I maintain my skill sets by doing some professional development work outside of work, but I guess by just keeping on doing things you maintain your skill sets. There is a thing called imposter syndrome which pretty much every rural doctor has.

The Hon. WALT SECORD: What is that?

Dr EVILL: That is that "I feel inadequate".

The Hon. WALT SECORD: What do you mean?

Dr EVILL: Any time I go to a job I am thinking about what happens if something goes wrong and I do not know what to do with it.

The Hon. WALT SECORD: Why do you persist then?

Dr EVILL: Because if I am there that is the best they are going to get.

The CHAIR: The Hon. Wes Fang.

The Hon. WES FANG: Thank you very much to all the witnesses who are appearing today, and apologies to those on the screen, I do have my back to you, but unfortunately the microphone is in front of me. Mr Colbran, your opening statement was remarkable; I think it really spoke to what my understanding is of rural doctors' and regional doctors' experiences and I wanted to drill down on some of that stuff initially because you touched on probably one of the biggest concerns I have got at the moment, which is the ability to attract doctors to rural and regional centres when we have inquiries such as this where we hear stories of difficulties in the workplace and then when we drill down on it they were six or seven years ago, for example. What do you see as the difficulties and what challenges would hearing those sorts of stories have with the morale of a workforce in a remote and rural setting?

Mr COLBRAN: I may have heard two streams of questions there: One is around the process and the opportunities to attract people to work rurally, and the second around morale and wellbeing. So if I may just talk to the attraction part first? It is actually in a very exciting time in rural health nationally; there is a superb group of young people coming through the training pipeline both in the medical professions and other health professions. There is some superb work happening through the university sector at the moment with support from both State and Federal governments in attracting young people or early career people to come through on a pathway towards rural. If I may refer to some of the comments that Dr Evill mentioned, we are talking about a very special breed of person. These are people who are dedicated to community, to their vocation and what they believe in. They do take up the challenge. While it is challenging, they do take it up. They are looking for that professional inspiration and opportunity. There are opportunities for people and they are coming through.

I think our role as a sector, and I include everybody in this, is to ensure that, where there are those barriers to placing people into a lifestyle of rural practice, we work our way through those. They are real, they are there and many of the submissions that I have read articulate some of those. It is not a dire case that there is no-one who wants to work rural. I think it is completely the opposite. There are rural born and bred people who want to work rurally, there are metro-based people who want to work and live rurally, and there are also international people who want to come to Australia to work rurally. Our job as the profession and the sector is to create those opportunities and to land them and to support them.

In terms of morale, I repeat my earlier statement that we are very concerned about how the people who we are talking about—the workforce out there in whatever role they have and that includes health administrators—are supported and encouraged to be the best they can be and that there is a community conversation that goes beyond just the negative issues and actually looks to support people. Because if we lose them, they will not come back and that is a very real issue at the moment.

The Hon. WES FANG: When we are talking about an inquiry such as this, where there is a tendency to focus on the negative aspects around rural and regional health, does that paint a fair picture of the state of rural

and regional health or is it the fact that we are not actually focusing on a lot of the good stories that are out there by the people who are dedicating themselves to their communities? Is that presenting a perverse view of what the health system is?

The CHAIR: Can I just interrupt the Hon. Wes Fang. I understand his line of questioning and it is up to him to ask questions as he sees fit, but he is well aware of the terms of reference.

The Hon. WES FANG: Yes, and I am well covered by the terms of reference, Chair.

The CHAIR: This inquiry has received a great deal of evidence, as you know, through submissions and oral evidence. So the way in which answers are coming back and forth and the way in which people are answering them is the way they wish to do so, and you are entitled to continue that questioning. But this inquiry, as you know full well, is looking at both the positives and the negatives in regard to the matters in the terms of reference.

The Hon. WES FANG: I believe I did that. That is exactly what I stated.

The CHAIR: I just think it is important you appreciate that—

The Hon. WES FANG: That is exactly what I stated, Chair. What is the point that you are raising here? Is it that you do not want to talk about the good stories?

The CHAIR: Now you are reflecting on the—

The Hon. WES FANG: I am asking what the point was of interrupting my time and questioning with the witness to raise that. What was inappropriate about the question that I asked?

The CHAIR: If you would like to continue the discussion, we can have the discussion now if you would like.

The Hon. WES FANG: No, I would rather hear from Mr Colbran about the good stories that are happening in rural and regional communities around health and why it is really important that we focus on some of those things and show doctors, particular in the city areas, why they might want to practise regionally.

Mr COLBRAN: I have one comment to make. Then, if you would not mind, I would like to pass to our chair, Dr Kramer, because he is a practising GP.

The Hon. WES FANG: I would love to hear from him.

Mr COLBRAN: One of the examples I may give quickly is that for the last 20 years there has been a program running in rural New South Wales called the rural medical cadetship program which looks to provide a wraparound support opportunity to early career doctors who are born and raised rurally. That program has become internationally renowned. I do not have all of the figures in front of me but we could provide that if you are interested. It is a program funded by the New South Wales Government and administered by the Rural Doctors Network. Across the 20 years, close to 400—I think it under that but close to 400—early career doctors have been supported in their career trajectory, and we have a retention rate of close to 50 per cent of those doctors. So one of the things we do find, which will be a common theme that you will see in our submission, is where there is well-planned and well-supported initiatives, be they in community or with particular workforces, we have great success because that program is internationally renowned. But Dr Kramer is well experienced in what he sees in rural New South Wales as well.

Dr KRAMER: I am feeling like a little bit of a dinosaur. I am 67 years old, so I represent the aging rural workforce and I have been in my town almost 40 years. But I love my job. I did four years as a solo GP when I started and the area grew. The population has actually increased about tenfold in that time. It also represents yet another model of practice in the country in that it is a rapidly growing coastal area. We have no hospital. The nearest is a base hospital half an hour away. We have to deal with people turning up with chest pain, asthma attacks, fractures, lacerations et cetera. My only point there is that there are so many different models of care in country towns that solutions to the problems have to be flexible. You cannot have a one-size-fits-all solution. That is doomed to failure. You have to be able to adjust it to the local needs.

One of the things that has kept me going is being involved with training. I have had GP registrars—young GPs learning the trade—for the last 30 years now and also medical students coming through. Rural training has really been running student wide—undergraduate wide—through the rural clinical schools for 20 years in our area now. We are starting to see retention of those. I have one of those doctors working in my practice now. That is very rewarding being involved. It also helps to keep you interested. We have to train our successors. Succession planning is a constant theme in our work.

The Hon. WES FANG: Mr Martin, my last question will be to you. I was very fortunate to have had a lot of experience around rural and regional health and part of that experience was my late father-in-law was a rural

generalist. He was trained in South Africa. He practised in Scone. He was able to perform a raft of services as a GP but also at the hospital. He noted that his ilk were slowly diminishing and I think that is certainly the evidence that we have heard. Can you provide us some insight as to why training rural generalists now and seeing an increase in that workforce is important for the provision of health services, particularly in rural and remote areas into the future?

Dr MARTIN: Certainly what I have seen—because Charles Evill and I are originally from Queensland but also certainly in New South Wales—is that we do have this crop of well-oriented, motivated, emotionally mature junior doctors who we certainly see come up the rural generalist program in New South Wales. We might be down to 200 but there were 50 that were in last year's intake, which is useful. Our issue now is to be able to make sure that we have got them trained well and that they have good access within the New South Wales hospitals as well as the general practice system, but also that those doctors are well cared for and nurtured in their early parts of training.

The doctors of your dad's ilk had different training settings around them and different expectations. They were trained very broadly. This generation of generalists have grown up constrained, probably appropriately. But the pinch point that we are approaching—and certainly we see this in the rural generalist program that I am a member of the steering committee—is that we may well have this group of 30, 40 or 50 doctors a year, but the John Kramers and the Charles Evills and the Rod Martins may not be there long enough to be able to do that nurturing role. Because as soon as we have enough of these people who have got motivation, orientation, training and resilience to be able to go and work in the Tenterfields and Casinos and Tumuts and places like that—when they have got that proximate backup of someone with a bit more grey hair, at least for a few years, they can generate that confidence and then they look after the communities.

It means that we do have a physical doctor in some of the towns that have had adverse outcomes who is capable not just of making the diagnosis but also doing the management. The expectation of a rural generalist is that if they are in that town, they have the skills to look after that town and, for example, they are not temporarily establishing an intensive care unit for two hours while they are waiting for retrieval to turn up. We need to make sure that there is enough generational crossover. Our numbers look okay, but the generational issue and making sure that the training endpoints and the good, solid, deliberate and precise assessment adequately fits them for the Tumuts and the Tenterfields and the areas where these—our sick patients are still going to turn up. They are still going to need someone there for the first two to four hours.

The Hon. WES FANG: Thank you very much for the work that you do around mentoring those trainees because it is really going to be so vital for our communities moving forward.

Dr EVILL: I would just like to have a little bit of a go at answering Mr Fang's question, if that is all right, or have you run out of time?

The Hon. WES FANG: I might put something on notice to Dr Evill just so that you are able to provide us with—

Dr EVILL: I will be very quick. I do not want to paint a picture of disaster in NSW Health but there are critical issues about support for hospitals. It is no good training rural generalists if there is nowhere for them to work. NSW Health has a problem, particularly in its internal decision-making and some of the culture. Pay attention to that, please.

The CHAIR: Thank you for making that point. The Hon. Wes Fang may indeed decide to place a question on notice if he wishes to. Thanks to you all and to your respective organisations for the excellent work that you have done and continue to do to enhance and improve both the availability and the quality of health services outside our large metropolitan areas. I appreciate it very much.

(The witnesses withdrew.)

(Luncheon adjournment)

BARBARA TURNER, Health Service Manager/Nurse Practitioner, Australian College of Nurse Practitioners, before the Committee via videoconference, affirmed and examined

BRETT HOLMES, General Secretary, NSW Nurses and Midwives' Association, affirmed and examined

KRISTYN PATON, Registered Nurse and Branch President, NSW Nurses and Midwives' Association, affirmed and examined

The CHAIR: Welcome to you all and thank you for making your time available. I note for the record that the Nurses and Midwives' Association has provided three submissions—numbered 258, 258a and 258b. The Australian College of Nurse Practitioners has provided a submission, numbered 259. All submissions are publicly available on the Parliament's website.

We have limited time, unfortunately, because there is so much to get through. We encourage witnesses and their organisations to try to keep their opening statements as brief as they can. If they have prepared quite a long opening statement, which sometimes does happen, it may be tabled and will be incorporated as part of the opening statement. So there is no issue of being truncated, but if we keep the opening statements relatively short that will open up the maximum time for questioning.

Mr HOLMES: Not surprisingly, there is so much to be said but there is a crisis in health care delivery and in healthcare services across rural, regional and remote areas of New South Wales. This is most evident in smaller communities, particularly in those serviced by small community, or D, hospitals and multipurpose services. The Government promised a few more nurses in the base or regional referral hospitals and district hospitals—that is, the B and C hospitals—but nothing for the small facilities. These health services are reliant on bare minimum nursing staff levels and very often without the assistance of any doctors being present. The shift to an increasing reliance on virtual doctors or telehealth does not acknowledge the fact that this has removed the very important pair of hands that doctors were once able to provide when they responded to calls for emergencies. And there has been no recognition that nurses are now forced to try and replace the hands of the doctors during these virtual referrals, as well as doing their own nursing role. It becomes an increasingly impossible task when you have an emergency such as a cardiac arrest.

We do not accept that telehealth is an adequate model of care in potentially life-threatening situations, for example, when there is no doctor present and only a nurse available. The nurse in this scenario must perform their clinical role of simultaneously acting as the eyes, ears and hands of the doctor. It is not safe for the patient and it creates an unreasonable level of pressure for the nursing staff. The notion that some of these local health districts have fixed this problem by saying that we can call in the ambulance paramedics to assist the nurses is fraught with the danger that they may be unavailable, again leaving the burden to lie on nurses. We have to fix this problem.

If we have to rely on virtual doctors, then numbers must be increased. There is no doubt a serious issue exists around the medical workforce which must be addressed as well. We need shift-by-shift nurse-to-patient ratios and we need minimum nursing numbers in our system—in our small districts and community hospitals and in our multipurpose services. We need at least the minimum numbers we have identified in our award claim to the Government. You have received the latest 2021 claim. That is, there should be a minimum of at least three nurses on every shift in every facility, two of whom must be registered nurses with skills and qualifications in first-line emergency care. We also need those nurses and midwives to be properly supported and to work in a safe environment.

Currently, the safety and security of our members, quite frankly, is at extraordinarily high levels of risk in these rural and remote settings. If this is not addressed, it is inevitable that there will be further tragedies in this area, and we will have all spoken about it and been warned. The question is: Will action have been taken? But if nothing is done, these facilities that operate in isolated areas, and do not have police or security available for hundreds of kilometres, then you must wonder how long it is before one of those tragedies occurs.

I will conclude by stating that the gross undervaluing of the role of nurses and midwives, who are expected to carry the burden of entire health services in rural, regional and remote areas—particularly after business hours—must be addressed immediately by this Government. The scale of these nurse staffing issues and lack of support is dire, especially if you consider how crucial our nursing and midwifery workforce is in delivering care, not to mention the critical need to attract young people to replace the aging workforce. Postcodes should not be the defining decision-maker of health care. We need safe staffing and safe working conditions in all regional and remote health settings to tackle the crisis. Thank you.

The CHAIR: Thank you, Mr Holmes, for a very clear and precise opening statement. I now invite Ms Turner to make her opening statement.

Ms TURNER: Thank you, Chair, for the opportunity to speak at this important inquiry on behalf of the Australian College of Nurse Practitioners. The Australian College of Nurse Practitioners is the national peak body for nurse practitioners and, with regard to this inquiry, represents those that live and work in rural, regional and remote New South Wales in both private and public practice.

The Australian College of Nurse Practitioners is particularly active in improving access to health care and the first nurse practitioners in Australia were authorised and worked in New South Wales, and this was some 20 years ago. The role of the nurse practitioner—to provide some background—is to improve access to treatment, provide cost- effective care, target at-risk populations, provide outreach services in rural and remote communities, and provide mentorship and clinical expertise to other health professionals. In some circumstances nurse practitioners provide patient rebates through Medicare through the Commonwealth, they can refer patients to hospitals and specialists, can order X-rays and diagnostic tests and are registered with the Nursing and Midwifery Board of Australia. Their role as a nurse practitioner is not to replace any other health practitioners; it is to fill gaps in health care and work together with others to improve access to care. Nurse practitioners work across all specialties in health.

It is the opinion of the college that there is much work to be done in all of rural, regional and remote New South Wales. Some of the issues that the college has identified in rural, regional and remote New South Wales are access to health, barriers for people including distance to travel and cost of services. One example is a lady who had breast cancer quite some years ago now. She was surgically treated in the city and then required radiotherapy. The treatment regime requested was for 12 weeks. This lady and her husband did not have the financial capacity or support to stay in the city for 12 weeks. Being in the city for initial surgery had already taken most of their personal resources. After much discussion this lady had her therapy doubled per week and condensed into six weeks and she was warned that although it might be life-saving she may have some scarring and ongoing skin issues. She had no other options for care and her story is that she is alive but has had terrible scarring and pain from the treatment and still suffers to this day.

A nurse practitioner may not have been able to prevent these particular circumstances from happening but would have been able to provide ongoing regular support to this lady in her own community when there were no GPs available. I think this is an outstanding example of where nurse practitioners can step in and provide care. The lack of nurse practitioner access to Commonwealth Closing the Gap Medicare initiatives and the lack of access to section 19 (2) exemptions, even in communities that meet the Commonwealth Government criteria, impact on services being provided in rural, regional and remote New South Wales areas where there are nurse practitioners living and working. It is the opinion of the college that New South Wales communities that meet the requirements for the section 19 (2) exemptions should automatically have the exemptions applied by NSW Health. The process for these applications individually is reported as being onerous and time-consuming.

The college is of the opinion that having this application process streamlined by NSW Health would provide better and quicker access for communities that could be receiving more services in a timely manner. Nurse practitioners can provide services under this exemption while working for NSW Health. Populations may be decreasing in some regional, rural and remote areas of New South Wales, however the care needs become more complex as people are aging and are very complex for our Indigenous peoples. Technology, including wi-fi and phone services, access in rural, regional and remote New South Wales is often unreliable and is also a barrier for provision of services including by nurse practitioners. I thank you for the opportunity to outline some of the background and issues that the Australian College of Nurse Practitioners believe impact on health outcomes and access to health and hospital services in regional, rural and remote New South Wales areas.

The CHAIR: Thank you, Ms Turner, for your considered and thoughtful opening statement which I am sure will lead to some questions from members. We have three tranches of 14 minutes across the Opposition, crossbench and Government members. I assure both organisations that it is an absurdly short time to get through all we want to get through so I am foreshadowing—and I am sure you will not be surprised to know—that quite a few questions on notice will be coming from Committee members after the hearing to inform us further. The submissions have been very helpful and the questions will elucidate a lot of information but we do have this time pressure which is beyond my specific control. We will start with the Opposition. The Hon. Walt Secord.

The Hon. WALT SECORD: Mrs Paton, I hope you do not mind if I ask you a few questions. Are you employed in a country hospital?

Mrs PATON: Yes.

The Hon. WALT SECORD: Where do you work?

Mrs PATON: I am a registered nurse in a rural remote multipurpose service [MPS].

The Hon. WALT SECORD: Which one?

Mrs PATON: Tumbarumba.

The Hon. WALT SECORD: This morning we heard evidence from the president of the Rural Doctors Association and he talked about working in the Casino hospital emergency department. He was the only doctor for 32 hours and saw more than 100 patients. I said, "How did you get through that?" And he said, "I would not have if I did not have the nurses." One person in an emergency department for 32 hours.

The Hon. WES FANG: Six years ago though.

The CHAIR: Order! We have agreed upon the terms of engagement. We have had this discussion once. I ask members to respect what we have agreed to collectively in dealing with the questioning. Please continue.

The Hon. WALT SECORD: Mrs Paton, I shared that story with you because I was wondering what your experience has been at Tumbarumba MPS. His experience was that he would have been troubled if it was not for the nurses; they were the backbone of the system.

Mrs PATON: In Tumbarumba we have one doctor on call. We have two medical centres. There are two doctors in one of the medical centres and only one has visiting rights to the hospital. The other medical centre is a locum that comes and goes. We only have the one doctor that actually visits there. His family live away from Tumbarumba so he is often out of town visiting. Last year we had absolutely no doctors on call; it was just the nurses at the hospital for up to four months in one block.

The Hon. WALT SECORD: Sorry, no doctor for four months?

Mrs PATON: No.

The Hon. WALT SECORD: What did you do as a medical professional?

Mrs PATON: We have the telehealth service which is good but we need the pair of hands, we need the extra eyes. Some nurses at the service have done courses that increase our scope of practice in this situation. It is called the First Line Emergency Care Course. There are interventions that we can do but it does not replace the fact that there is no doctor there. A lot of the time our patients for simple assessments and treatments have to be transferred 1½ hours away on a road that is absolutely terrible.

The Hon. WALT SECORD: How do you feel about tele-medicine?

Mrs PATON: It is not a bad thing. It has its place but it should not replace hands-on assessments. We get patients assessed over the videoconference but the doctors need their hands-on assessments not just video; you have your smells, you have your sight, you have your feel. Some nurses are just not skilled enough to be able to perform these assessments, whereas some of us are.

The Hon. WALT SECORD: What was your reaction when you found out after four months that you were finally getting a doctor?

Mrs PATON: Elated—support. With no doctor in town there is just no support.

The Hon. WALT SECORD: Did you feel there was a lot of pressure put on to you as a nurse?

Mrs PATON: Yes, there is always a lot of pressure.

The Hon. WALT SECORD: You described something called a frontline course?

Mrs PATON: Yes, the First Line Emergency Care Course.

The Hon. WALT SECORD: Is that for situations like this?

Mrs PATON: Yes. It is for MPSs that often work with no doctor on call.

The Hon. WALT SECORD: And what does an MPS do?

Mrs PATON: Our multipurpose centre has an emergency department, a medical ward and we have residential aged care facilities.

The Hon. WALT SECORD: So it is an all-in-one shop.

Mrs PATON: Yes. And we often only have one registered nurse looking over the whole thing at a time.

The Hon. WALT SECORD: Do you do long shifts and overtime?

Mrs PATON: Yes, there has been a lot of that.

The Hon. WALT SECORD: That is not by choice, is it?

Mrs PATON: Not really. It is more by obligation.

The Hon. WALT SECORD: Do you feel an obligation to your community that you have to do this?

Mrs PATON: Yes. I grew up—I have lived in this community my whole life and a lot of the staff that work there have also lived there their whole lives.

The Hon. WALT SECORD: The doctor that you have there now—you do not need to go into details about the doctor personally. So, the doctor is in the hospital. Does that person work long shifts too?

Mrs PATON: He runs his GP clinic during the day and he will come to the hospital if we call him, if we have an emergency or a situation.

The Hon. WALT SECORD: Do you have friends who are nurses in other communities?

Mrs PATON: Yes.

The Hon. WALT SECORD: Do they tell you similar stories?

Mrs PATON: Yes.

The Hon. WALT SECORD: What are those communities that have similar stories? Are they in the mountains in southern New South Wales?

Mrs PATON: Yes, everywhere.

The Hon. WALT SECORD: Everywhere?

Mrs PATON: Yes.

The Hon. WALT SECORD: Mr Holmes, is Mrs Paton's story an outlier or something that you hear quite often?

Mr HOLMES: Most unfortunately, it is not an outlier. This is reported. There are 90 MPSs across New South Wales and they all have the same problems with inadequate staffing. There is this idea that because statistically the incidents look small to the Ministry of Health it is unnecessary to staff for emergencies, and that you can rely on other emergency services, such as paramedics, being somehow available when the crisis occurs—assuming they are not elsewhere in the community. It is common that we have one registered nurse on duty, particularly after hours.

During Monday to Friday you will have your nurse manager and then you will have your registered nurse and enrolled nurses or assistants in nursing looking after aged care. But one registered nurse at Tumbarumba is covering 28 aged care residents—nine acute care—plus the emergency department. When someone presents to the emergency department it is often the case—and Mrs Paton can talk about what it is like now with COVID—that they expose themselves by having to go outside by themselves in order to take the temperature of a potential patient before they come in. If I could defer—

The Hon. WALT SECORD: Yes, please. Can you share an experience with us?

Mrs PATON: Yes, sure. We have almost a brand new hospital. It is absolutely amazing. It was set up to protect the security of the staff. We were able to look at people standing outside the front door and then we could remotely let them in—

The Hon. WALT SECORD: Yes, I have seen that.

Mrs PATON: —to protect ourselves. At the moment, because of the temperature checks, we have to go through three separate locked doors to go outside and take the temperature of the person standing at the front. They might look unthreatening on the camera, but it is not until we go outside and engage with that person that we are putting ourselves at a security risk. We are doing this 24 hours, so it could be at two o'clock in the morning.

The Hon. WALT SECORD: People show up at two o'clock in the morning for a COVID test?

Mrs PATON: No, not for COVID tests. It is COVID screening to let them into the hospital. We screen every single person who comes to that front door. Monday to Friday, it is usually the administration officer that does it. But after hours and on weekends—any other time—it is your registered nurse.

The Hon. WALT SECORD: What has happened with the 28 patients inside? Is it one registered nurse doing that and looking after the patients and the emergency department?

Mrs PATON: The registered nurse is supported by an enrolled nurse in the emergency department and the medical ward. In residential aged care there is usually one enrolled nurse and about three or four assistants in nursing.

The Hon. WALT SECORD: Okay. Mrs Paton, if I tossed you a magic wand, what would you want to see at Tumbarumba hospital?

Mrs PATON: More staff.

The Hon. WALT SECORD: More staff—as simple as that?

Mrs PATON: Yes.

The Hon. WALT SECORD: More nurses? More doctors?

Mrs PATON: More nurses.

The Hon. WALT SECORD: More nurses?

Mrs PATON: Yes.

The Hon. WALT SECORD: Would more doctors help, too?

Mrs PATON: Yes, it certainly would.

The Hon. WALT SECORD: Thank you. Mr Holmes, there was one part of your recommendation which jumped out at me. Number 11 says:

> That nurses and midwives are paid all their Award entitlements.

Is that not the law?

Mr HOLMES: Yes, it is. But what local health districts have done for some time with these small communities is operated on the basis that they will use the guilt and camaraderie of nurses to look after their colleagues. So, they do not pay or set up an on call arrangement. They just rely on—for instance, if Kristyn is on duty and needs urgent assistance, she has to get on the phone and beg one of her colleagues to come in, because none of them are on an official on call because they would have to be paid to be on call. We have this problem right across rural New South Wales where there is this abuse of the goodwill of nurses, expecting that they will respond to any desperate call. It is a pretty hard thing not to; it is their community.

The Hon. WALT SECORD: Mrs Paton, is it hard for you to say no? Do you just go in?

Mrs PATON: You just go in. It is what you do to support your colleagues and your community. We had an incident recently where I had to call two registered nurses to come in, in an emergency. If somebody calls in sick there is usually no-one to replace them. A lot of the time very recently, we are doing double shifts because it is really hard to get people to come in and work. They are burnt out and exhausted.

The Hon. WALT SECORD: How long is a double shift?

Mrs PATON: A morning shift and an evening shift, which is about 14 hours.

The Hon. WALT SECORD: Fourteen hours?

The CHAIR: May I ask a question? Could you please explain, Mrs Paton, why does the responsibility fall to you specifically to be the one to put the calls through to deal with the absences that you have become aware of? Why does it fall to you?

Mrs PATON: Because usually, at the time, we are the nurse in charge of the floor.

The CHAIR: Right.

The Hon. NATASHA MACLAREN-JONES: Could I just ask a follow-up question from that? I am happy to take it out of our time. I am a former registered nurse myself but I worked in the metropolitan area, though I have now moved to the regions. In relation to the on call matter and having to call colleagues, I am interested to know—Mr Holmes will probably be able to answer it in more detail. I recall when I was on the ward working as a nurse, the nursing unit manager would do the same thing—put a call out for even the people working there, asking them to do extra shifts and things. How does that differ in other areas where you are actually asking a colleague to come in and help out?

Mr HOLMES: If I could just clarify that—and this is the contrast. In a Sydney hospital, if they want operating theatre nurses to be on call, they pay them to be on call and they develop the roster—

The Hon. NATASHA MACLAREN-JONES: This was on the ward.

Mr HOLMES: The same thing should occur anywhere where you are calling someone in. You are expecting everyone to be available at all times, 24 hours a day, and not recompensing them for it. There is no nursing unit manager after hours. It is the "in charge of hospital", who is also the only registered nurse. This is a disaster because you can be in the middle of trying to save someone's life and you are supposed to be finding someone to come and help. It is an impossibility. You could have the doctor via teleconference—trying to talk to them and trying to get someone else to ring for you, or ring to get help, whilst you are doing the hands-on of the doctor, trying to help them do the assessment. This is an impossibility. The unfortunate thing is that it is the nurse on duty who faces the Coroners Court.

The Hon. NATASHA MACLAREN-JONES: But I am just clarifying—you are talking about being paid on call wages. This is not a wage issue; you are talking about staffing. I just want to clarify that.

Mr HOLMES: Well, there is the one thing about everyone having the obligation placed upon them to be on call. The award provides for an on call payment and it is not paid for because the hospital says, "No, we won't have an on call roster. We won't pay an on call. You just find one of your mates to come in when you need it."

The Hon. NATASHA MACLAREN-JONES: But that is standard across—like, that is usual practice where unless they have them on call in theatres—

Mr HOLMES: No, that is not a usual practice in a big city hospital.

The Hon. NATASHA MACLAREN-JONES: In theatres and things you have on call, but on the ward you would just be asked to do extra shifts.

Mr HOLMES: That is right, if you are on duty and if you want to. But this is—there is a choice factor. In a big city hospital you can say no and they can find someone else. In a rural area you cannot say no because they cannot find anyone else.

The Hon. WALT SECORD: Mrs Paton used the word "obligation". That is a bit different. Mr Holmes, you mentioned—

The CHAIR: We are conscious of ensuring the equitable distribution of time. Perhaps the following question and then we will move to the crossbench and Government.

The Hon. WALT SECORD: Sorry. Mr Holmes, you mentioned smaller hospitals, which are called D-level hospitals. There are 90 MPSs; about how many D-level hospitals are there? If you do not know, about how many are there?

Mr HOLMES: I do not know off the top of my head but they are community D1a and community D1b in the classifications of hospitals. For example, that might be the Wellington Hospital.

The Hon. WALT SECORD: I was going to say Crookwell, Wellington—that kind.

Mr HOLMES: That is right.

The Hon. WALT SECORD: What is happening at those hospitals? The same thing? Are there one or two doctors and the nurses are flat out? What is going on there?

Mr HOLMES: They can also have difficulties getting GPs to attend their EDs but it is not at the same distressing level because they are in bigger towns. Often there are a couple of GP practices that will support. Not everyone in a GP practice now will agree to be a visiting medical officer. The possibility is that you will have more staff in your hospital in the D hospital. It is a slightly bigger hospital but it is often the case that you will have a single registered nurse who is responsible for the emergency department and then they have to call people off the wards—so leaving their patients to assist in the emergency department. We have made that claim particularly about the smaller MPSs and hospitals; that minimum level of staffing is just so crucial. Even then it is not enough to do a proper resuscitation. This is an impossible situation that our members are put in and they are held to account for it. It destroys people. Kristyn Paton can talk about how hard it is to keep people in these rural centres—to recruit and retain.

The CHAIR: I apologise for cutting off Mrs Paton. We way come back but I will move now to the Deputy Chair, Emma Hurst.

The Hon. EMMA HURST: I will start with one question and then I will come back to Ms Turner. I want to ask a question about the submission from Mr Holmes and Mrs Paton. You note in your submission that

rural and regional nurses often miss out on training and professional development opportunities as well. Can you give me a bit more detail about that and what you think should be done to help address that issue?

Mrs PATON: Geographically, our particular facility is an hour and a half from the nearest major training centre. With the staffing as well it makes it more difficult. We get denied professional development and training because you cannot replace the shift, basically. To have the day off, if we are currently working to have the day off to go and do training or professional development, we need to be replaced on the floor. There is actually not enough staff to replace those who want to go away and do training and professional development.

The Hon. EMMA HURST: So it goes back to some of the other issues that we have been discussing this afternoon. It is all the same things piling up as well. What do you think the Government should be doing to help improve staff retention, to increase the number of staff and to ensure that all of these problems that you have identified—so that we can start to get some sort of relief for you guys?

Mrs PATON: We have had lots of new recruits come through over the years—lots of young staff with a lot of potential. We are just not able to keep them in the rural and regional areas. They are being denied professional development. Sometimes they want to come and expand their skills and they are just being denied these opportunities, so they move on to the next hospital. It is also a factor of being supported as well. With no doctor on call, being the only registered nurse on shift is a really, really big put-off for a lot of people. We have actually had agency staff come through who walk through the front door with their suitcase, they have found out that they are the only registered nurse on the floor and they have turned around and walked straight back out again. So if we had at least one other registered nurse working, that is a little bit more support.

Mr HOLMES: I would add that the other problem that we now face is that people who are prepared to work in rural and remote areas have a financial choice—the choice between New South Wales and Queensland. There are special benefits to working remote areas in Queensland that add up to about $25,000 difference in terms of the entitlements, plus they also get subsidised accommodation, professional development allowances, two weeks' professional development leave with paid travel, appointment and relocation costs are paid, fly-in and fly-out with their spouse and dependents, and recreation leave twice per annum. So if someone has an interest in working in these remote areas or in regional, isolated areas, there are plenty of financial incentives to go elsewhere. New South Wales wages are now below Queensland, which is a historical situation that we have never seen before in the life of our union, since 1930. Victoria is very fast catching up and South Australia and the ACT are all ahead. So if someone is able to move around then there are choices to be made.

The Hon. EMMA HURST: That is really good to have on record as well. Thank you. Ms Turner, I hope you can hear me. I only have a few minutes left but I have a couple of questions for you. The example that you gave us in your introductory comment was quite distressing about the cancer survivor who had to double her treatment because she could not afford to stay in the city. Is this common amongst the patients who many nurse practitioners are helping?

Ms TURNER: Yes, it certainly is. The college certainly has lots of examples of situations exactly like this, particularly from the more remote areas. The distance and cost becomes significantly more onerous the further out you are. So it is not uncommon.

The Hon. EMMA HURST: You also note in your submission that patients do not have equivalent subsidies for health care if they choose a nurse practitioner for their provider. What subsidies are patients actually missing out on if they are treated by a nurse practitioner?

Ms TURNER: That is more to do with the Commonwealth Government subsidies under Medicare. The rebates provided for patients are actually significantly more in some cases.

The Hon. EMMA HURST: You note in your submission that certification for nurse practitioners in and of itself is an issue. One of the examples you gave was that they cannot certify a death. What sort of challenges does this cause, about the certification of nurse practitioners?

Ms TURNER: Nurse practitioners are not able, as you stated, to certified death. Also in New South Wales they are not able to do WorkCover cases. There are several examples like that where if the nurse practitioner is working in a remote, regional or rural area and there is no doctor available, this then causes significant problems and time delays, particularly in the case of certification of death where it may be some hours before that person is able to be certified and then transferred through to the appropriate afterlife caregivers. Yes, it is about time delay and stress to families. In the case of WorkCover, it is about people in remote areas sometimes having to travel some hundreds of kilometres to see a doctor because then they actually need to be physically seen, whereas a nurse practitioner could have done it on site.

Ms CATE FAEHRMANN: I want to hear a little more about solutions, if you like. Mr Holmes, you very helpfully mentioned bonuses and special benefits in Queensland. If people are going to move remotely, I think potentially remote New South Wales versus remote Queensland is not such a big choice to make. You have the package here as well that we have just had a look at—your new ratios campaign. What are we talking about in overall costs for government to have to make to improve some of these things? I recognise it is a step-by-step process and we are talking billions, but that is the Health budget for you. Has the union costed any of this?

Mr HOLMES: I do not have the costings for the multipurpose services [MPSs] in D, but as I said, there are 90 MPSs and probably a smaller number of the D hospitals. The Government is committed to increase staffing in the Cs and Bs. There is still a lot more work to be done around that. In terms of rural, the increase of an additional registered nurse on afternoon and night shift is not insurmountable. There does need to be work in order to retain them and that work is about saying you will not be left alone, that you will be working in a safe and secure place and that you will get the support that you need to maintain and expand your clinical expertise. They are very basic things that are achievable in the current environment. The people of New South Wales, particularly those who live in regional and rural New South Wales, surely deserve no less than that.

Ms CATE FAEHRMANN: The Queensland Government has made a choice to do as much as it can and to fund benefits and incentives to get staff out to remote Queensland. It obviously can happen if that is the choice that a government makes. Mrs Paton, I will come back to you. In the evidence from various nursing staff, again the submission by the ANMF, one of the quotes particularly stood out—they all do of course—but this one states:

> Too often we rely on kitchen staff to "keep an eye on the patients".

Mrs PATON: Yes.

Ms CATE FAEHRMANN: It continues:

> There are no wardsmen, there are no security staff, there are no clerical staff after hours and frequently there is only a doctor on the end of the phone who is working in another busy emergency department in another hospital.

Mrs PATON: Yes.

Ms CATE FAEHRMANN: They are seriously getting kitchen staff to observe patients. That is not unusual?

Mrs PATON: No, that is common. If we had an emergency we have got the registered nurse, say myself, and my supportive nurse, which is an enrolled nurse. In an emergency I would take the staff from the residential aged care first, which is one enrolled nurse and an assistant in nursing over there. Once they are taken off the floor over there, there is nobody to look after 28 aged-care residents. So the kitchen staff then just keep an eye.

Ms CATE FAEHRMANN: Do the kitchen staff receive any special training to do this?

Mrs PATON: They do their basic life support, I believe, and that is it.

Ms CATE FAEHRMANN: They may as well be asking members of the public who have done basic life support training to come in and check patients.

Mrs PATON: Yes.

The Hon. WALT SECORD: Who made the decision to use or utilise kitchen staff? Were you forced to do it?

Mrs PATON: There is nobody else.

The Hon. WALT SECORD: There is nobody else?

Ms CATE FAEHRMANN: You find the nearest person.

Mrs PATON: We probably leave one assistant in nursing down there in the residential aged care and the kitchen staff to support them, that is, at the time.

The Hon. WALT SECORD: Do the kitchen staff say "We are part of this community" and they pitch in too?

Mrs PATON: Yes, they are usually walking around doing their thing there anyway, so they just get asked to keep an eye, to help. That is when we will call extra staff in, call them at home, see if they can come up and help. The paramedics, we call supportive services.

The Hon. WALT SECORD: Do you have paramedics coming in and staying in the emergency department longer than necessary just to help out?

Mrs PATON: Sometimes.

The Hon. WALT SECORD: Really?

Mrs PATON: That is if they are not on fatigue or they could be out of town. Tumbarumba has a very wide farming community. It is a huge area that come to this little hospital.

The Hon. WALT SECORD: The residents in aged care, are they high care or low care—the old classifications that used to exist?

Mrs PATON: Yes. No, it is all considered high care. Probably half of these people need two people to transfer and lift.

The Hon. WALT SECORD: How do you do it?

Mrs PATON: We just manage.

Ms CATE FAEHRMANN: When you refer to transferring and lifting, would that mean that some patients who need to be, say, lifted, are not because there is only one person there?

Mrs PATON: Yes.

Ms CATE FAEHRMANN: With regard to the impact on patient health, we know what that means when people are not rolled or lifted enough when they need to be.

Mrs PATON: Yes.

Ms CATE FAEHRMANN: What can happen? What can the consequence be?

Mrs PATON: They can get pressure areas. It depends if they are continent or incontinent. Sometimes in an emergency—we had an emergency that went for over two hours where there was only one assistant in nursing left to monitor the aged-care residents. They could not change those people. Some of those people need two people to perform hygiene needs. They have to lie there, stay there like that while we have got an emergency.

The CHAIR: Moving across to the Government. Given that two minutes of the Government's time has been used, 12 minutes remain.

The Hon. NATASHA MACLAREN-JONES: I want to touch on the doctors in rural, regional and remote areas. We know that it is a challenge to get doctors to those areas. Is it fair to say that it is an Australia-wide problem, in fact an international problem?

Mr HOLMES: My understanding is it certainly is an Australia-wide problem. I have only had discussions with a couple of the doctors' groups over the last couple of years about what we could do to work together to try to encourage a solution here. I know that some efforts are being made to look at new models of employment and new models of training and we are certainly supportive of that. It is absolutely critical that there is a team approach to the delivery of care. In rural New South Wales obviously that team centres often around—because they are the people there 24 hours a day—the nurses and then the doctors to assist. On a very small amount of time allied health may be available to come in once a week or something like that. The people in rural New South Wales deserve access to the full healthcare team and they are not getting it.

The Hon. NATASHA MACLAREN-JONES: Going back to getting doctors, Mrs Paton, I am interested to hear from your experience, particularly because you live in the community. What do you think is the challenge of getting doctors to areas? If we look back 30 years ago, 40 years ago we would have doctors in local areas, GPs, they would stay, invest in the family, all of those things. There are a lot of incentives that have been coming out, and we heard from the rural doctors this morning about some of the initiatives and they are trying to get doctors to stay in the areas. I am interested to hear your view and what you are hearing on the ground as to why we cannot get doctors there and why they are not staying.

Mrs PATON: I am not really sure how to answer that question. The doctor at the moment, his family lives away. They live in Melbourne. I think schooling, rural areas, they do not have the private schools. They have to travel an hour and a half, two hours to the closest private school. Incentives, housing, transport, activities for families in rural areas. You have got your football and your netball and that is basically it. You have got to travel. It does not matter where you go, you have got to travel at least an hour and a half to get to these activities. I think—I do not know—if there was more incentive for doctors to come to rural areas, give them somewhere to bring their families. It is an amazing place to grow up, it is a beautiful community and we have lots of amazing things there, but—

The Hon. NATASHA MACLAREN-JONES: It is a challenge.

Mrs PATON: It is.

The Hon. WES FANG: Mrs Paton, thank you very much. I live in Wagga Wagga so I know Tumbarumba very well and I just want to say thank you for supporting the community there. I think that is fantastic. I am listening very intently to what you have to say and, in fact, I would love to come and meet with you after this to have a look at the facility itself and to have a chat with you about that. I have some questions for Mr Holmes, so if you do not mind I will jump to him.

Mrs PATON: Sure.

The Hon. WES FANG: Mr Holmes, I have been listening very intently to your opening statement and the testimony you have given so far. Have you had a chance to estimate the number of nurses you think would be required to support a model that you would advocate for in remote and rural communities?

Mr HOLMES: No, I do not have access to enough data from the Ministry of Health to be able to give you accurate figures on that. We can count the number of hospitals—I am sorry I do not have in front of me the number of D hospitals, but I can certainly provide you that whole list. It is available on the Ministry of Health's website; every facility is designated on there. That is something that the powers of the Ministry of Health have—to do the calculations of what is needed. I am sure as part of the negotiation arrangements they will take the time and effort to cost our claim.

The Hon. WES FANG: I am sure they will. We said there are around 90 MPSs in the State, was that correct?

Mr HOLMES: That is correct.

The Hon. WES FANG: Do you have an estimate of that what you think about D hospitals?

The Hon. WALT SECORD: I asked that question.

Mr HOLMES: Sorry, off the top of my head I am not—

The Hon. WES FANG: That is okay.

Mr HOLMES: I think it is 40 or so or less. But I am guessing. Sorry, there are 13 D1a hospitals and 30 D1b hospitals

The Hon. WES FANG: Pretty close—43 in total. Plus the 90, so you have about 130-odd facilities. How many nursing staff would you estimate would be required for that?

Mr HOLMES: Well, to cover two shifts you need at least 2.4 full-time equivalents for each.

The Hon. WES FANG: For each location?

Mr HOLMES: Yes.

The Hon. WES FANG: So let us say about 500—thereabouts. If I said, Mr Holmes, can you provide 500 of your members to go rural and remote so that we could do this, how many think be volunteering?

Mr HOLMES: Under the current circumstances, very few.

The Hon. WES FANG: Do you think that is potentially because you have given testimony today with melodramatic statements like—

The Hon. WALT SECORD: Oh, Wesley!

The Hon. WES FANG: Walt, I did not interrupt you.

The Hon. WALT SECORD: Okay, fair enough.

The Hon. WES FANG: So just sit there, please. By terming it as "being in crisis", saying it destroys people, do you think that helps get your members to want to go to those areas? Because I know that in those areas you get a wonderful chance to practice a variety of medicine and that a lot of people want to go there. Do you think it is perhaps a disincentive when you describe it like that because you want to push a certain agenda with your claims?

Mr HOLMES: Well, it is not actually me who simply says that, it is our members. On Tuesday night we had members from Warren MPS on zoom, we had members from Canowindra on zoom and in the room we had members from Corowa—all MPSs describing the same situation in the desperation that they feel about their situation of trying to deliver health care. I did not make this up. This is coming from our members, like Mrs Paton,

who lives on a farm and is a lifelong member of the community. These are people dedicated to their communities and we can only reflect what they tell us and what we see when we go to visit.

The Hon. WES FANG: I accept that. Mrs Paton, particularly, has been very genuine in her testimony and I very much appreciate you coming here to provide that. But we also heard evidence this morning that said that there is a level of attack on morale when we have people continually providing negative stories around rural and regional health care when so many of our rural and regional healthcare workers are doing an amazing job and doing it in wonderfully brand-new facilities. It is no wonder that there is a difficulty in attracting people to these facilities when you use emotive language like—

The Hon. WALT SECORD: Point of order: Respectively, Mr Fang, you should ask a question to be fair to witnesses. You should not be rude to the witnesses. They are here giving their own time, so I ask that you ask Mr Holmes a question.

The Hon. WES FANG: You are right, Mr Secord, I apologise. I really should follow your lead on how we treat these inquiries. Mr Holmes—

The CHAIR: I have not ruled on the point of order.

The Hon. WES FANG: Apologies, Chair.

The CHAIR: I think we know how we best proceed. That is, a question without a whole lot of editorialising of evidence given at a time when witnesses were not present. In all fairness to them, ask a direct question and then permit them to answer the question.

The Hon. WES FANG: I will practice my succinctness, like you, Chair, I apologise. Mr Holmes—

Mr HOLMES: If I could answer, then—

The Hon. WES FANG: I have not actually posed a question.

Mr HOLMES: I have heard your question—"Is this real or not?" Is it real for the nurses who are facing the Coroners Court—

The Hon. WES FANG: I only have two minutes left. The question I want to ask is: What has your organisation done to look to promote rural and regional attractiveness to your membership and working with the health department to get your members there?

Mr HOLMES: We are claiming conditions that we believe would improve the situation for our members and potential members in these workplaces. We are reflecting what our members are saying. They need to be able to retain and recruit nurses and midwives into these facilities. For nurses one of the strongest driving forces is satisfaction that they have done what needs to be done for their patients. When they walk out at the end of the shift, whether it is a single shifter a double shift, and know that they have not delivered the care that the patient does, every time that happens that chips another part off their ability to stop there. Just to say, "Is this real or not?"—

The Hon. NATASHA MACLAREN-JONES: Sorry, can I just interrupt because I only have a couple of minutes left? I want to go back to staffing. In the past 10 years we have seen about an 18 per cent increase in nurses into rural and regional areas, which is around 3,300. You talked about before, in a follow-up question from Ms Emma Hurst in relation to other incentives that other State's show. I am interested to know what your members have said about the programs, the scholarships—I think there have been about 200 to 300 nursing scholarships, particularly to encourage people into rural and regional areas. We have a new pilot program that is being rolled out, which is the transition to rural and remote nursing program—

Mr HOLMES: Four nurses.

The Hon. NATASHA MACLAREN-JONES: Four nurses? Yes, but just for this year at the start. I am interested to find out what your members are saying about the programs that have been rolled out, which has led to a 20 per cent increase in nurses in rural and regional areas?

Mr HOLMES: Those increases are a result of population change—

The Hon. NATASHA MACLAREN-JONES: They are jobs that have been created and are being filled by nurses.

Mr HOLMES: Yes. The claims that we have been able to achieve in our claims for nurse to patient ratio—and, obviously, most recently the Government response to promise to increase staffing in B and C hospitals so that it looks like matching the A hospitals in the cities. So, yes, there have been some increases. But there are

parts of rural and regional New South Wales that are missing out, and Tumbarumba is an example. All of the MPSs have got nothing out of that.

The Hon. NATASHA MACLAREN-JONES: But that is what I am asking. I am specifically interested in the feedback there. I am happy for you to take on notice the programs that have been rolled out over the last 10 years that have seen a 20 per cent increase in nurses on the ground in these hospitals. I am interested to find out from your members what more could be done in additional programs to see further people taking up the job offers that are there. I am happy for you to take that on notice.

Mr HOLMES: Well, I suppose we will keep coming back to saying, "Get the staffing, the skill mix and the security right and you have a chance to actually recruit and retain people." Make sure they are properly supported with their education. Of course, nurses will absorb any little thing that helps them and they will welcome that. They do welcome any little bit because it seems that they are getting a little bit. They are starved of what they need in order to be able to deliver what the community needs as well. It is devastating when they go in front of coroners' courts—Tenterfield, Glen Innes, Wee Waa, Gulgong, Dubbo, Cobar, Tumut, just to mention a few. If we do not speak up and say that there needs to be change, then who will?

The CHAIR: On that note, on behalf of the Committee I thank Mr Holmes, Mrs Paton and Ms Turner for coming along today and participating here in the Parliament building or remotely. I thank you all and your respective organisations for the excellent work that you have done and continue to do in enhancing and improving the availability and the quality of health services to the citizens of New South Wales outside the metropolitan areas.

Ms CATE FAEHRMANN: Thanks for your advocacy for nurses and midwives too.

The Hon. WALT SECORD: Mrs Paton, thank you especially for coming. I know it is intimidating and daunting but thank you.

The CHAIR: We appreciate it very much.

(The witnesses withdrew.)

GERARD HAYES, Secretary, Health Services Union, sworn and examined

MARK JAY, Organiser, Officer, Health Services Union, sworn and examined

TONY SARA, President, Australian Salaried Medical Officers' Federation, sworn and examined

The CHAIR: Joining us in our second panel this afternoon is Mr Gerard Hayes, Secretary of the Health Services Union, Mr Mark Jay, an organiser and officer of the same organisation, and Dr Tony Sara, the President of the Australian Salaried Medical Officers' Federation. Gentlemen, you are all welcome. I will invite both organisations to make opening statements. May I request that they be kept to just a couple of minutes. If your opening statements have been prepared and are quite long, you can hand up to Committee secretariat members the longer or full opening statement. That will be incorporated into *Hansard*. The reason I ask this is to maximise the opportunity for questioning from Committee members. I will leave it for you to determine, but two or three minutes would be most helpful. On that basis, perhaps we will commence with Mr Hayes.

Mr HAYES: Thank you, Chair, and thank you everybody for giving us the opportunity to speak to you today and make a contribution to this very important regional initiative. I have been a paramedic since 1986. Before taking on this role, I was an intensive care paramedic based in Sydney and in regional New South Wales, namely Kempsey. There are a lot of challenges in the rural areas. There are a lot of challenges in the metropolitan areas. Both areas have a lot of satisfaction to be given as well. I am very mindful that health takes up one-third of the State budget and there is a lot of competing interests in relation to that. The disadvantage that I see overall in terms of regional areas is the tyranny of distance, limited services—we see services that once existed now cannot exist due to the lack of personnel who would be able to supply those services—and attraction and retention strategies. It is interesting to note now that through COVID and the last 12 months we have seen more people want to go to regional New South Wales. Regional New South Wales is such a great place to live but unfortunately it took COVID to get some people to understand that that is an option.

Another disadvantage is the transfer of cost between the Federal and the State sectors, so there are many areas in aged care which are the responsibility of the Federal Government. That gets reflected onto the State Government to be able to deal with. We also see inadequate investment in skills and qualifications. I can talk further about that in terms of ambulance paramedics where, while it is very good to get intensive care paramedics in the city, it is probably not achievable at all in the country. There is limited industrial scope in dealing with the change in technology, the qualification skill mix, efficiency and productivity and also wages and staff establishments that reflect 2021. Our awards deal with incinerator allowances from 1950. We have people now doing roles that are not reflected in the award and our society changes so rapidly that those enhancements are not reflected. They are important things. I think that if we can work together and come together, regional New South Wales will do a lot better and New South Wales will do a lot better. Thank you very much.

The CHAIR: Thank you for that very prescient and specific opening statement. I am sure there will be a number of questions that flow from that. Could I please invite Dr Sara to make his opening statement.

Dr SARA: Thank you, Chair. I had understood that we had four minutes so I have actually done something that is four minutes.

The CHAIR: Listen, I feel generous this afternoon. You have got me on my weak afternoon. It is a Friday afternoon so you take your four minutes.

Dr SARA: As I have already advised, my name is Tony Sara. I am a doctor. I am a medical manager with the relevant college fellowship. I am the president of the union for the last 10 to 15 years. Thank you very much to you, the Committee and the Parliament for allowing us the opportunity to make a brief opening statement based on our submission and our fairly rigorous member survey.

There are a number of barriers to the provision of quality health services in rural New South Wales. The first of these is the tyranny of distance, which is well known in our country. Concomitant with that, there are geographical and structural barriers that cannot be fixed overnight. We cannot have a major teaching hospital in every town, but clearly we can and must do better than we are at the present time. The Government needs to face these challenges to ensure that quality health services are accessible to rural populations and strive towards a more equitable health system.

As I have already said, we have consulted with our members and they are deeply concerned about patient safety, dangerous understaffing and chronic under-resourcing at rural hospitals. Rural hospitals do not have the resources they need to properly address the challenges of rural health; I think that is a fact. The issue, then, is what we need to do about it. How are we going to manage better? How are we going to distribute the resources? How are we going to train our staff so that they meet the challenges as best they possibly can? Doctors tell us that their

requests for extra patient resources or extra staff are repeatedly rejected by management. When doctors are crying out for more staff and resources, our view is that NSW Health and the Government must listen and must do better than we are at the present time.

The current staffing models for both permanent and rotated staff in rural hospitals make it impossible to deliver a standard of healthcare which the community considers reasonable. We know that workforce shortages increase preventable deaths, morbidity, permanent disability and so on, yet many rural and regional emergency departments have no doctor on site in the evenings and overnight. This begs the question: How can NSW Health advertise rural hospitals as being open for business when there are not doctors on site to deliver care? Rural doctors are overworked, stressed and unsupported by a system that blames them when things go wrong, exactly as my colleague Brett Holmes noted for the nurses. We have heard reports from members, which we have not substantiated, that some hospitals are purposely keeping the roster concealed from doctors so that they do not know they are working solo until they arrive for their shift. As I say, that is unsubstantiated—it was in a submission. But it certainly would be of concern if you are a PGY3 or 4, you have not done an anaesthetic term and you are uncomfortable with very sick persons and tubing them, to be there by yourself—

The CHAIR: Sorry, doctor, but just for the purposes of Hansard and the notation, the PGY means?

Dr SARA: Postgraduate year, PGY. It is years after graduation from medical school.

The CHAIR: Thank you. It is just for the record, so that people reading this evidence after today will be able to understand. I am sorry to have interrupted you.

Dr SARA: Our view is that NSW Health and the Government must ensure safe rosters and build proper staffing models that include enough permanent and rotated salaried doctors to meet the needs of that hospital and that rural population. There are limited incentives for doctors to move to rural towns. There are no geographical allowances in the health system. You do not get paid more because you are at Broken Hill, Lismore or wherever, and they are not allowed by the Government and by NSW Health. The doctors need a supportive and safe working environment, which is more likely to attract and retain doctors for short-term, rotated and long-term employment. We believe that NSW Health must develop a comprehensive recruitment and retention plan with additional funding to incentivise junior and senior doctors to relocate to rural areas. This could include scholarships, HECS reimbursement, subsidising relocation costs and so on.

Let us talk about telehealth. Telehealth can deliver better flexible modes of health services, but it must be staffed adequately. We underline that and put it in bold letters, Chair. The equipment is there in many rural places but the networked system of providing comprehensive, stable, senior clinician support is very often lacking. Let us be clear: Telehealth does not deliver quality care; the staff do, the doctors and the nurses. You need staff at the sending end who are trained in what telehealth is and how you use it, and you need senior doctors at the other end to interpret, assist and coach the doctor and the nurses at the sending end. Those models are not yet stable and well supported enough to be a system you can always rely on.

I think that is something we as a health system—I am part of the health system; I was an intern in 1984. We as a health system need to do better. It is not putting in the technology. The technology is an enabler; it is what the staff do with it. Of course, understaffing is also an issue for telehealth. You have to have seriously experienced nurses with Between The Flags who know enough to see a sick person from the end of the bed and to say, "Whoops, this is beyond my scope. I need to get the telehealth going. I need to get a seriously experienced emergency doctor and anaesthetist at the other end." It is the training as well as the technology.

The CHAIR: Are you nearly there?

Dr SARA: Nearly there. Coupled with telehealth is the need to improve the relationship between the remote sites, the rural sites and the big metros. Our submission would suggest that the rural LHDs should not be the ones to broker these relationships with the metros. The ministry needs to take control of this and say, "How are we going to deliver these services via telehealth? How are we going to get the metros to support the rural-remotes?" The ministry needs to drive those processes. It cannot be left to the LHDs.

The last issue to talk about—and my colleagues Mr Holmes and Mr Hayes have already talked about it—is the dollars. Rural sites do not have enough dollars. They are only marginally viable under activity-based funding because of the low levels of clinical activity compared to the metro sites. There needs to be thought given as to minimum amounts of dollars and staffing for the rural sites to get to an acceptable level of health care. The bottom line is that we would suggest that NSW Health and the Government need to recognise the challenges, the additional tasks and additional costs associated with working in rural health. We as a union and our members—I think we have 5,000 members or something like that—are very happy to assist and participate in those processes. We are doctors first and unionists second. Thank you, Chair, for your time.

The CHAIR: Thank you very much, Dr Sara. That leads now to effectively three rounds of questioning: Opposition, crossbench, Government. Each round of questions will go for essentially 13 minutes. I know that is an absurdly short period of time. What I am getting at is there will no doubt be questions on notice we will have to provide to you that we will not be able to get to, by virtue of the limited time. We apologise in advance for that, but we will get through as much of the questioning as we can. When it comes to the questions on notice, I will give some further information when we get to that point. We will commence with the Opposition and the Hon. Walt Secord.

The Hon. WALT SECORD: I do not know if the witnesses were actually here for the previous evidence, but there was a young registered nurse at Tumbarumba Multipurpose Service [MPS]. She talked about there being four months without a doctor, and a lack of staff at the MPS where, in fact, they had to have kitchen staff help with patient care. Mr Hayes, those would be your members.

Mr HAYES: Yes.

The Hon. WALT SECORD: We asked a question about what training they would have and she said they would have the most basic first aid. Are you aware of similar scenarios where you have members who are called upon to do things well out of their scope of training?

Mr HAYES: I do not know that it would be—it is certainly out of their scope of training, but "well out", I do not know about that. But it is not uncommon in regional New South Wales, particularly at MPSs in some of the smaller regional and remote areas, that people work as a collective. They work as a community, and that does not stop at the door of the hospital. The resourcing of these hospitals and communities is tough. To attract and retain staff, whether it is clinical staff or allied health professionals, is very difficult. I do firmly believe what has been put forward to you to be absolutely correct and it would not be, in my mind, an uncommon situation.

The Hon. WALT SECORD: It is not a surprise to you?

Mr HAYES: Not at all.

The Hon. WALT SECORD: I am looking at your submission and the rural, regional and remote health workers' major issues of concern. Number one is lack of staff/unreasonable workloads. Pay does not come up until the fourth level. Yes, pay is a concern, but a lack of staff is the number one item mentioned by your members. Would those members be people who work in the hospital as cleaners? Does that also extend to paramedics?

Mr HAYES: That extends right throughout our membership base. Whether it is a cleaner, an allied health professional or a paramedic, the workloads are enormous and continue. Particularly regionally, many people have to work alone. You can imagine that if you are a physiotherapist, and you do not have the resourcing to do the administrative side of your role and then you are trying to get the outcomes that you need to keep people out of hospitals and prevent them coming back to hospital, that becomes incredibly frustrating. Ultimately people will make a decision whether they are prepared to put themselves and their families through that, because the stress levels that will come on the back of it will be enormous. We are seeing now that it is not uncommon that paramedics would do their day shift and would be on call all through the night. That would go for about five days straight. Living on about two to three hours' sleep is just a socially acceptable thing. I have done it many times. We want to be able to deliver quality services. Again, being a paramedic, you are dealing with very serious drugs. If you are going to do that and you are not functioning particularly well then you will eventually harm yourself, harm others or leave.

The Hon. WALT SECORD: There are situations where the nurses said that they would, quote, "call in the paramedics"—particularly at Tumbarumba Multipurpose Service.

Mr HAYES: Yes.

The Hon. WALT SECORD: If you are a country paramedic then you are travelling great distances, you have a lot of people calling upon you to do things and then you find yourself working with people in an emergency department. Would there be situations like that?

Mr HAYES: Absolutely, and I have done it many times in Kempsey hospital. It would be called up that I needed to intubate a patient, which is pretty serious, and I would do that. We would be running cardiac arrests in the emergency department of the hospital. In recent times I have found out that was ad hoc when I was doing that, but the Ambulance Service now has a clinical emergency response initiative where this is now in train. If the hospitals need help, they will send the ambulance paramedics there to give that assistance. I want to be very clear on this: It is not just helping put a bandage on something. This is dealing with cardiac drugs and dealing with arrhythmias that can be fatal. That is something that we really need to be concerned about. I talk later about the opportunity for more paramedics of an intensive care nature in the bush. That is something that has been prevented at this point in time, to a degree, but those things are reasonably commonplace.

The Hon. WALT SECORD: You said that you have been a paramedic since 1986.

Mr HAYES: Yes, through to 2000.

The Hon. WALT SECORD: In the past decade, have you seen a deterioration? Have your members told you that in the past 10 years they feel they are more under pressure than in the past?

Mr HAYES: I think I can put it like this. Many of the people that I joined with are still in the job now and getting close to retirement—35 or 40 years. People now joining as a paramedic stay five, maybe 10 years. I think the pressure that is on paramedics now is intense. To give you an idea of the numbers, the Productivity Commission has shown that in 2000 there were 37.7 paramedics per 100,000 people. In 2021 there were 40.8 paramedics per 100,000 people. That compares to Queensland and Victoria, with 61.9 paramedics per 100,000 people.

The Hon. WALT SECORD: A third more.

Mr HAYES: So at this point in time we effectively need an extra 1,700 paramedics. It also indicates we are about 50 per cent behind those other two States, which have smaller populations than we do.

The Hon. WALT SECORD: Do those other States and Territories have better entitlements, better systems in place?

Mr HAYES: In terms of industrial entitlements and that, they are better. But unfortunately—and I say this with no sense of pride at all—paramedics in New South Wales have some of the highest rates of injury and workers comp and stress levels. Some of the very bad outcomes for paramedics are increasing, not decreasing. We have had those discussions before and it is something that we need to be able to commit to. But this will go to a funding issue. I appreciate, per my comments earlier, that the funds are not unlimited but we just cannot have people thrown under the bus.

The Hon. WALT SECORD: Dr Sara, you gave the example—which I concede that you were not able to verify or substantiate—of doctors not being told about rosters because they did not want them to find out they were the only person on the shift. Are there situations in rural and regional New South Wales where very young doctors—I guess newbies—would be tossed into situations well beyond their experience levels?

Dr SARA: That is a difficult question in the sense that if you go on a rotation from a city hospital to the bush, we know that you will be asked to have higher levels of responsibility.

The Hon. WALT SECORD: But that can also—

Dr SARA: In one sense that is a good thing because it extends the person.

The Hon. WALT SECORD: Absolutely.

Dr SARA: It means they have to think on their feet more, but you still must make sure that there is adequate support and supervision. Maitland Hospital was in the press over the past few months and our press release made it clear that it was not just staffing; it was support and supervision. That, of course, could be perceived as a bit of a conflict for me as the president of a union that covers staff specialists and junior doctors. But nevertheless our responsibility to the health system, to hospitals and patients and to our junior doctors is that there needs to be adequate supervision either by staff specialists or by VMOs. The issue at Maitland was that there was not enough staff and not enough supervision, and we called that out. We called out our own members and VMOs for not providing enough support and supervision, but we also called out that the LHD did not have enough staff for the workloads that were expected.

The Hon. WALT SECORD: I listened carefully to your opening statement and you talked about where telehealth could actually deliver care.

Dr SARA: It can.

The Hon. WALT SECORD: I understand there are certain situations where telehealth is the only thing. I have seen it in the Northern Territory in extremely remote communities. But in some cases—we saw several years ago at Murwillumbah District Hospital that telehealth was replacing a doctor in the emergency department. How do you strike a balance on telehealth in rural and regional areas? I know that it has to be there and there are benefits.

Dr SARA: I guess it is a tension between the number of doctors you want to have and the number of doctors you can actually get, and also the volume and quantum of work that doctor would do if they were there. In a 10-bed MPS—so there is a nursing home of 40 beds out the back, a 10-bed acute area and a small emergency department—there may not be enough work for a doctor to be employed, to get gainful employment and to have

satisfying work conditions. If they are a VMO, the town is not big enough that they would be able to live and feed their family. There will be a tension between the size of the hospital, the workload and who you can get. Even in bigger hospitals, particularly in rural and remote regions, it is very difficult to incentivise doctors to go to the bush.

Section 51 xxiiiA of the Constitution says we cannot use any form of civil conscription, so we cannot force doctors to go to the bush. We therefore have to incentivise them. That means support structures, more money and better leave processes. The Federal Government and the general practitioners in the College of Rural and Remote Medicine have those sorts of processes in place. It means having rural clinical schools so that people who go to medical school in the bush are more likely to stay there. It is a vexed problem, it is a hard problem and it probably is not completely solvable. But with attention to those various factors—retention, recruitment, support, leave arrangements and telehealth with trained staff at both ends—our view is that we can do better than we are at the present time. I say again that we will not get a North Shore, a Prince of Wales or a Prince Alfred in every town.

The Hon. WALT SECORD: No, I understand that.

Dr SARA: But with better management—my training is as a medical manager—better distribution of resources and incentivisation, we believe that we can do better than we are at the present time.

The Hon. WALT SECORD: Dr Sara, I am mindful of my time. I will ask you this question and then I will ask Mr Hayes too. The relationships with country LHDs, rural LHDs—we have had other evidence and people touching upon it but we have not been able to explore it fully. How does that interplay with your workforce?

Dr SARA: My sense of it, Mr Secord, is that rural LHDs in many cases do the best they can. The chief executives are deeply committed to doing the best they can.

The Hon. WALT SECORD: They are part of the community.

Dr SARA: They are part of the community, but they are constrained by the resources made available to them. They are constrained by the awards. The awards are set at State level and if they are told they cannot add rural allowances then they are not allowed to. It could be that there are deals done to attempt to incentivise doctors to go and work in these locations. Chief executives are people. Some of them have particular mindsets for or against doctors, for or against nurses, for or against whatever but they are still reporting to a board and to the secretary with State-set rules. If activity-based funding [ABF] is applied to their hospital, then ABF funding is based on a 400-bed teaching hospital with these costs and it probably may not work for a 50 or 100-bed hospital. So, it is about management of scarce resources, doing better, pushing more resources to the bush, managing better, training the staff, using telehealth when you cannot get, you know—you want people to get a doctor or send the doctors to work.

The Hon. WALT SECORD: May I toss the same question to Mr Hayes? I will be very quick. Are these rural and regional LHDs?

Mr HAYES: Yes. Look, I think Dr Sara probably covered a pretty well, if it is going to help the Chair.

The CHAIR: Thank you very much.

The Hon. WALT SECORD: It does not help me.

The Hon. WES FANG: Who would?

The CHAIR: I am sure you may circle back somehow. The Deputy Chair, the Hon. Emma Hurst.

The Hon. EMMA HURST: Thank you, Chair. Dr Sara, I am just going to throw back to you. Your submission highlights some specific challenges for workers accessing the rural medical trainee scholarship that is meant to incentivise workers in rural areas. Can you expand on what some of the issues here are?

Dr SARA: I did not write the submission and I read it a long time ago. What page is that, please?

The Hon. EMMA HURST: Oh, I do not have it in front of me, I am sorry.

Dr SARA: Okay.

The Hon. EMMA HURST: It was just a note that I have made.

Dr SARA: I am not—that terminology is not something that I am familiar with. Rural medical schools, I understand those, but I am not aware—and there is a rural generalist pathway that the NSW Health runs similar to the Queensland one, but I am not aware of the rural medical scheme, as such. I am not too sure what that is.

The Hon. EMMA HURST: It is the rural medical trainee scholarship, but the Chair might—

Dr SARA: Oh. That is to do with the medical school. That is a Commonwealth initiative. I am not too sure how successful it has been. I mean, the evidence is fairly clear. Rural medical schools, rural clinical schools, have a significantly better rate of keeping doctors in the bush and there was a rural scholarship scheme—I am not too sure that it worked that well. I think the Commonwealth—I and my college is representative to what used to be called the National Medical Training Advisory Network [NMTAN]. It has got a name-change that I cannot remember. It sort of worked but there was a lot of resistance to it.

The Hon. EMMA HURST: So why do you think that there might have been resistance?

Dr SARA: The difficulty was the higher education contribution scheme [HECS] fees were paid for someone on the condition that they would go to the bush. The problem with that is you are taking a city slicker and you are possibly taking people who are doing a graduate medical program so they have had three years at university. They may well be married and have children and I think I said this to the ABC TV cameras a couple of weeks ago, when I finished medical school, by the time I finished medical school I had three children. I was not going anywhere. I would hope to not have been silly enough to sign up to such a scholarship, but I did it in the days when it was at no charge. But the scheme struggled to get people to go from the city to the bush. They trained in the city. If they wanted to be a specialist, then you need to train as a specialist in the city. NMTAN or the Medical Workforce Reform Advisory Committee [MWRAC]—Brendan Murphy changed the name and he has been driving it—but the way they are talking about doing it is establishing training schemes for surgical and medical disciplines in the bush and rotating to city hospitals for certain terms that they would need to do.

That does not work for all specialties. If you are going to do neurosurgery, you are going to train in the city. You are never going to train in the bush. But for general surgery, you could do two years out of four or one and a half years out of three in a 100-bed or 200-bed bush hospital and come to the city for certain terms. That is what the Commonwealth is considering. My personal view is that I think they should try that and see how it works. The fund holder becomes the rural hospital so NSW Health would say, "You are going to have three surgical registrars." Do the deal with the college of surgeons. They will be credited on the basis that they have rotations to the big city metros. I think that that is something that if the Commonwealth that says, "Let's do it", I think NSW Health should say, "We'll trial that."

The Hon. EMMA HURST: Okay. The complexities are interesting. I know that in your answer to the Hon. Walt Secord you were talking about how we develop a good retention plan and how to incentivise that, but it sounds like there are specific incentives that will work much better than others. I guess this is a question for anybody and everybody: What do you think are the incentives that should be prioritised?

Dr SARA: This is really hard to know because we do not have a whole lot of evidence.

The Hon. EMMA HURST: Okay.

Dr SARA: It is a matter of people, personalities, so I think that a combination of money—but it is not just the money—it is about the support processes and networks. So, it is having a capacity to take your family on holidays. If you are one of three doctors in a town and if you go for anything more than a week, then the other doctors are going to struggle to do on-call. So it is a matter of looking at the totality of that doctor in that town and saying, "What do you need?" So it would be leave arrangements, it would be professional support arrangements, it would be money, it would be making sure that there is child care, et cetera, providing extra money for them to go and do their continuing professional development [CPD], extra money to come to Sydney to participate in their college activities. So, it is making the person feel comfortable that they can continue a reasonable life, that they are not discarding all their friends, their family, their collegiate support networks with their colleagues, other doctors, or whatever. There is not a single answer.

The Hon. EMMA HURST: Yes. It is quite complex. Do you guys have anything to add to that?

Mr HAYES: Yes. I think saying money is the first thing that is probably important, and it is the simplest thing to say, but I think you have really got to carve up regional New South Wales in different areas. One can be quite different to another. We have had some people transfer to particular towns. They cannot get accommodation in those towns. So it is simple things like that. We have had other people transferred where there is an incentive of a career advantage, a training and qualification advantage that is going to be supported so that they can go to these towns and actually develop within themselves. I think that is really important at the end of the day. Money is certainly important to be able to live on a day-to-day basis, but to project to the future I think people would be far more engaged if they can see "I am going somewhere" as opposed to just "Here is some cash and we'll see you in 10 years", sort of thing.

The CHAIR: Thank you very much. Ms Cate Faehrmann?

Ms CATE FAEHRMANN: Thank you, Chair. I might start with you, Dr Sara. I am just focusing on those incentives again. Basically, there is no additional salary incentive for doctors to work in remote or rural New South Wales. Is that right?

Dr SARA: Yes. The award applies across the State. I remember talking to Bob McGregor, who is the secretary a very long time ago, and that is showing my age, and he said, "It's never going to happen." That is the way it is.

Ms CATE FAEHRMANN: We have just heard from the previous witness from the Nurses and Midwives' Association, Mr Holmes, about the subsidies and incentives in Queensland for nurses. Is there something by comparison in other States and Territories that you are aware of?

Dr SARA: I do not know. Certainly not in New South Wales. We suspect that there are over-award deals for some specialists in some places. Now, even if I knew about it I would not tell you because if they are undone, it means that person is going to say, "I have been here for 10 years on this promise. It is a written deal. We have not told the Ministry."

Ms CATE FAEHRMANN: No, no. Don't worry. We do not want you to dob anybody in.

Dr SARA: But you know what I am saying. Essentially, that is what the rural LHDs chief executives and managers do. If you struggle, if you advertise for months and no-one applies and you get a phone call from someone saying, "Look, I am looking for a bit of its sea change for 10 years, but I want something extra", then you will have a conversation with that person to get that expertise to live in your town, your city, and money does—I think as Mr Hayes and I have said—it is a combination of money and other factors.

Ms CATE FAEHRMANN: So, similarly, your submission points refer to the fact that—it says here: "Multiple registrars at rural hospitals cautioned against 12-month employment contracts due to the burdensome cost and effort required to move themselves and …" and it seems that you are advocating for "Contracts for 24-36 months". Talk us through. At the moment there are 12-month contracts in relation to—

Dr SARA: For rotated junior staff, they are rotated from the big teaching hospitals and so if you are at Prince Alfred, Prince of Wales, North Shore, then you may do a term of three months or 12 weeks or six months as a rotation. So those big teaching hospitals send staff all over New South Wales, it may be for three months, six months or whatever. Some hospitals, like Wollongong hospital—I was a Director of Clinical Services at Wollongong hospital a few years ago—has bought a number of three-bedroom home units. They allow the staff to rent those at a subsidised rent and so, therefore, they find it easier to attract staff.

Mr Hayes talked about his members going to work in the bush and they cannot get accommodation. Some hospitals buy houses, do them up, and they are for doctors being rotated from city hospitals. So there is somewhere for them to live, it is furnished, it is close to the hospital and it is so much easier for those staff to be rotated. It means that they feel welcome. If you are rotated and you go to them and you say, "Where do I stay" and they say "Sorry" then you immediately do not feel welcome so why would you want to go there? It is combination of all those sorts of things—activities, daily living, where you live, costs and support.

Ms CATE FAEHRMANN: Yes, thank you. I turn to the Health Services Union. I thank you for your submission and your work. I was curious with your recommendation 5 that calls on the New South Wales Government to initiate a review to identify the real levels of staffing required in regional and rural and remote health services. First, is that not happening? Has that not happened? That is an extraordinary thing to recommend because I would assume the Government is doing that—reviewing to identify the real levels of staffing.

Mr HAYES: I think the word there is "real". We see review after review. At the moment we are going through our second security review after people have been shot out at Nepean hospital twice. This current review has been going for two years. The previous review went for three years. We have not seen any major changes at all. When we talk about doing reviews, we would like to see an element of transparency and independence in those reviews. Many of the reviews are done by chief executives or their delegates under the ability of their financial constraints. So it becomes a reactionary not a proactive review. We would like to contribute to a proactive review that is going to say, "This is where it needs to be." It may not be able to be achieved but this is what is real. Whereas at the moment we are seeing a range of professions, whether they are allied health professionals or whether they are security officers, who are literally holding it together, particularly in regional New South Wales, and it is a very vulnerable system. The reviews are not real. The injuries that are occurring are real. If adequate staffing was there those injuries would decrease.

Ms CATE FAEHRMANN: Has an independent review that the public and the health sector can trust been undertaken into levels of staffing? What is required for patient safety and health workforce safety? Are you saying that that has not been undertaken?

Mr HAYES: I do not believe there has been. We called for this in 2017, a review conducted by an external body that could see how we do equate to not only here but also overseas. I have not seen a result of that.

Ms CATE FAEHRMANN: It is very surprising for me to hear that that is the case. Therefore, in some ways, what has only ever come out of government around the levels of staffing, as you said, comes out from, "This is the money available"?

Mr HAYES: Effectively so. I think if we went back into the 1980s—

Ms CATE FAEHRMANN: As opposed to, "This is what we need to do to keep people safe"?

Mr HAYES: Once there was a point where there would be establishment figures and we could be clear about what those establishment figures are. I am not aware that any local health district has establishment figures for staffing any more.

Ms CATE FAEHRMANN: What are establishment figures?

Mr HAYES: If you have an establishment figure that means this is the amount of people for this particular department, in this particular hospital of this particular size. It is very clear that that makes sense. You can benchmark and do all those sorts of things. Now I have not seen any establishment figures for staffing. We can sort of say the Sydney Local Health District might have about 20,000 staff but what is the actual breakdown and how does that compare to other areas of a similar size? I have not seen that,

The Hon. NATASHA MACLAREN-JONES: Dr Sara, we heard this morning about the challenges of getting doctors to regional areas. Is that something that is relatively new—we also heard evidence today that it is an Australia-wide issue—or is it something that has been around for a decade or more?

Dr SARA: It has been around forever. It is the nature of this country. The issue and the difficulty is that due to increasing acuity of presentation to our hospitals, increased need by health systems to demonstrate accountability to the public, to our insurers and to our management, these issues have become more obvious. As well, with increases in technology and acuity of patients we need more junior doctors. In the old days illnesses would go their course, there were some treatments for some things, people would then go to hospital, the senior doctor would come in, do a ward round, and say "Let's do this" and they would come back in two or three days' time.

Health care, with the increased acuity, the increased technology and the increased capacity to actually do something for these patients as a result of better medical technology, more drugs, more operations and better operations and so on, there is an increased need for junior doctors to be on-site in the hospital on a 24 hour basis. Therefore, we need more doctors in these hospitals than we used to provide. That means, of course, that if you are a junior doctor you are going to be rotated out of a big hospital somewhere else—John Hunter or the big Sydney metros. It is unlikely that all of those doctors will go and work in a country town but we need to provide the manpower to those hospitals from the city and the big teaching hospitals.

The Hon. NATASHA MACLAREN-JONES: As you said, it has been going on for a number of decades. Under the previous Labor Government that was in office for 16 years, is there anything that you are aware of that it actually implemented that is not being done now that could be done?

Dr SARA: I do not tend to see things in political cycles or parties in power.

The Hon. NATASHA MACLAREN-JONES: Well just as decades. Let us say the past 10 years. What is different now to what it was 10 years ago?

Dr SARA: I think what has happened over the past few years is that the community is becoming more fractious about health care that is available. The community has increased its expectations, and that is a combination of technology, media, the public having greater awareness of these issues, the increasing acuity of persons going to hospital and the fact that the community is aware that there are treatments for some things that there did not used to be. I do not know that any arm of any particular political party when in government has done better or worse than any others. There is a fixed pie for the State Government and it divides it up into different portions. Depending on the political drivers at the time—I do not want to be too cynical—it depends partly on the individual interest of the Minister.

At my college conference not last year but the year before I had Andrew Refshauge, Jillian Skinner, two ex-Federal Ministers for Health and Peter Garling, SC, who led the Garling inquiry. I got together a panel at my college's conference and asked the ex-Ministers, "What does it all mean?" Some of the lessons I learnt from that were that particular initiatives often come from individual interests of Ministers. I was aware that Jillian Skinner—

The Hon. NATASHA MACLAREN-JONES: I am sorry, we have a limited amount of time—

Dr SARA: But essentially Jillian Skinner went to town in Cabinet and got an increased share of funding for both capital works and recurrent expenditure for health. I spoke to the Premier about that, because she is my local member, and she said, "Yes, I lost money out of transport" because she was the transport Minister at the time. So it is about the politics of that. It is about the interests of the Minister—

The Hon. NATASHA MACLAREN-JONES: And where resources need to be invested.

Dr SARA: And where the resources need to be invested. The purpose of this inquiry, as I understand it, is that issues have been raised about the comprehensive nature and the adequacy of care in the bush and I think it is fairly clear that we are not doing as well in the bush as we might. I do not think we can sheet it home to any one political party or not.

The Hon. NATASHA MACLAREN-JONES: No. The reason I say it is that we have been seeing a record investment in health. You said that Jillian Skinner came in in 2011 and there was a record investment into health, into capital expenditure. We have seen around 65 per cent of that going into rural and regional areas in the past 10 years which has meant that we have seen upgrading and the building of new facilities. In your opinion does that help to attract more staff, including doctors?

Dr SARA: Yes, it certainly does help but I think the point is, as I said in my opening, I think we can do better than we are doing now.

The Hon. NATASHA MACLAREN-JONES: I am interested in your background and your experience, particularly in regional, rural and remote communities. In your personal experience, what can we do to attract more doctors to those areas? We are hearing that numbers will retire, they are not staying on and we are not getting new ones. I am interested in your personal experience on that.

Dr SARA: As I said, I finished medical school with three children so I did not go on any of those rotations. When I was studying for my royal college fellowship, I did locums at Blue Mountains, Wollongong and Hawkesbury so I do not have the experience of working beyond the sandstone curtain to be able to say—

The Hon. WES FANG: Shame.

Dr SARA: —this is my personal perception.

The Hon. NATASHA MACLAREN-JONES: That is okay; that is fine.

Dr SARA: I can reflect. The learnings that I have gained over the past 30 years from the colleagues, from the survey we conducted, from being my college representative on the National Medical Training Advisory Network or the Medical Workforce Reform Advisory Committee or whatever it is now and the literature on attracting doctors to the bush, it is a combination of those things. I do not think I could say it is a combination of this one or that one. It is a combination of things. It is making the person feel welcome. It is more money. It is the support networks. If you are rotated as a junior medical officer [JMO], it is having a three-bedroom house that you go and live in so you do not have to go to a hotel or live in some fleabag place. It is a broad brushstroke to want that doctor—male or female—to go there for a rotation as a JMO and as a staff specialist or a VMO. It is to do whatever can be required now.

We have seen in the press in the past five or 10 years that what some rural towns do is they buy the surgery, they buy a house, they advertise, they allow people to go on tours, they allow them time to work on a sort of with-a-view basis, they invite them to the parties, they invite them to the local council, and they do whatever they can to attract that person to stay. We are humans; we cannot conscript. It becomes incentivising and we are social beings so it is a matter of working out everything that possibly can be done to attract doctors to the bush.

The Hon. NATASHA MACLAREN-JONES: We had a witness this morning from the AMA and she said that she actually thought the priority should be that young doctors should be made to fill the vacancies in rural and regional areas first, then looking at metropolitan areas. What is your view on that?

Dr SARA: My interpretation of that—and we need to be careful about this—is that if we have rotated doctors from city hospital to the bush, when we have a vacancy in one of those positions we should backfill from the city hospital rather than leaving a vacancy in the bush hospital. That has been suggested for quite a time as the way that it should be done. One of the difficulties with that is the teaching hospitals have got more political power, they are closer to the levers of power and they are closer to the rotational mechanisms. I would think that it is reasonable if you have got a PGY3 doing an unaccredited surgical registrar job that it would be better if that person left to rotate someone from the city hospital out to fill that job rather than leaving that one vacant because that is going to have more effect on that town and the patients there than having a vacancy in the city hospital. A vacancy in the city hospital—yes, the surgeon may have less hands to assist and other people can backfill that person's work on the wards. But in a small rural hospital, you feel that vacancy much more. If that is what my

AMA colleague was saying—that we should leave the vacancies in the city hospitals and not the bush ones—then I think that would be supported.

The Hon. NATASHA MACLAREN-JONES: You mentioned financial incentives. I am not sure if you are aware of an article put out by the World Health Organisation last year that actually said that financial incentives did not work, particularly in Australia, to attract doctors. I am not sure if you aware of that article.

Dr SARA: I am not aware of that but my sense of it is that it is partly about the money but it is also the support processes, the capacity to take leave and the collegiate networks. I have not seen anywhere that said that unequivocally—which is what you are suggesting, Madam—money does not help.

The Hon. NATASHA MACLAREN-JONES: I am happy to provide you with a copy of the article.

Dr SARA: I would be very happy to read it. But my sense is that that does not fit with my perceptions at 68 years of age with lots of grey hair. It does not necessarily sit with my perceptions of human nature.

The Hon. NATASHA MACLAREN-JONES: That is okay.

The Hon. WES FANG: Thank you, gentlemen, for appearing today. Mr Hayes, thank you for your advocacy for your members, particularly in the past few days. I want to ask you about the membership that you have got in those rural and regional communities. We heard testimony earlier today that there is a lot of negativity that is being presented around rural and regional health care and the provision of health care, and that is having a detrimental effect on those people that are providing that health care in those areas. Have you had any feedback from your members about people talking down the aspects of rural and regional medicine when they are working hard, enjoying their jobs and providing that wonderful level of health care that we know is happening in parts of the State?

Mr HAYES: I think there is an expectation, and I think it goes to one of the previous questions about where we are at now and where we were some years ago. Communication has changed dramatically and I think COVID has just shown us that everyone has got a view right around the world, whether it be right or wrong. My overall experience in regional and remote New South Wales is that the community groups are wonderful people who support their local hospital, but they get disappointed with the ability or lack of ability to be able to be at Coonabarabran and have to be transferred to Dubbo or have to be transferred to Sydney and so forth. I think there is a negativity along those lines. I do not think that is directed at the staff. It certainly has not come to my attention that people feel as though they are being impacted upon from their community generally. There will always be individuals who are different. But in general terms I think people in regional New South Wales are a very solid group.

The Hon. WES FANG: That is certainly the take-home message that we have had as well but it has been the feedback that I have had as someone who is rural and regional, and we heard it today from the Rural Doctors Network as well. Dr Sara, you mentioned that the rural clinical schools being put forward are potentially one of the solutions that will see more doctors attracted to regions because they are training there. They are going to need time to be able to start outputting their graduates before we are going to see a change. We could be talking about a decade. Is that right?

Dr SARA: It is multiple years because essentially it is four to five years to do medicine. The Orange clinical schools have been going for quite some years. There is one at Broken Hill. There is one down in south-west New South Wales. They take a long time to have an effect because of the time lag in the pipeline. Plus, if you get an increased rate of retention, then it can take another 10 years for that increased rate of retention to mean that that town has enough doctors who are willing to practise in that town.

The Hon. WES FANG: The Federal Government and the State Government that are partnering to output these things—

Dr SARA: Yes, for a long time.

The Hon. WES FANG: The work is happening now but we will not see that output for quite a while.

Dr SARA: There are some recent ones in the past couple of years. Yes, it will take a long time for those to work, but again I think that is another piece of the puzzle. That increases the number of doctors prepared to work in the bush but it will not be enough. It is a matter of all of those things put together in a comprehensive plan, supporting them, paying them, more rural clinical schools—

The Hon. WES FANG: What are your thoughts on Medicare numbers for regional and rural positions only? Attached to that would be rural item numbers. Both are Federal issues, I understand, but I am just curious as to what your thoughts are.

Dr SARA: They are Federal issues and I do not know that I am in a position to comment particularly that much. Rights of private practice is a way that we encourage doctors to bill Medicare. It is a cost shift from us to the Commonwealth. We all know about it, but it is lawful; it is allowed. The hospital and the employee both benefit from that. There are not very large numbers of staff specialists in large towns with a right to private practice—some do. But the item numbers issue is a Commonwealth issue. The State Government does have increased payment rates under the rural scheme for VMOs. Is that enough? I am not representing VMOs, I would not be in a position to comment. But those issues of what the Commonwealth pays rurally is not something that I could really comment on; that is up to the Feds and the State Government to negotiate.

The Hon. WES FANG: Thank you.

The CHAIR: Chair's prerogative: One quick question to Mr Hayes. Mr Hayes—you may wish to take this on notice if you want to provide a thorough and lengthy response to this one—why has the New South Wales Government prevented the recruitment of intensive care paramedics to regional, rural and remote ambulance stations?

Mr HAYES: Thank you, and that is a wonderful question. When we are talking about trying to take the pressure off when there is a lack of resources in regional New South Wales, this is just something that I struggle to understand. I have done cases in Darlinghurst Road where two ambulances and a motorcycle turned up when five minutes from St Vincent's emergency department [ED]. I have done cases west of Kempsey 50 kilometres, putting chest drains into people on a farm by myself once and waiting for backup with a partner. This is where you make and break families and you do save lives. It is very important to have intensive care paramedics in the city, but it is far more important to have them in the country because when you are five minutes from a hospital compared to 45 minutes to an hour from a hospital, someone is going to live and someone is going to die, and that is all there is to it.

The enhancement of the quality of paramedics now is outstanding, and to have them in regional areas will take the pressure off a strained medical system and will buy time for people. Can I make just one very quick point on this? Cases have been done where people are having a cardiac infarct, they are incredibly sick, they potentially are about to die and, through the intervention of the paramedic in those regional areas, they get to hospital and they are asymptomatic, they have no symptoms, because of the early intervention that they were able to have. What that does, and nobody I can see measures this, there is the back-end saving of keeping someone out of an ICU bed for five days. Where is the back-end saving of having someone who is not partially brain dead? Where is the back-end saving of the family unit that fell over? If we measure the big outcome of this small investment, it is just going to be a huge saving not only for regional communities but for the Government as well.

The CHAIR: Thank you for that. Thank you all, on behalf of the Committee, for the work both your organisations obviously do, and the excellent work that you continue to do to enhance improving the availability and the quality of health services outside of the major metropolitan cities in New South Wales.

(The witnesses withdrew.)

(Short adjournment)

NIGEL LYONS, Deputy Secretary, Health System Strategy and Planning Division, NSW Health, sworn and examined

PHILLIP GREGORY MINNS, Deputy Secretary, People Culture and Governance Division, NSW Health, sworn and examined

The CHAIR: We welcome you both and thank you for coming along this afternoon. We appreciate it, being a Friday afternoon and your other very busy commitments in the context of the important work you are dealing with at the moment with respect to the COVID-19 work in New South Wales. I am sure you probably are aware of this, with respect to inquiries like this an opportunity is provided at the start of the inquiry for the Government to come along and, through its representatives, give evidence. As you know, there are presently set down six visits to communities outside of the major metropolitan centres. There is some work being done, and I cannot go beyond saying this, but there may be some additional ones to that.

There will be, subject to resolving some issues, a further Sydney hearing and then after these what may be additional hearings outside of Sydney there will be a final hearing and the New South Wales Government, NSW Health, will be invited to come along and, as we normally do, we will provide them with the opportunity to raise, to deal with, to complete or to confirm or otherwise matters that have been raised. We are not looking to depart in any way from providing the Government with that opportunity to be there at the start, so to speak, and obviously observe on the way through, and at the end come along as well. That will be an invitation forthcoming in the fullness of time, but that is essentially the program of work that we have got before us today, and as you both note, it is the first hearing date of this inquiry.

I am not sure if you wish to do so but you are certainly entitled to make an opening statement. Keep it as brief as you can—a couple of minutes. If it is a particularly long opening statement, I will ask you to precis it and table it or provide it to us electronically and that will be incorporated into *Hansard*, but if you can keep it relatively tight that will provide the opportunity for the questioning. Thank you very much.

Dr LYONS: Thank you, Chair. I do have an opening statement. It is about five minutes in length.

The CHAIR: Sorry, I should have corrected that. I was informed this morning that both of you have up to five-minute statements to make. I withdraw what I said. You have five minutes each to give all the context you need to give and then we will move to the questions.

Dr LYONS: Thank you for the opportunity to appear at the inquiry to discuss NSW Health's submission and issues pertinent to the health of people in rural, regional and remote New South Wales. Firstly, I would like to acknowledge the traditional custodians of the land on which we meet and pay my respects to Elders past, present and emerging. The clinicians, staff and managers that make up NSW Health work hard to ensure that people living in rural, regional and remote areas of New South Wales have access to the best clinical care available and experience optimal health outcomes. Our staff working in regional New South Wales have strong connections to the communities in which they live and we acknowledge their dedication and commitment to delivering exceptional care to the people they serve.

We share a responsibility to care for all our citizens regardless of where they live or the level of care that they might need. The New South Wales health system is by far the biggest in the nation with more than 140,000 dedicated staff and an annual budget of $29 billion. Whilst it is recognised as one of the best in the world, no health system is without its challenges. We know there are patterns of poorer health outcomes as rurality and remoteness increase, in part due to social isolation, socio-economic status, distance from services and access to primary care. This pattern is consistent across Australia and is not unique to this country.

Our compounding challenge for health care delivery is the split and responsibilities between the Commonwealth Government and the States and Territories, with the Commonwealth having responsibility for primary care, diagnostic services and specialists in private practice. Where State governments typically build and manage public hospitals and community health centres, and employ staff to manage those facilities, it is the Commonwealth tasked with ensuring access to the other services.

In regional areas the Commonwealth has found it challenging to ensure that GPs are available. Australians access general practice more than any other area of the health system, with more than 80 per cent of the population visiting their GP at least once each year. Generally, the number of GP visits increases with age, with almost half of people aged 75 and over reporting an average of more than four GP visits a year. These figures are important because primary health care and GPs are the absolute backbone in keeping people healthy and avoiding unnecessary hospitalisations, and the care and supports that they provide improve health outcomes. GPs also make up an important component of the hospital workforce, as many of these doctors provide emergency

cover and after-hours cover for hospitals in rural towns. Where there are not sufficient numbers of GPs to cover rosters, then gaps pose a problem for continuity of care. Communities quite rightly do not always see the distinction between Commonwealth services and State services or know that it is the State health services that are often stepping in as default primary care providers to find solutions when medical workforce shortages exist.

As a result of not having primary care services available locally, there are flow-on impacts to the wider hospital system, which are felt in emergency department presentations, issues with medication management and then potentially preventable hospitalisations. This is a challenge that faces every State and Territory across Australia. It is the fundamental health problem facing rural and regional communities across the country. Access to the full range of healthcare services requires a coordinated effort between State and Federal governments, local health districts, clinicians, patients and local communities. Together we must find a solution to a sustainable GP service and other workforce incentives. Like other States and Territories, we are also seeing significant demographic changes that are influencing the way in which health care is delivered. As younger people move to more urban centres, the profile of towns is changing. The regional population is aging, and we are seeing more chronic and complex health issues emerge. These all impact on the way local health services are planned and delivered.

In relation to funding for hospital and community care, it is important to note that in New South Wales the population growth rate of rural and regional areas over the last eight years has been 7 per cent. Over the same period the population growth in metropolitan health districts was 15 per cent. Despite this significant difference in population growth, rural and regional districts have experienced almost the same increase in recurrent budget expenditure—an increase of 45.2 per cent in rural and regional areas compared to 45.9 per cent for metro local health districts over this same period. While the same overall funding methodology is used across rural and metropolitan health services, NSW Health applies a range of adjusters and grants to account for social and demographic differences between populations and to ensure equity of access to health care.

Recurrent service funding is complemented by investment in capital infrastructure that is a critical enabler, as we have heard, to support access to health care for people in rural New South Wales. Over the last eight years, about a third of the overall capital expenditure has been allocated to regional New South Wales, with more than 60 per cent of the 130 capital works projects that have been completed across New South Wales being in rural New South Wales. This year's budget allocation was more than $900 million for health capital works in rural and regional communities throughout New South Wales, against a total of $3 billion capital expenditure. Of the 40 New South Wales hospital redevelopments or upgrades underway or commenced since last year, more than 65 per cent are now in rural and regional parts of New South Wales. This investment in services and capital is paying important dividends and, complemented by a keen focus on quality and safety, underpins initiatives to support clinicians and managers with improving health care for patients.

Of all patients who pass through our public hospitals, including rural and regional sites, greater than 99.9 per cent will have a good experience. A small fraction of all patients discharged from hospital will be involved in a clinical incident or mishap which requires investigation. We take these investigations and reviews very seriously and have dedicated quality and safety structures in place to share learnings across the whole system. Of the almost three million people attending New South Wales public hospital emergency departments last year, more than half were in rural, regional and remote areas. In the emergency department, the expectation is that, within four hours of presenting to a public hospital emergency department, patients will be seen, assessed, treated and physically leave the emergency department either to be discharged or transferred for admission.

In the last reporting period, rural and regional LHDs achieved a result better than their metropolitan counterparts by more than 5 percentage points. Over the past six financial years, rural, regional and remote LHDs have achieved a triage category 1 performance of 100 per cent, which is equal to metropolitan districts. In triage category 2, the performance for rural, regional and remote sites is better than the metropolitan sites. Of the 1.8 million admissions to New South Wales public hospitals last year, 42 per cent were in rural, regional and remote areas. This trend has been consistent over the last five years. Importantly, while there was 42 per cent of all admitted activity in rural and remote health services, just 27 per cent of adverse events occurred in these settings. This means that there are proportionally fewer adverse events occurring in rural and remote areas compared to metropolitan areas. The excellent work of rural and regional hospitals has ensured that New South Wales has consistently been the top performing Australian jurisdiction in elective surgery measures. Performance is comparable across metropolitan and rural and regional hospitals on all elective surgery categories.

In relation to population health measures, they are also an important quantifier in the overall health of our communities. In the last 10 to 15 years in New South Wales, in rural communities, life expectancy is trending up; mortality rates and potentially avoidable deaths are down; infant mortality rates are down; importantly, Aboriginal infant mortality is down and the gap between Aboriginal and non-Aboriginal infant mortality is closing; maternal mortality rates are down; and the proportion of people living in regional New South Wales

getting adequate exercise is up. Our latest data from 2019 reveals that hospitalisations for vaccine-preventable conditions in rural and regional areas is better than the metropolitan areas; low birth weight in babies is better in rural areas than in metro ones; more people in regional New South Wales rate their overall care in emergency departments as good or very good compared to metropolitan services; and more people in regional New South Wales rate their overall care in hospital as good or very good compared to metropolitan.

We recognise that there is a lot more to be done, particularly in certain clinical areas like mental health, but we have made significant progress in delivering different models of care to accommodate small populations and overcome the challenges of distance to ensure the best possible clinical care. We have got examples like the multipurpose services, and we are using technology like in the Telestroke Service to ensure that stroke care is provided optimally right across our rural centres. Over 600 people in rural New South Wales have now benefitted from access to world-class, life-saving stroke treatment using that technology. Our submission also points to important initiatives in virtual care and electronic medical records and imaging projects that are maximising the benefits of use of technology.

As a result of our response to COVID-19, traditional health care delivery has changed and, while the New South Wales health system has embarked on making these changes to reflect technological and cultural shifts, we need to involve our communities on that pathway. We acknowledge that, through this inquiry, rural and regional communities are asking us to hear their stories and learn about their individual experiences so that, where care has not been delivered at the highest standard, we take steps to improve. We recognise this sentiment in the personal submissions that we have seen and we value this inquiry as a real opportunity to listen. As one tier in a system of Commonwealth and State governments, we know we have an important part to play in examining how we can do things better. We look forward to answering questions from the Committee.

Mr MINNS: I acknowledge the traditional custodians of the land on which we meet today and pay my respects to Gadigal Elders past, present and emerging. Attracting and retaining the required workforce to rural and remote locations is a longstanding challenge for NSW Health and other jurisdictions in Australia, as well as international comparator countries. The challenge is experienced most acutely with respect to attraction and retention of the medical workforce. NSW Health has relied upon a stable GP workforce to enable the delivery of appropriate healthcare services in our smaller facilities through the GP/VMO model. Since 2015 the supply of trainee GPs generally, and especially in rural and regional communities, has been declining. Between 2015 and 2020 there has been a 17 per cent decline in the number of applicants to the Australian General Practice Training Program. In New South Wales, the number of first-year GP trainees fell from 519 in 2016 to 461 in 2019. The most significant fall was in western New South Wales, which saw a 33 per cent decrease.

In essence, once there are not enough GPs, or enough GPs willing to work as a GP/VMO, the traditional model for delivering services in these smaller facilities is threatened and needs to be either buttressed by locum medical officers or completely reinvented. The issues are also compounding. As GP numbers decline, the demands on those who remain increase. As trainee GP numbers decline, this reduces the time available in GP practices to support the local health facility. In this demanding context, coupled with a changing life and work paradigm, some GPs are not seeking VMO appointments at all, or, if they do, are looking for a less onerous appointment, meaning more GPs are required to support a medical presence in the facility than was previously required. Locum medical officers are therefore a critical fallback strategy.

NSW Health expended $140 million in the financial year 2019-20 on locums, of which 85 per cent, or $126 million, was spent in the rural and regional LHDs. This spend represents 12.6 per cent of the total rural and regional medical workforce bill. At times, despite offering locum rates significantly above the guidance rates and the prevailing market rates, LHDs are unable to secure a doctor to cover a shift. This data suggests that the simple application of more money to attract doctors is not a solution for the problem. In this context, rural and regional LHDs have devised and implemented a range of innovative programs to address this unfolding market failure. Many of these programs pursue an exemption initiative under the Health Insurance Act, allowing eligible NSW Health public hospitals to claim against the Medical Benefits Scheme for eligible, non-admitted, non-referred professional services.

Of a possible 94 NSW Health facilities, 45 have been approved under the initiative to date. Twenty-three of the approved sites are in Murrumbidgee, and 11 are in Hunter New England LHD. The Murrumbidgee Rural Generalist Training Pathway is trialling the single employer model enabled by this initiative. The pilot, a first in Australia, commenced at the beginning of this year. Under the model, the LHD employs GP trainees and rotates them across hospital training positions and GP practices. GP trainees in this model are paid under the New South Wales medical officers award and maintain their entitlements whilst moving between the different clinical locations. The Commonwealth has granted a Health Insurance Act section 19 (2) exemption to allow the single employer model to be piloted over five years at Cootamundra, Young, Deniliquin, Gundagai and Narrandera. There is potential to scale this model across New South Wales to improve employment arrangements for GPs.

In October 2020, the Australian Government announced funding of $3.3 million over 18 months to support collaborative care workforce models in five areas of western New South Wales and Murrumbidgee. These include the canola fields, the "4Ts"—Tottenham, Tullamore, Trangie and Trundle—the Wentworth Shire, the Lachlan health region and the Snowy Valley health region. To look at one of these, the 4Ts program is exploring how to employ staff to work across the different sectors rather than hospitals and private practices trying to recruit separately. The program utilises pooled resources of funding, data and people using a networked model, and it supports clinicians to work to full scope of practice. All these programs, and many others, are examples of rural LHD initiatives with their partners to address the absence of GPs in the primary health care setting.

At a system level, NSW Health has also sponsored multiple programs designed to attract and retain critical staff in rural and regional locations. Training medical students and junior doctors in the regions is an important rural medical workforce strategy. Time does not permit the detailing of these; however, there is additional information in my statement. To highlight one, the NSW Rural Preferential Recruitment Program was developed to enable junior doctors to work their first two postgraduate years in a rural location. In 2021 there are 150 rural preferential recruitment positions, an increase from 75 in 2012. Since the program started in 2007, over 1,000 doctors have completed their internship in a New South Wales rural hospital. Another important development is the support for medical student places in rural and regional medical schools. Students now have the opportunity to study at rural clinical medical schools in Albury, Armidale, Broken Hill, Bathurst, Dubbo, Coffs Harbour, Griffith, Lismore, Lithgow, Port Macquarie, Orange, Tamworth, Taree and Wagga Wagga.

Turning to nurses and midwives, NSW Health offers a range of scholarships to nursing and midwifery students and employed nurses and midwives. The statement refers to these, as well as a new initiative for allied health professionals. Two key facts though: Over 100 scholarships to the cost of $8 million have been awarded since 2011 under the Rural Postgraduate Midwifery Student Scholarship. In 2019-20 more than $3 million was expended on 700 postgraduate scholarships to support nurses and midwives in NSW Health. More than 25 per cent were located in rural and regional areas. Despite the challenging context, New South Wales has managed some significant increases in its rural and regional workforce. From June 2012 to June 2020, the medical workforce has increased by 43 per cent, or 1,438 full-time equivalent [FTE] positions. The nursing and midwifery workforce has increased by 18 per cent, or 3,315 FTE. The allied health workforce has increased by 29 per cent, or 1,146 FTE.

NSW Health accepts more needs to be done and that a reinvention of working arrangements is likely part of the solution. However, the array of programs and investments canvassed in this statement, which is a sample only of the total suite, demonstrates that there is not a single and simple solution to the challenges faced. NSW Health is hopeful that the inquiry generates more potential initiatives to meet the challenge. I particularly hope that the inquiry process demonstrates gratitude for the NSW Health employees already working in regional, rural and remote communities, acknowledging their professional capability and their commitment to their patients.

The CHAIR: Thank you very much. I am conscious that we were informed that each of you would have a five-minute statement, which would be a total of 10 minutes. In effect it has been 25 minutes between the two of you, which is fair enough because that is the way the balance played out. I think that will mean that there will be the likelihood of an interest to go beyond a bit after five o'clock to ensure that we can get through the questioning that we want. We will play that by ear but we were told explicitly five minutes each from the both of you. I did not want to interrupt because you were obviously in full flight and I thought that might be a rude thing to do, but there may be some desire to make sure we can get the questions asked.

The Hon. WES FANG: I was prepared to volunteer, Chair, that the Government may not use its entire allocation.

The CHAIR: That is fine. I do not want to be awkward and difficult but we just need to ensure that we are able to get through what we need to because there is much to be asked. We will get things underway.

The Hon. WALT SECORD: Dr Lyons, listening to your overview and reading the submission, particularly your opening statement, it is quite clear that you are blaming the Federal Government and a lack of GPs in rural and regional areas for putting impact and pressure on the hospital system. Is that a summary of your position?

Dr LYONS: Not at all am I laying blame. All I am saying is that there is a complex interplay between what we do in the State system and what happens in the system that is outside of what we are responsible for. It is in stark relief in the rural communities, particularly when there is limited other workforce available. The GP workforce is actually the backbone of the medical workforce in rural towns. That is one significant change that has occurred over the last 10 or 15 years which is really impacting on the ability of there to be primary health care in those towns and support for people's health care.

The Hon. WALT SECORD: When you say primary care, you mean GPs?

Dr LYONS: I mean general practice but not only general practice. As I outlined in my statement, the GPs have historically been the medical workforce for our small rural hospitals as well through the GP/VMO model. So if they are not resident in the towns, then they are not available to be on the roster at the hospital to support clinical care in hospitals as well. It is a really interesting interplay, Mr Secord, because what we are seeing with the changing population is that attracting and retaining GPs—historically, GPs were vocational. They would go into a town and work a one-in-one roster for supporting that community.

Those times are gone. In fact, in those days the GP used to do the operations and the deliveries; they used to do everything. Health care has changed, as well, so that is no longer the model that can operate effectively. We have got a situation now where for a small town to have a viable and sustainable roster at the hospital, you probably need three or four GPs at least in the town. Often there is not enough work for a general practitioner during the day to sustain three or four in practice, to enable that roster to be available at the hospital. It is a tension that plays across both and creates some of the challenges that we face in delivering these services.

The Hon. WALT SECORD: We heard from previous witnesses that Queensland—particularly The Royal Australian College of General Practitioners. They pointed to Queensland being able to deal with having enough doctors and staff in rural and regional centres.

The Hon. WES FANG: Well, that was not quite their evidence.

Dr LYONS: I am aware of the arrangements in Queensland that have been in place for many years. They had a rotational arrangement of more junior doctors that used to go out to staff these hospitals. Doctors who were employed in the hospital sector would rotate out and run the rural hospitals for a period of time. That is not a model that we believe is an appropriate model in New South Wales because these younger and more junior doctors do not have the experience, training and capability. You are putting them in an environment where it may not provide the optimal care to the community, and—

The Hon. WALT SECORD: What is the difference between Queensland and New South Wales?

Dr LYONS: Just to finish my response, my understanding is that Queensland is now being just as challenged as other States and Territories in these rural settings. It is not a silver bullet that one solution solves the problem. We are seeing the same patterns play out right across the country, as I indicated to you. Every State and Territory is indicating that they have got the same challenges. There is no place that has solved this and has a solution that means it is no longer a problem.

The Hon. WALT SECORD: We heard earlier today about issues at MPSs—the Tumbarumba MPS going four months without a doctor at the facility. How many emergency departments in New South Wales, including MPSs, currently do not have a physical doctor available?

Dr LYONS: Well, that changes from day to day, Mr Secord. The rosters are variable. The rosters go on a day-to-day basis and there might be a GP available one day who is not available the next day in some places. That is a question that would be extremely difficult to answer.

The Hon. WALT SECORD: Is it rare that a New South Wales MPS would not have a doctor on duty?

Dr LYONS: As I said, the challenge in having workforce available in these small rural towns—not having enough GPs to have a sustainable roster means there are gaps in rosters.

The Hon. WALT SECORD: Okay. So, is four months an acceptable gap, to use your word?

Mr MINNS: Throughout that period, Mr Secord, there would have been considerable effort in recruitment. Very often the LHD is engaged with the local council, the shire council. They will engage with whatever parts of the community they can in a campaign to try and attract a practitioner to the location. It is constant in these LHDs.

The Hon. WALT SECORD: But, Mr Minns—

The Hon. WES FANG: Point of order—

The CHAIR: I know what the point of order is. Mr Minns must be able to complete his answer.

The Hon. WALT SECORD: But he was not answering my question.

The Hon. WES FANG: He was being—

The Hon. WALT SECORD: Wes, do not burn up my time. Sorry, Mr Minns.

The CHAIR: Let us be clear: If you want to take a point of order, you can, but do not have exchanges across the table. I think we have resolved this.

Mr MINNS: Over to you, Mr Secord.

The Hon. WALT SECORD: Do you have data showing the number of MPSs that do not have a doctor available in periods that were described as "gaps"?

Mr MINNS: On a periodic basis we might work with the LHD directors of medical services and their workforce directors because we meet with them each month to have a conversation about—what is their current status? What is their current exposure to lack of supply? When we do that we might establish that across the entire State there might be in the order of 40 instances where they currently—as Dr Lyons mentioned, it can change during the week—have not got the supply that they would seek to have.

The Hon. WALT SECORD: When you say "supply they seek to have" do you mean 40 instances where there are hospitals with no doctors?

Mr MINNS: There would also be instances where the arrangement is to try to have a doctor in the facility for three days a week and to share that with another facility in the network of the district.

Dr LYONS: Can I just say: There are examples where that occurs. In parts of our State where there are towns that are located within 20 or 30 minutes of each other, there are arrangements in place where those towns might have a doctor on and there is a rotation of when the doctors are available. The communities are aware of when those doctors are available in those different towns, as an example. In addition to that, when there is not a doctor available there is always the nursing staff on duty, as we have heard. The nursing staff are provided a backup through arrangements using technology to support getting advice from doctors if a patient presents and they need that care.

The Hon. WALT SECORD: You are referring to telehealth?

Dr LYONS: Virtual care.

The Hon. WALT SECORD: Yes, virtual care. I just want to roll back a bit. Mr Minns, you said there would be about 40 instances where there would be hospitals or MPSs in New South Wales where there are no doctors.

Mr MINNS: I could not tell you that that is the number now, but the last time we posed the question and received responses from districts at the end of last year, it was in that order.

The Hon. WALT SECORD: Now, you used the word "gap". What is an acceptable gap?

Mr MINNS: Well, the districts would regard any gap as being unacceptable and they would be working to recruit a doctor to it. The historic model of these smaller facilities is to try and have GP VMOs available to support the delivery of care.

The Hon. WALT SECORD: Mr Minns, in your opening statement you said that more money was not a solution to attract doctors. I wrote that down as you were saying it. You said it was market failure. Do you stand by that in the context of what we have heard today, what we have read recently and what Dr Lyons has said about a lack of GPs and a reluctance of GPs to go to rural and regional areas? Paying them more would not attract more doctors?

Mr MINNS: The first point to note for GPs is that they are provided with more payments under the Medicare system, under the MBS system, to work regionally. It is quite considerable. That already exists in the framework and we would happily provide that detail to the Committee on notice.

The CHAIR: Thank you.

Mr MINNS: That is occurring for the GP workforce, as is. When you then turn to that workforce—let us say we have got some GPs in a rural community. Our districts will approach them to see if they would like to become a VMO at our facilities. As Dr Lyons indicated, it is more common that they choose not to or that they are only available for a small fraction of time because of the requirements in their own practice. But the money that is available for people to work as GP VMOs in our rural facilities is considerable.

The Hon. WALT SECORD: Dr Lyons, is it acceptable for kitchen staff to be brought out to help with patients? Sorry, my colleague corrected me. Is it acceptable to have kitchen staff come out to observe and—the phrase was "keep an eye on" patients?

Dr LYONS: I heard some of the testimony that was provided from one of the earlier witnesses around care at Tumbarumba, I think it was—

The Hon. WALT SECORD: Yes, Tumbarumba.

Dr LYONS: —and the multipurpose service there that would have a combination of residential aged care residents, not patients. These are people who are in aged care and living in a homelike environment. That is the aim of residential aged care facilities.

The Hon. WALT SECORD: These are high-care patients. High-care patients are not in a home environment.

Dr LYONS: I think we need to understand because I do not think there is such a classification as high-care and low-care patients anymore.

The Hon. WALT SECORD: When I probed the nurse, I said, "It used to be known as 'high care'," and she said, "Yes."

The Hon. NATASHA MACLAREN-JONES: No, that was not exactly it.

The Hon. WALT SECORD: Yes.

The Hon. NATASHA MACLAREN-JONES: No, no. She said "high care" but you did not say the correct terminology and definition.

The Hon. WALT SECORD: Okay, but is it acceptable in New South Wales for kitchen staff to be asked to come out and keep an eye on patients and/or residents in aged care?

Dr LYONS: I have made some inquiries following hearing that testimony. I think from the district's point of view there is an escalation process if there were concerns around the clinical activity in the MPS, which is to call the executive on call at the hospital who then has the responsibility to provide the additional staff to respond to the clinical situation. It is not the policy of the hospital to rely on HealthShare staff or kitchen staff to be observing residents while clinical staff are doing other things. There is an escalation process if extra staff are required.

The Hon. WALT SECORD: You said in your opening statement that 27 per cent of adverse events—you said there were fewer adverse events in rural and regional hospitals. What is an adverse event?

Dr LYONS: Proportionally, I said, for the occupied bed days in admissions. So these are the events that go into the Incident Information Management System that we have across New South Wales, which is where, for any situation where there is a near miss or a concern about the care that is provided, staff have the ability to log that. Those are tracked across the whole system and we look at the comparisons of those incidents. They are categorised into severity. So you might have heard of severity assessment codes [SAC] 1, 2, 3 and 4?

The Hon. WALT SECORD: Yes, I am familiar with that.

Dr LYONS: That is the system that I was referring to.

The Hon. WALT SECORD: Are those preventable deaths?

Dr LYONS: No. Only the most serious of those are SAC 1. They are not always deaths; they can be where somebody has had something that has led to some complication, a length of stay in hospital becoming longer or having to return to operating theatre. Lots of those go to the SAC 1.

The Hon. WALT SECORD: How many SAC 1s have we had in the past two years in New South Wales?

Dr LYONS: I will have to take that on notice, Mr Secord. Across the whole State?

The Hon. WALT SECORD: Yes. Can you take that on notice and give me a breakdown of how many of those occurred in rural and regional hospitals?

Dr LYONS: Certainly.

The CHAIR: I have a follow-up question. Dr Lyons, you spoke about innovative thinking, solutions and work being done and work that has been done in regard to attracting doctors, specifically GPs, to deal with the shortage in regional, rural and remote New South Wales and also Australia. I am wondering, with respect to nurses and other allied health workers—if you are aware; please take it on notice if you need to—who are integral to the overall provision of the highest possible standard of health care that we can provide to citizens outside the metropolitan area, what work is being done to provide incentives that may attract them to consider going and living and working in these communities?

Dr LYONS: There is a huge amount of work going on right across the board in all the health disciplines, from the training that goes on through the university sector and having more of that training provided in rural environments.

The CHAIR: I am specifically talking about nurses and allied health workers.

Dr LYONS: Yes. Both of those train through universities and both of those disciplines—the broader disciplines of allied health and nursing—are providing educational opportunities in rural environments across our health system. But I am also aware that, having worked in the rural environment for many years, the ability to attract people from outside into rural towns is often seen as the way to fix the problem, when in fact there are people who live in the community who, if given the opportunity to gain the skills, training, experience and qualifications—that is a workforce that we are keen to try and support as well.

There are pathways within nursing, for instance, where nurses can come in under an arrangement where they come in initially as an assistant in nursing, then receive support for training in the facility to move to an enrolled nurse and then they are supported to gain their registered nurse qualifications. I am aware of examples of those that exist right across the system as well. We provide a pathway for training in the community for people who are already residents in the community, which is quite an attractive thing to do to enable those employment opportunities for people who are residents in the town already. They are already committed to living there. Phil Minns might have some examples of that.

The CHAIR: Sorry to interrupt, but how do people in the community make themselves known or become aware of things like this? Is this something that is advertised and promoted and do people understand that this is in fact there?

Dr LYONS: My colleague might be able to assist.

Mr MINNS: Yes, Chair. One of the branches that reports to me is the Nursing and Midwifery Office. It is a small team but it is completely focused on the professional capability of the nursing and midwifery workforce. That is its role and it exists as its own office because of the importance of nursing and midwifery to the health system; you know, the proportion they represent of our clinical frontline workforce. They administer a range of scholarships for both nurses and midwifery students and employed nurses and midwives. We try to direct those programs to the rural and regional locations. Generally speaking, about a quarter or above of all of the recipients are from rural and regional locations. The Nursing and Midwifery Office [NAMO] has a fund which—

The CHAIR: Sorry. The office of?

Mr MINNS: The Nursing and Midwifery Office.

The CHAIR: Sorry.

Mr MINNS: The Nursing and Midwifery Office has a fund which enables it to move funding around according to need and according to feedback that we get from the LHDs.

The CHAIR: May I ask what the size of that fund is? If you do not know you can take it on notice.

Mr MINNS: I can take it on notice and I can give you a detailed list of all of the different arrangements.

The CHAIR: That would be appreciated.

Mr MINNS: But just a flavour: 37 rural undergraduate scholarships were awarded in 2019-20 and they were for $5,000 each for undergraduate nurses and midwives. But I will give you the whole list on notice.

The CHAIR: I have a small number of additional questions on a completely different subject but I would like to get through them in the time available. On the issue of the provision of palliative medicine, nursing and care outside of the metropolitan areas, I want to break it down. Perhaps the first one is difficult because of the interface between Commonwealth and State with respect to the matter of nursing homes and facilities that our seniors reside in. But time and again it strikes me as hard to believe that in the facilities where many of our senior citizens' lives are coming towards the end, instead of having access to high-quality palliative care, which invites the necessary qualified staff to be there to provide for that—namely, at least nursing qualified staff, RNs or higher in qualification—to be able to liaise, if not with a doctor who may be present but with an offsite doctor, with respect to the administration of the necessary pharmaceuticals obviously to control pain and related matters, why are we not concentrating on that and obviating the situation whereby we find that towards the very end often there is the dialling of 000 to get the ambulance to come to take the elderly person or senior citizen literally to an emergency department where, perhaps within a matter of days or maybe a few weeks, they die?

This ability to enable our nursing home facilities to provide better palliative care—it is obviously a traumatic experience to go through, to be taken out onto a gurney, into an ambulance, through the emergency department, to be placed into a ward and then ultimately to deal with the whole experience of being in a hospital. I am wondering if you can make any comments on that whole issue about the way in which palliative care can be

better dealt with, managed and considered in terms of dealing with our senior citizens in particular who reside—and I do understand the dichotomy issue of State and Federal.

Dr LYONS: A couple of things. We have invested significantly in enhancing palliative care services right across the board. I think the Government has, in the last four years, put in about $145 million specifically targeted to palliative care.

The CHAIR: I note chapter 4 in your submission.

Dr LYONS: Our focus is very much on providing support for people at the end of life in the environment in which they choose to be and not bringing them into hospitals where that can be avoided. The focus there is on investment in giving GPs skills, getting our clinical nurses in the clinical environment palliative care skills, supporting those who do have those skills already and increasing the number of palliative care specialists, particularly in rural and regional areas. We made a submission on this in relation to the royal commission on aged care as well.

The CHAIR: Yes, we have spoken at budget estimates hearings.

Dr LYONS: There are a number of recommendations that relate to this in the royal commission's response, or their findings. In specific relevance to this inquiry, there have been 80 additional palliative care nurses and 11 medical specialists that have been committed to regional, rural and remote LHDs over the past four years, with a particular focus on how we ensure that we have got the medical specialist backup. That includes a couple of the specialists who actually are there to provide relief to the specialists who are in the rural environments. We have provided additional nurse practitioners across the districts, we have provided additional Aboriginal health workers with a particular focus on providing Aboriginal patients and families targeted support at end of life, and there are additional allied health positions that have gone in as well across the rural local health districts. It has been a real focus about how we can support people who have end-of-life care appropriately.

I was at Dubbo just recently at one of our regional health forums, with the Commonwealth actually, and heard an amazing story from a man whose wife passed away in a nursing home in one of the rural MPSs. He talked so positively about the support that was provided for her to have that care without having to be moved and what a dislocation it would have been for him and for his family to have her moved out of that environment for that end-of-life care. It was actually backed up by access through virtual care to specialists in the metropolitan settings who were able to provide the advice that meant that she did not have to be moved.

The CHAIR: And the multidisciplinary support that goes with that.

Dr LYONS: Absolutely, the multidisciplinary support starts there. I think it is an example of what we are doing. We are making these investments. These things are being done and they need to be continued to be supported, but they are very positive. When you hear the stories from people who have been impacted by the benefits, it is very impactful to hear those stories.

The CHAIR: Yes. I have done it before and I am happy to do it again. I acknowledge the work that the Government has done since 2011 in its focus on palliative care.

The Hon. EMMA HURST: There has been a lot of discussion about telehealth and obviously there is a recognition that there is a really good place for telehealth, but then there are also some concerns that there is an over-reliance on telehealth in certain circumstances. How do you think that we find that balance on being over-reliant on telehealth in rural, regional and remote areas?

Dr LYONS: The first thing I want to say is that we do not see telehealth or virtual care as being a substitute for having face-to-face, on-the-ground clinicians. Our primary focus is to have those health professionals available in the communities to provide face-to-face care. The virtual care and telehealth is actually used to support those on-the-ground clinicians. That is the focus, to enable them to have access to information, to have backup from people who have got expertise and capability to help them deliver optimal care to their patients in the environment in which they work. It is an opportunity with technology to make that available. We have seen some amazing changes. I talked about the telestroke service, I will not go into that but I can later.

I will give you an example of the imaging services that we now provide that are all linked up. A patient who presents to a rural hospital might have a fracture, for instance, that needs to be set. The image can be taken in that environment, beamed directly to the specialists who can provide the advice about what is the best care for that patient: Is it able to be plastered and set at that site, or does it need to be transferred for an orthopaedic surgeon to look after? It saves inappropriate transfers, because sometimes the patient can be cared for there with the support and advice that is provided by that teleradiology backup. We have got huge examples of that. I gave the example of the palliative care services, paediatrics, and there are huge benefits in providing that backup to general practitioners about the care of children in those rural environments as well.

The Hon. EMMA HURST: We have heard today that there is definitely a place, and I do not think that there was an overall negativity. I guess the concern is, and we have heard today, that some people are reporting that in some places there is an over-reliance on that. Is that a concern and is anything happening to help any communities that are feeling that there is an over-reliance?

Dr LYONS: This over-reliance would be a perception because there is not a face-to-face clinician available. As I have said, our efforts are focused first and foremost in making sure that we have got health professionals available in the communities, but if they are not available then having the telehealth and virtual care as a backup to support the clinicians who are there. My sense would be that this is reflecting the concern that rural communities have about not having a doctor in their town or not having somebody who is available for after-hours call at the MPS or the small rural hospital. That is where I would think that these concerns will be coming from.

The Hon. EMMA HURST: We have also heard some safety concerns being a big issue for rural and regional health workers, particularly nurses. We received a number of submissions calling specifically for increased funding for uniformed security guards in hospital settings. Are there mechanisms in place to ensure that nurses and other staff are safe, particularly on late shifts? You may have heard some of the evidence we have heard today as well, particularly from nurses on late shifts.

Mr MINNS: Ms Hurst, I think it was mentioned in evidence earlier that we did have completed a long and deep inquiry into security issues. It was extended to particularly focus on rural and regional locations. It was conducted by the Hon. Peter Anderson. One of Peter's observations in his final report was that when he visited regional and rural centres it struck him just how important the physical environment was in maintaining the safety of staff. Features such as perimeter controls, access controls between clinical and public areas and havens for staff to retreat to provide the best opportunity to minimise risk to staff.

Since 2016 the ministry has allocated funding to upgrade the physical environment in rural and regional facilities, and also the general program of building new facilities in the regional communities, they have all been applying this kind of framework to design out risk as it relates to smaller facilities. We understand the issues in those small towns that the police station may be some distance away, the town itself may not be that large in terms of the backup that can be available. The provision of that sort of designed-in safety is critical.

The Hon. EMMA HURST: Another issued raised was the lack of certification services available for nurses. The example that was given was that a practice nurse may be the only medical practitioner on site but they are not able to certify a death, for example. Are you aware of some of these issues that have been brought forward, and are steps being taken specifically to address them?

Mr MINNS: They were issues raised by the witness from the clinical nurse practitioner—

The Hon. EMMA HURST: Correct, yes.

Mr MINNS: I think we will concede in the ministry that the ability to have more clinical nurse practitioners in rural and regional locations is something we should aim to do. We do have them there, but they have tended to be picked up more consistently in metro areas, perhaps to do with the specialisation of the nursing function in those instances—I am thinking emergency medicine and paediatric care. But it is quite a commitment to become a clinical nurse practitioner, it is both the education and the 5,000 observed or supervised hours. But, I know from the chief nurse that there is interest in how do we promote and support more clinical nurse practitioners in rural and regional facilities. If you like, the specific question about certification, I will take that on notice.

Dr LYONS: I can add to that a little bit I think. We have policies and guidelines within NSW Health that support where there is not a doctor available having nurses able to declare life extinct. Then certification is completed by the medical practitioner as required after the event. There is the ability to declare life extinct as part of that process, as policy guidelines.

The Hon. EMMA HURST: There is a step that these nurses can take?

Dr LYONS: Yes.

The Hon. EMMA HURST: Another thing that came up today and was also received throughout our submissions was the lack of career development and training opportunities for health practitioners in rural areas. Today we have also heard that even where there are opportunities available, that the nurses were saying that they could not get the time off to be able to take on these development opportunities because of the pressure within staff and shifts and timing and being understaffed. What work is being done to address this for people who are wanting to actually expand their skills?

Mr MINNS: We would share the view that if you come from a very small facility that the kind of agility and flexibility that enables you to do programs will be less than what is in a larger workplace, no question. In

response to the Chair's question, I mentioned that we would provide on notice that list of all of the nursing and midwifery scholarships programs that we provide. Some of those particularly provide funding to an LHD for someone to be backfilled so that they can be relieved for training.

The Hon. EMMA HURST: If there is no-one available—has that been something that has come to your attention? The evidence that we heard today is that they would like to be able to do it but they just cannot take the time off.

Mr MINNS: That is why we need to provide funding for backfill. Some of these initiatives specifically make funding available for that purpose. We also do the outreach training where districts have clinical nurse educators who visit these sites, so one of the ways that training and upskilling can occur is in fact on-site.

Dr LYONS: Can I just add to that? Because that is an important factor. In these smaller facilities we know that taking the staff away will be difficult for somebody to backfill. There is also a benefit in training the team in the environment in which they are going to work, so there is a real focus on providing clinical nurse educators. They are allocated to those sites to provide ongoing support and education for the teams, but also providing outreach where there is a simulation bus that goes out to the sites with sophisticated technology available to provide support and can actually go to the rural sites.

We also have the specialist teams that go out to a range of the districts and provide training in emergency management of patients in the facility where the staff are delivering the care. So those all exist in recognition of the fact that we need to make sure that we have appropriate education support into those facilities. The other thing that our Health Education and Training Institute [HETI] is focused on is making sure that a lot of the education training is available through use of technology so people can do that wherever they are by logging onto our HETI education modules.

The Hon. EMMA HURST: Do you think, though, that just providing this funding or making it easier to access—it sounds to me from what we have heard today is that it is simply a time issue. You can provide the funding for more people but if there are no people there—the evidence we heard from the nurse today was that she simply could not. She would be doing 14 hours, she would be doing a double shift and in between that just sleeping and the fact is that even if there was funding to try to get some more people in, there were not more people there. Is there something done to address that specifically?

Dr LYONS: So following that evidence I asked the district again for some specific advice around what training goes into that site. There is a clinical nurse educator who is allocated and there is a calendar of training needs that is established for the site. There is a clinical nurse consultant across the network who brings the training around paediatrics, respiratory and stoma et cetera to the hospital—actually takes it to the hospital. There is emergency medicine training and simulation training that is provided by the specialist in emergency medicine that goes out to these sites. I mentioned the simulation bus—the Sister Alison Bush bus that does simulation training—which goes out to the sites and provides the staff in that setting an opportunity to do skills and upgrade their skills using simulation models. There is also nurse-directed emergency care module that goes out to the sites. That is due to visit Tumbarumba in July, I think. So there are plenty of examples where we are actually taking the education and the training to the staff in recognition of their needs and the fact that taking them out of this facility will leave the facility short of staff.

Ms CATE FAEHRMANN: I want to go back to the issue of security staff. Mr Minns, I believe in response to the question before in relation to this, your response mentioned upgrades—I think there was a survey of different areas and visits out to regional hospitals—and various different physical building-type changes, if you like, and upgrades. The question was about staffing in terms of security staffing. Has that been considered by the Government to give hospitals more funds or to be able to just either employ their own security guards or have security guards as an employer for New South Wales public hospitals to be able to staff these regional hospitals that need security so much?

Mr MINNS: The point of the Peter Anderson work, particularly the time spent in the regions, was to try to develop for us a series of actions that were about a proportionate response based on risk. There are 107 recommendations in Mr Anderson's report and he was pointedly asked at some point—I think when the report was publicly released—about the question of staffing. He said that he did not feel security staff was the solution if the rest of the recommendations in his report were enacted. So the situation we have with some of these small facilities is that we probably would be unable to recruit a security guard to them, in all likelihood because of the nature of the location—where it is and so on. The aim of the building refurbishment has been to put some control in the hands of the staff, particularly the night staff, to just not admit people if they feel there is risk and to have options for them around like duress alarms and the ability to leave an environment—so more than one entry into rooms et cetera—so that if something that apparently looked fine starts to go to a bad place they can remove themselves from the environment and lock the area down.

Ms CATE FAEHRMANN: Was it Professor Anderson, did you say?

Mr MINNS: The Hon. Peter Anderson.

Ms CATE FAEHRMANN: Could you just expand a little on what the reasons were for not recommending or suggesting a security guard or security people would be useful too in terms of safety? I am just looking at your submission, for example, the Government submission on page 10, it is particularly alarming. The Special Commission of Inquiry into the Drug "Ice" found that the alarming increases in the use of methamphetamine and opiate-related hospitalisations—but I think methamphetamine is really the issue here in terms of danger to nursing staff—in outer regional, remote and very remote communities, hospitalisation was 8.4 per 100,000 in 2010/2011 and now it is 154.4 hospitalisations for methamphetamine. That would suggest that there are increasing situations, simply just as a result of this one factor, that there are more people potentially being aggravating and posing a danger to the staff. I just do not know how—I get that separate rooms and panic rooms and what have you are useful, but I would also think that increased security presence would be useful.

The Hon. WES FANG: That is why you should say no to drugs, Cate.

The CHAIR: Order!

Ms CATE FAEHRMANN: That was an unbelievable statement. Yet again another dumb contribution by the member.

The Hon. WES FANG: No, it was pretty accurate.

The CHAIR: I think we can move on. That contribution was most unhelpful.

Ms CATE FAEHRMANN: The question is, firstly, what were his reasons?

Mr MINNS: I do not think I am able or qualified to speak on behalf of Mr Anderson.

Ms CATE FAEHRMANN: In the report.

Mr MINNS: There were 107 measures that are about strengthening and tightening the entire approach across the system—the education, the training, the management, the risk identification, the risk escalation. I think his observation is that the very small facilities that we are talking about at the moment might have some nights where they do not see patients at all. They might have average presentations in ED on a daily basis for a year that are in the range of four to nine. So the question becomes, does that justify security on-site and what does that security guard in fact do? In the rural and regional areas we promoted a model of employment called a health and security assistant [HASA]. The logic of that is to try to combine the role and have someone who is doing some support functions to the clinicians but who can also potentially fulfil a security role.

One of the issues about the HASA role is it requires the class 1A qualification and one of Mr Anderson's recommendations is to look at getting support from New South Wales police. The branch is called the Security Licensing & Enforcement Directorate [SLED]. But his recommendation is that we seek an exemption in rural and regional for that qualification so that we might have more success in recruiting HASAs to roles. But I think it is just a function of many strategies coming together and—

Ms CATE FAEHRMANN: In your response you just said that it was the—using examples in terms of particularly remote hospitals. Can I check then because that statistic, for example, is regional and remote and very remote, so would regional hospitals, say, Coffs Harbour or Port Macquarie or something like that, generally have or employ some kind of a security guard at the front?

Mr MINNS: Well, they would have security onsite and they would be fulfilling roles in terms of walking around and perhaps patrolling outside. One of the issues that we have looked at is the nature of the security presence in a facility. Peter suggested that we needed to promote the idea of health security and we needed to make sure that their uniform was relatively clear and identifiable such that their presence in parts of the hospital environment or the facility sends a message. We have trailed in 2019-20 assigned security working in emergency departments and the trial generated pretty much no databased variance from incidents in the ED prior to the event.

Ms CATE FAEHRMANN: I will move to the kind of workforce planning issues, if you like. You would have heard, I assume, a line of questioning to the Health Services Union around—like surveys, for example—exactly what the need is in different hospitals in terms of nursing and health staff. What is the methodology, if you like, of how you work out what levels of staffing are required? I know that is a big question, but it is important for this Committee to get their head around that.

Mr MINNS: Yes. Look, I did hear the mention of establishment and establishment is a sort of historical concept back in the time frame of the New South Wales public service board. When I first started my first job in New South Wales Government somewhere in the 1980s, the public service board still existed and you needed to

get public service board approval to create a new role anywhere in the New South Wales public service. I think most people would take the view that that kind of structured, capped, meticulously overseen establishment number by a body like the public service board that was a long way from the front line was not particularly agile and not a very helpful way to support the delivery of services. We do not use that model anymore. It lingered a little bit in workforce planning because of the way payroll systems were historically designed.

But these days we are able to focus more on the people that we employ and allocating them to roles. Sometimes we allocate them to more than one role if they are doing two tasks. So the idea has lost its kind of relevance. In NSW Health we do a 10 year—and we are just in the process of refreshing our 10-year overall strategic workforce plan. It would have been out by now but for COVID last year. In that we have very detailed considerations of our clinical workforce requirements across the entire system. We then expect that that is guidance for the strategies we want our local health districts to work on to attract and retain their workforce. Each of our districts would have a detailed workforce plan that represents how they convert those strategies and join them to their budget allocation annually and their service planning for how they want to run services in their district. All those things will come together and produce a workforce requirement that would be quite well known in the executive team within the district.

The Hon. WALT SECORD: Dr Lyons, after *The Sydney Morning Herald* report about Dubbo Base Hospital, where thousands of test results were never followed up, did the department follow that up or investigate what actually happened in Dubbo?

Dr LYONS: It is my understanding that it was followed up by the local health district. It was around tests that were ordered by junior staff on different shifts, not having had someone more senior assess those and ensure that there was nothing untoward in those that required a recall of the patient, making sure that the appropriate action had been taken on those tests when they were initially ordered. So my understanding is that, yes, that was followed through, Mr Secord.

The Hon. WALT SECORD: And why were thousands of test results not examined?

Dr LYONS: It is not that they were not examined. It was this next step, which was actually the review of those tests by someone more senior. As you appreciate, our emergency departments have a lot of staff in them and a lot of staff that are more junior and are supervised by more senior staff. Those staff may order investigations. Sometimes the results of those investigations do not necessarily come back until a decision around the care of the patient has been decided on. The patient may have been allowed to go home from the emergency department based on—sometimes it is even that there is an X-ray that is reviewed by the staff. They do not see a fracture. There is a small fracture on the X-ray that is seen by the specialist when they review it. It is about making sure that there is a fail-safe and quality assurance check. It does not mean that the investigations were not reviewed at all. It is just a double step of checking those to ensure that we are offering high quality of care and that there are not any things that need to be followed up that are not actioned.

The Hon. WALT SECORD: Are families still bringing their own bandages to Griffith Base Hospital?

Dr LYONS: I do not know the detail of anything around that. Can I just say to you though, Mr Secord, our hospitals are funded and you heard about the funding that we provide—the growth in the funding that has gone out to rural hospitals over the last eight years and the increases that have occurred well over and above population growth. Our hospitals are provided with the resources to ensure that they provide high quality care.

The Hon. WALT SECORD: Has the matter involving the death of 85-year-old Allan Wells from Cobar, where he died without water or food in Dubbo Base Hospital, and his family members were charged for his hospital records and medical files—was that matter resolved?

Dr LYONS: My understanding is it was. We take all of these concerns seriously and they are investigated very thoroughly. My understanding is that there was a charge for the medical records but that has subsequently been reimbursed with the family.

The Hon. WALT SECORD: What about claims that in New South Wales the New South Wales Government is providing over a two-tier health system, where in Sydney, Wollongong and Newcastle you get better treatment, better care—

The Hon. WES FANG: Point of order: That is a pretty wild claim by the Hon. Walt Secord. I would like him to elucidate where those claims are being made and actually quantified.

The CHAIR: The honourable member knows that that is not a point of order. He knows that it is a question. We are dealing with a very experienced representative from NSW Health.

The Hon. WES FANG: I appreciate that, but I think these sorts of—

The Hon. WALT SECORD: Dr Fang, we received more than 700—

The CHAIR: Order!

The Hon. WES FANG: Well, Professor Secord—

The CHAIR: Gentlemen, we have had a reasonable afternoon. We are nearly there. The position is that that is not point of order. So please present the question and the witness will answer as he is entitled to answer and as he sees fit.

The Hon. WALT SECORD: Thank you, Chair. We had more than 700 submissions to this inquiry and there were claims of a two-tier health system.

Dr LYONS: I think in my opening statement I outlined some of the performance of our rural and regional hospitals by comparison with the metropolitan hospitals—things like emergency department performance, which is at or better than metropolitan emergency departments. I talked about the elective surgery access, and it is at or better than metropolitan hospitals. The experience of people who present to our hospitals that they provide in the patient surveys about good and very good care is better than the metropolitan hospitals. I do not think there is evidence that would back up that claim.

The Hon. WALT SECORD: Do you believe that there is a role for the State Government in assisting—we had evidence this morning that there would be up to 41 towns in 10 years that will be without a GP.

Dr LYONS: I think this is a serious matter. It is one of the issues that we have been highlighting as a really critical component of how we can respond as a health system, including the Commonwealth and all of the other stakeholders, in how we address this looming shortage of doctors, particularly general practitioners. The trends are concerning because there are fewer people going into general practice training and the distribution of GPs into rural and regional environments is less, and that is continuing to occur. All of the things that we have been doing over the last 10 years have been about how we can support a shift. How do we get training for medical students in rural and regional environments? We talked about and heard about the pre-vocational rural preferential program, where we actually allocate specifically in the first two postgraduate years into rural hospitals to give people experience of providing clinical care in those environments and living in those environments in their early postgraduate years. We have got to get pathways that continue to support all of the training being available.

I think that is the next step for us: How do we get agreement from the colleges that vocational training in the specialities and in general practice can occur in those rural environments, in a way that supports a pathway and a pipeline that enables people who are committed and who come from rural environments to live in those rural environments—and who are committed to staying in those environments—to be able to have all of their training in those environments and stay there for their careers and be supported? The other issue is being supported once they are in roles in a way that allows them to be able to continue to live, work and prosper in those communities. There are a whole lot of other factors that come into play as well. But we are really committed about what we can do from our side of things to ensure that we have got those opportunities available for our workforce.

The Hon. WALT SECORD: Thank you, Dr Lyons. I will yield to Mr Amato.

The Hon. LOU AMATO: Could I just ask one question? It carries on from the Hon. Walt Secord—

The Hon. WALT SECORD: No, I will yield to Mr Amato.

The Hon. LOU AMATO: I just wanted to know whether there has been a reduction in the number of people who are taking up medicine and other health professions.

Dr LYONS: Not a reduction in the numbers that are going into those professions, but there is a trend that is occurring when people come through their initial training into specialisation versus general training. The numbers going into general practice have been reduced over time and the numbers going into the specialities for training have been increasing. That is the trend that we are concerned about because we have got to value general practice training and general training in the specialities like surgery and medicine as well. The trends for health care have gone into specialisation and sub-specialisation, and those things have been valued and rewarded. We have got to start to reward those other aspects that are really important for health care to be provided for communities, particularly in rural and regional.

The Hon. LOU AMATO: Yes, I was just curious there. I know in the trade professions there has been a reduction in the number of young people getting into those sorts of professions and that is having an impact. I was just wondering whether the same was occurring in the medical profession.

Dr LYONS: It is certainly a trend towards specialisation and having expertise in a particular deep and narrow area.

The Hon. LOU AMATO: One field, yes. Thank you, Chair.

Mr MINNS: Chair, if I may—

The CHAIR: Please continue. That is fine.

Mr MINNS: I will table for the Committee a summary document from a roundtable meeting of GP trainees that met in the last quarter of 2020, in which they outline a range of issues that they see as trainees in the GP stream.

The CHAIR: That would be much appreciated.

Mr MINNS: It goes to the question asked by Mr Amato.

Ms CATE FAEHRMANN: Earlier I looked at the *NSW Rural Health Plan: Towards 2021* that you had, which I think has finished this year. I am just thinking about the evidence that we have heard today, and in many submissions we have received for this inquiry, as to whether the Government has pivoted in the last 12 months in any way as a result of what is, I assume, a bigger demand on regional, rural and remote health services because of the departure from our capital cities, if you like, as a result of COVID. Firstly, has there been an increase in demand over the last 12 months for our services outside of our big centres? Has that started to appear yet? I am thinking the Government is encouraging everybody to tour in the regions.

Dr LYONS: We certainly see increases in activity at holiday times in some of our rural communities, particularly the coastal rural communities. There will be increases in those towns and you can see that flow through into particularly emergency department activity and hospital activity. But we have not seen—

Ms CATE FAEHRMANN: Comparatively to previous—

Dr LYONS: Comparatively, I do not think we have seen a trend yet that demonstrates we are seeing an increase in demand that is over and above the longer term trends at this point in time.

Ms CATE FAEHRMANN: Is the department forecasting that? Are you starting to take that into consideration, in terms of the previous question that I asked in the last session around staffing and the modelling of staffing?

Dr LYONS: We take the population projections as being the primary driver and then the demographic changes, in terms of the proportion of population and age adjusted, as major drivers of health service requirements. I do not think, at this stage, the population projections have adjusted yet to these sorts of shifts. As they do, we will certainly be factoring them in to our service planning across the State.

Ms CATE FAEHRMANN: Because there is visitation as well as population?

Dr LYONS: That is right, yes.

Mr MINNS: To your earlier question about how we try to approach workforce planning, once we have that notion of predictable activity that is going to occur in a district that is when the workforce locks in behind that. We allow the districts to work on that locally because they are much closer to that requirement than the ministry is.

Ms CATE FAEHRMANN: This question is also relevant to changes in the past 12 months in relation to the pandemic. Has it come to the department's attention regarding questions around housing and the difficulty for the workforce in particular regional areas to get housing close to hospitals? I am hearing horror stories, for example, about northern New South Wales—

The Hon. WES FANG: "Horror stories"!

The CHAIR: Excuse me.

The Hon. WES FANG: That is what is has been: "horror stories".

The CHAIR: Excuse me!

Ms CATE FAEHRMANN: —about people being pushed out almost beyond Lismore and Casino who need to work around Byron, for example. Have you started hearing stories like that?

Dr LYONS: Not that have impacted—we have not heard those stories directly. We know the rental market is tightening in a lot of regional and rural communities. We have not heard about it flowing on in terms of an impact on ability to recruit or retain staff at this point in time.

Ms CATE FAEHRMANN: It is relevant because we have heard of, for example, some hospitals providing accommodation for doctors. Does the department do that in any way?

Mr MINNS: The planning that goes on—

Ms CATE FAEHRMANN: Nurses, as well.

Mr MINNS: The planning that goes on when Health Infrastructure NSW and the ministry and Dr Lyons' team determine that there is going to be a capital project in one of the districts will look at those issues. We have seen some upgrades and provision of accommodation for the rotating workforce that visits where it would be unreasonable to expect them to find their own accommodation.

Ms CATE FAEHRMANN: Can you give the Committee an example of where you mean?

Dr LYONS: There are towns right across the State. Most of the local health districts have arrangements where they have accommodation that they have purchased or might rent on an ongoing basis that is available for people who they recruit in to the town, which enables them to settle before they actually find ongoing permanent accommodation, or for staff who are seconded on rotations because there are many examples of networked services where our staff rotate through to provide continuity of service and to give people opportunities for training, as well. Those arrangements are in place, and invariably the districts have accommodation that they have got already set in place for those arrangements. Some of them also have purchased facilities to actually enable a family that might relocate, if there is a particular recruitment activity underway, to settle into that home while they are actually looking for further accommodation down the track. Most of our districts would have those arrangements in different towns around the State in rural settings.

Mr MINNS: I can vouch for the fact that I have been in one of those new accommodation facilities in Murrumbidgee. I just cannot remember which site.

Dr LYONS: For our junior medical staff who rotate around rural areas on registrar placements and junior medical officer placements, there is a standard of accommodation that is required to be provided. It needs to have internet access to enable them to be undertaking ongoing studies. A whole range of things are factored in.

Ms CATE FAEHRMANN: Okay, thank you. You mentioned the change in graduates essentially wanting to specialise much more than going into general practice. Given that decline, what additional incentives is NSW Health currently considering? Are you giving consideration to more than what is there at the moment? Clearly more needs to be done.

Dr LYONS: We are moving away from the GP VMO model, which we are saying is not working well in the current environment—this idea that people go into a town, access the MBS if they are in general practice and work as a VMO at the hospital. What we are hearing from the younger people who are coming through is that they want an arrangement where they have continuity of service and employment. They are happy to be employed under a specialist arrangement, for instance, if they gain their qualification as a general practitioner. We are looking at models now where we can support them to be a medical trainee, be a graduate, train as a GP under an employment arrangement with our services and then ultimately be employed and recognised as a specialist in our services. I think some of those models, as we progress them, will be more attractive to some of the younger people who are coming through now than actually owning a practice and being a small business operator. That is an example of the sorts of things we are doing.

The Hon. NATASHA MACLAREN-JONES: I am also mindful of time so I am happy if you want to take some of the questions on notice to give some more details. I am interested in the rural generalist training program, which you have mentioned in the submission but not in great detail. I think it has been in operation for seven or eight years. Could you just outline how it works, and has it led to an increased number of GPs?

Mr MINNS: The answer to the second question is yes. To do it justice I might take it on notice, because it is not just that program. It is also the Rural General Practitioner Procedural Training Program. They are a suite and they support each other, so we will provide you with a detailed answer on notice.

The Hon. NATASHA MACLAREN-JONES: The other question is in relation to the university outreach work and the new clinical school at Wagga Wagga. I am interested in the arrangement that has been made with the universities and NSW Health, and how that will work towards increasing recruitment of doctors and supporting trainee doctors in regional areas.

Mr MINNS: That is the Murray-Darling Medical Schools Network?

The Hon. NATASHA MACLAREN-JONES: Yes.

Mr MINNS: Okay, we can definitely provide you with a brief on that.

The Hon. NATASHA MACLAREN-JONES: Thank you.

The Hon. WES FANG: I just have one last question in the little time we have. It is probably for you, Mr Minns, but I would be also interested in Dr Lyons' opinion. I am sure you have caught a lot of the evidence today and we have heard what I would term as disappointing terms used around rural and regional health care. I think we heard "horror story" earlier.

Ms CATE FAEHRMANN: That was about the rental market.

The Hon. WES FANG: We have heard a number of disparaging comments around rural and regional health from a number of witnesses who I would say were pushing agendas.

The CHAIR: Order!

The Hon. WES FANG: Chair, I am allowed to ask the question as I—

The CHAIR: Order! I gave some latitude for you to be able to ask a specific question.

The Hon. WES FANG: And I am asking one question of these witnesses. I think, Chair, there is no doubt there has been a number of agendas pushed today.

The CHAIR: I rule the question out of order.

The Hon. WES FANG: Let me rephrase, then. There has been a number of assertions made about rural and regional health care that the numbers do not reflect. Do you have an opinion on how that makes it more difficult to attract workers and people that provide health care to the regions to those areas?

Mr MINNS: Mr Fang, as a public servant—a traditional one—I do not think I am allowed to have an opinion.

The CHAIR: Mr Minns, may I say that the Hon. Wes Fang knows exactly that that is the case. It is particularly disappointing he posed a question in that way.

The Hon. NATASHA MACLAREN-JONES: Just to end on a lighter note, one last thing that I am happy for you to take on notice. We have had a lot of witnesses today mention the State-Federal divide and funding and things. Could you provide a bit more detail to the Committee in relation to the Bilateral Regional Health Forum and how that has been operating over the past 18 months? We obviously hear about it in the media but not a lot of general detail, so I think it might be interesting.

Dr LYONS: Happy to do that, and we can also talk about our relationship with the primary health networks, our focus on a "one health system" mindset and the work we are doing to set a standard for how we want things to work across the whole of the State.

The Hon. NATASHA MACLAREN-JONES: Yes, that would be great. Thank you very much.

The CHAIR: On behalf of the Committee, we have got to know you very well over a number of hearings. It is good to see you again. Thank you very much for the frankness with which you have both received and answered the questions today. We will look forward to seeing you further down the track with respect to this inquiry.

(The witnesses withdrew.)

The Committee adjourned at 17:01.