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 Deni RSL (Dunlop Room), 72 End Street, Deniliquin, on Thursday 29 April 2021

The Committee met at 10:45

PRESENT

The Hon. Greg Donnelly(Chair)

The Hon. Lou Amato
Ms Cate Faehrmann
The Hon. Wes Fang
The Hon. Walt Secord

The CHAIR: I welcome everybody to the second 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 Wemba Wemba/Wamba Wamba and Barapa Barapa/Perrepa Perrapa peoples who are the traditional custodians of this land. I pay respects to Elders past, present and emerging, and any who may be joining us over the course of the day. Today we will be hearing from a number of stakeholders including local councils, private citizens, advocacy groups, health organisations, the local health district and the primary health network. I thank everybody for making time to give evidence to this inquiry. The evidence at these hearings is very important in terms of informing us, the Committee, of the matters we need to be alive to.

Before we commence I will make some brief comments about the procedures for today's hearing. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcast guidelines, media representatives—we do have some here today and you are most welcome—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. I therefore urge witnesses to be careful about comments you may make to the media or to others after you have completed your evidence.

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 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 Legislative Council in 2018. If witnesses are unable to answer a question today and want more time to respond then they can take a question on notice and that is perfectly acceptable. Written answers to questions taken on notice are to be provided within 21 days. If witnesses wish to hand up documents over the course of their testimony they should do so through one of the Committee staff. In terms of audibility of today's hearing I remind both Committee members and witnesses to speak into the microphones and it may be helpful to identify who questions are directed to. Finally, will everyone please turn their mobile phones to silent for the duration of the hearing.

JOHN SCARCE, General Manager, Murrumbidgee Council, sworn and examined

RUTH MCRAE, Mayor, Murrumbidgee Council, sworn and examined

NORMAN BRENNAN, Mayor, Edward River Council, sworn and examined

PHILIP STONE, General Manager, Edward River Council, sworn and examined

The CHAIR: We welcome our first witnesses. I will commence by thanking both councils, represented by their mayors and general managers, for coming along today. The role of local government is exceedingly important in all communities but is of particular importance in rural, regional and remote parts of the State. In the Commonwealth of Australia they play an integral role in representing their communities, providing the communities the support they need and advocating on behalf of the communities for the services that are required and necessary for them. I invite both councils to make a brief opening statement, which may be done by the general manager or the respective mayor. Once that is done we will revert to questioning.

Mr BRENNAN: Thank you, Mr Chair. On behalf of the Edward River Council, thank you for allowing us to participate in this very important inquiry. On behalf of council and the community, welcome to Deniliquin.

The CHAIR: Thank you.

Mr BRENNAN: We are home to over 9,000 residents and occupy an area of 8,800 square kilometres, so it is a fair bit of country. But it is estimated that our health services, which include a 28-bed hospital, serve around 17,000 people because of the area that they cover across the wider Riverina. We are over eight hours' drive to Sydney and we are 300 kays' drive to Melbourne, so we are isolated out here in the south-west of the State. Many people in our community feel like it is an afterthought in the wider region when it comes to health care. There is much debate in our community regarding what should be done about health care, from building a new hospital to more doctors and nurses and increased specialist services. What is not in debate from our community is that our health services are not sufficient. Consultation with community members and health care professionals has told us local people requiring paediatric, oncology, immunology and other services travel to Victoria—Shepparton, Bendigo, Cheetham and Melbourne—or Wagga and Albury to seek health care. Some of them may be referred by local service providers, but it seems credible that others bypass their local health services and seek those services directly elsewhere.

It is clear to council that we need facilities and expertise to be able to provide more than basic paediatric, oncology and other care. We also need a concerted effort to demonstrate to the community that health services are responding to the community's needs. Therefore in council's advocacy strategy—which I will document and leave with the staff—we submit that immediate investment and support is needed for an independent clinical services plan to understand the objective needs of our community and provide a clear set of actions to fill the gaps to ensure paediatric, oncology, immunology and other common health issues can be treated locally in Deniliquin. By doing this we can move forward. We acknowledge the funding commitment from the New South Wales Government recently of $3.2 million and also Federal funding of $1.4 million for the upgrades to the Deniliquin Hospital, especially in the emergency department. That has not happened yet but the planning is in tow and I believe it will be finished by June 2022.

We also acknowledge the work that is undertaken by our local health practitioners in our health district. Many of these professionals are overworked and under-recognised—a symptom of the challenges which our community faces. We also acknowledge the support and cooperation of the management of the Murrumbidgee Local Health District in supporting a solution to these issues. Edward River Council has championed a policy to encourage health practitioners to relocate to Deniliquin with financial support and incentives and has placed improved health services as a high priority in its efficacy strategy. We ask State and Federal counterparts to immediately support a strategic approach to fit-for-purpose health care in our local community. Thank you again for letting us participate in this inquiry. We are happy to answer any questions you might have.

The CHAIR: Thank you very much. We will move to the second opening statement.

Mr SCARCE: Murrumbidgee Council is a small rural council of about 4,000 population. Our immediate medical referrals are Griffith, Deniliquin, Shepparton, Albury-Wodonga and Wagga Wagga. In support of Edward River Council's submission, whatever happens here we will support our referrals to somewhere closer than where we are currently going to now. I stress, and we stressed in our written submission, we live in the bush because of the lifestyle, and part of loving the lifestyle is knowing that everything in it cannot be on our doorstep and we are happy to travel. We said in our written submission that determining a different model of delivery for the bush is required.

We also stated in our submission that we have ideas and are willing to share as it relates to the elderly wanting to remain at home until their last breath. One of those ideas could be just we centralise the governance of multiple outreach nursing homes—15 to 20 beds—in smaller regional towns, supported by governance and operations from larger centres so that the elderly can stay closer to home, where they want to be. Recruitment, selection and retention is essential in ensuring that the services that we do have remain in place. A greater streamlined process needs to be implemented, shortening the process so as we do not lose the limited talent that does put their hand up to come to work in our health districts. The determinants of health, we spoke just broadly that a person's health, only 25 per cent of that actually relates to the health care system, 50 per cent of it social and economic, about 15 per cent is biology and 10 per cent is the built environment. We need to acknowledge that providing resources to more than just the health care system can achieve huge results.

Mental health and wellbeing, we are saying within the agricultural industry—and possibly true for most sectors—that you capitalise the good and you socialise the bad. Having lived most of my life in the bush you see firsthand in a good year 100 people at a local horse race, in a bad year 2,000 people come to the local horse race. We are not encouraging the socialisation aspect, particularly in the bad times. That is part of the determinants of health of 50 per cent. We are also hearing since COVID-19 mental health plans have extended sessions, which is the right thing to do. However, this has created a huge backlog and waiting times. As such, the risk is ever-increasing for those caught with mental illness; mental and physical health problems are compounding; children and youth even more so as less people are working with children as a result.

In trying to work out what the problem is, it possibly stems from the fact that allied health professionals with Medicare provider numbers are what are being used by NSW Health to deliver these health programs. We have professional counsellors who can fill the gap, who are professionally trained in counselling, but unfortunately do not get a Medicare provider number, so many thousands of people with mental and physical health problems fall through the cracks. I know we must start somewhere when we are assessing risk, but having to wait for pathology and diagnosis is too late for mental health conditions. Let us be proactive and on the front foot when it comes to those people presenting with mental illness. We also propose that we look at expanding telehealth for mental, physical and family health. I thank you very much, Chair.

The CHAIR: Thank you very much, Mr Scarce. Before I commence questioning—I should have done it earlier on so I do apologise—I acknowledge the presence of two other members of Parliament who have joined us today. Helen Dalton, the member for Murray—welcome, Helen, and thank you for the ability to liaise with you over the development of the witness list and your input into the preparation for today. Thank you for that. Also joining us is Ryan Park, MP, a member of the Legislative Assembly and the shadow health Minister. Welcome, Ryan, and Janelle from his office. We have senior representatives from NSW Health. Without naming each and every one of you, can I warmly welcome all of you and thank you very much for coming along and for the cooperation and assistance that has been given for the preparation for today and the subsequent hearings. It is greatly appreciated and we very much welcome your input and look forward to your evidence later today.

Of course, members of the public, you are most welcome. These public hearings are very important for the political process in this State. It is important that the Parliament, so to speak, through its elected representatives, go out and engage directly with communities all around the State, and the public not just think that we sit down in Macquarie Street and are the font of all wisdom. Getting out there and engaging is very, very important and I thank very much the members of the public who have joined us already and may join us over the course of the day.

In terms of the questioning, we will move around the table and share between ourselves—we are very good at sharing; believe it or not, we will behave well and share between ourselves. We will be on our best behaviour. Before we do that can I open up with this question and direct it to both councils—and who answers it is a matter for yourselves. The submissions that have come in are very good submissions; they are relatively short but very much on point in terms of the specificity about the points that you actually want to make and they are made very clearly. So thank you for that. My question is: Once upon a time it was not normally the case that a council, a shire or a council, would be dealing much with matters to do with health, so to speak—not traditionally seen as something that would be bought into by the council. But increasingly over recent years—not just in this State but around Australia—we are finding councils very much alive to issues to do with health and medical matters in their communities.

Just a very brief explanation from both councils about how you get yourself informed about these matters that become the basis of you coming and giving the advocacy, because you obviously have become quite informed and it would be useful to know a little bit about that informing that has taken place to sort of provide a base to it so we understand where the knowledge and the information and ultimately the recommendations have come from. If you could just open up with a bit of an explanation that would help us understand the development of it.

Ms McRAE: Historically, council has become involved because we are the end of the line: When all hope is gone the council will fix it. I refer to 25 years ago when we were looking at the redevelopment of the primary acute facility in Jerilderie, the hospital there. They were going to close it and put a primary health centre there. The community had a great deal of anxiety around that, so council became involved to help drive a clearer and more in-depth view of what the council's needs were. They looked to council for the lead, but they are happy to drive as long as they have a connection to somewhere. That is why council becomes involved.

Council, historically, when we could not get doctors, you then became engaged in the incentivised program to try and attract people to come to town: you build houses, you build doctors' surgeries, you provide cars, you provide income guarantees, you almost sell your soul—not quite, but recognising the value of having that medical service in your town. You look at people say, "I can't stay here, there's no doctor. I can't stay here if we haven't got a doctor, we haven't got a pharmacist." As Mayor Brennan identified, it is about that first-line emergency care and then being able to deal with that at the local level, and then that brings in the aged-care component, and then we are happy to access the greater, more in-depth services at a regional centre or even a centre the size of Deniliquin. But as far as that, first-line emergency care gives surety and peace of mind to the community that live there, from the very young to the very old.

The CHAIR: What animates the council is that constituents are directly raising these matters with—

Ms McRAE: Yes, they are.

The CHAIR: —the representative of the local ward, and that is how it becomes a matter for council.

Mr BRENNAN: We both merged councils in 2016; we got disbanded and then put together. I think what happened with the new council structure—I was in the old Conargo Shire Council for 20-odd years. We did not really, from a councillors' point of view, worry too much about health because of 8½ thousand square kays of rural agricultural land with some villages, whereas we relied on Deniliquin. But when the new council was formed, the matter of health became very important from the community to the new council. Hence my involvement has been a lot more than the previous 20 years. It has been very challenging because the dynamics across the landscape are wide.

The Hon. WALT SECORD: I am Walt Secord and I represent the Labor Party. I am also the shadow Treasurer. I just want to take this opportunity to also cite the work of Helen Dalton, who is the local member. She is a tireless advocate who is always advocating for improved health services in the region. On that note, I notice that in the submission you said that there are more than 1,500 local patients who had to leave the region and go to Victoria, go down to Melbourne for oncology, immunology and other services. Did COVID in fact—what did your residents do when the borders closed? Did it heighten the problem? What happened during COVID with the border closures?

Mr STONE: Yes, it was a particular challenge for this community. Those numbers are an estimate. It is very difficult to find out what the facts are within our health outcomes, but we certainly heard lots of information back from our constituents about the challenges they had in trying to get over the border when the borders were closed. That really said to us that there is maybe even more of these people who need to go over the border to access health services that are not available in Deniliquin.

The Hon. WALT SECORD: But what did that highlight about the health services in your region? When they could not go, what did the residents do? Madam Mayor?

Ms McRAE: It increased their level of anxiety greatly. The ability to attend this very confronting next level of health care was compounded. We had to get these passes to get across the great divide. We were really ably assisted by our local members. They fought really hard in that space to get best carriage for these people who were seeking these high level—lots of the people would end up going to Bendigo, to Melbourne, to Albury, to all of these places. It is that higher level of care—which we really acknowledge, to some extent—but it is the issues then associated with accessing that level of higher care, which comes to transport, timely attention and cost. It then becomes a social issue because sometimes it is cost-prohibitive that we have to access that level of care at a metropolitan centre.

The Hon. WALT SECORD: In one of the opening statements—I think it was Mr Scarce's—you mentioned that there was an acknowledgement that you, in fact, have to resort to telehealth in some circumstances. But what is your view on telehealth? Madam Mayor, you are moving your—

Ms McRAE: I am very happy with telehealth as a complementary measure, not as the only measure to rural and remote areas. We would be really happy to engage fully with telehealth if the communications were A-1.

The Hon. WALT SECORD: You were very careful in your wording; you said "complementary".

Ms McRAE: Yes.

The Hon. WALT SECORD: Do you feel that it is actually becoming a substitute for human contact?

Ms McRAE: As a consumer, I like to see somebody sitting in that chair. It gives me a level of confidence. It gives me a level of being listened to. It gives me a level of confidence that my next step in this really challenging process is actually going to have a human element attached to it. However, I do recognise that you cannot be everywhere. We cannot have all of these specialists and next-level care sitting in our small rural communities. What that does tell us is that the health initiatives like My Health Record and all of those things are so valuable because they can actually enable that telehealth facility.

The Hon. WALT SECORD: I will make this my last question for a while. Thinking back, in 2017 there were a number of problems in the region involving the local health district—I remember this—cutting services at Deni and across the region. Have the cuts ceased?

The Hon. WES FANG: What are you talking about?

The Hon. WALT SECORD: I am talking about 2017.

The CHAIR: If members have a point of order, they put the point of order. We do not have cross conversations. Mr Secord, perhaps repeat the question?

The Hon. WALT SECORD: Madam Mayor—

Ms McRAE: I have a comment regarding funding. Health will never be as adequately funded as we would all love it to be. What that tells us is that we have to better use the money we have. What that tells us is that these electronic initiatives, these collaborative initiatives—we have to embrace these new ways of delivering the health service. We get that. What we do not get is not having the ability to embrace the new initiatives or health services because we simply do not have the resources to step up to embrace the initiatives. While we acknowledge that the money is generous—Mayor Brennan has just said that there is $3.2 million and $1.4 million coming to this community; that is amazing—it is about using our money better, pooling our resources and working collaboratively to ensure that our communities are serviced—not a token service but a regular, engaged service that allows us that equity of access.

Mr BRENNAN: Can I just add to that? In 2017 we had a meeting—my general manager, Adam McSwain, and myself—with Brad Hazzard's office. One of the issues raised there was the cuts that had been happening. We were trying to make sure that they would not continue. I believe, if my memory is right, that Jill Ludford was on a phone hook-up there and she appreciated the concern from us that there just seemed to be an eroding away and we just wanted to call it quits. To my knowledge, I do not know of any significant cuts that happened after that period of time.

Mr STONE: Just a slight addition to that: I was not here when those alleged cuts happened, as a general manager, but what I do see is that the community sees these things happening and it adds to their level of anxiety and the debate around what services are available. We get lots of cross information from the community speculating about what we do or do not have and what services have been cut and have not been. That adds to all of the diminishing confidence of the community in the health service.

The CHAIR: Ms Cate Faehrmann has the call.

The Hon. WES FANG: Oh—

The CHAIR: It is Opposition, crossbench, Government. That is the order.

The Hon. WES FANG: No, fine. Whatever.

Ms CATE FAEHRMANN: You will get there, Wes. I am Cate Faehrmann from The Greens; I am The Greens' Health spokesperson. Thanks for allowing us to be here to today, and thank you for appearing. We have had some very interesting submissions—a lot of submissions from members of the community, as you suggest, talking about the various instances where they have not been able to access the health services they need. I just wanted to particularly focus on the submission by the Edward River Council. In it, you talk about the lack of paediatric services, particularly, within the Deniliquin Hospital. You specifically mention that 2,063 children aged under 15 years required treatment in 2018; that does not include the broader Edward River region. In the end, most of those children travelled to Victoria, I think you said in your submission, for treatment. Is there a reason you are aware of that the upgraded Deniliquin Hospital did not include paediatric services?

Mr STONE: It is very difficult for us to be able to comment on the specific designs of that money that went into upgrading the hospital. What we have tried to reflect there in that submission is that they were the numbers that we were given at the time, but I understand they have potentially been brought into question again.

So this goes to the point of our submission—as Edward River Council—that there is a lot of debate in the community about what is and is not available for services within the central health cluster of Deniliquin. We got one set of figures at one point, and then at some point it was put forward that nobody in a paediatric setting could be seen to by the hospital. Then we were given some statistics that refuted that.

Ms CATE FAEHRMANN: Can I just check that? Because I note that in the brochure that you have handed out here on the advocacy strategy for your council, on the page with the Deniliquin Hospital, you have crossed out that bit that says, "Children under 16 cannot be treated at Deniliquin Hospital and are usually transported by ambulance or parents by to Victoria to Echuca … " That was also in your submission. You were contacted by representatives of the local health district or NSW Health to correct that. Is that what happened?

Mr STONE: Yes, that is right.

Mr BRENNAN: That is correct. There was misinformation through the system. In fact, one of the things for the health action group since it has been formed is they really cannot give the detailed level of actions that happened in and out of the region.

Ms CATE FAEHRMANN: So it is quite extraordinary, isn't it, as councillors—and this is not an attack on you—that you have made a submission thinking—no doubt a lot of people in the community have told you stories of children unable to be treated, I am assuming, and being sent across the border. So much so that you have stated it unequivocally in your brochure. It is 2,063 children, so there are a lot of stories there. So what is it—that there is not the paediatrician on site and you receive all these stories? Because it is rather unusual, don't you think, for NSW Health to be so equivocal one way or so equivocal the other way?

Mr STONE: As local government, we are not intimately involved in health. We have a representative on our local health action group. We have good dialogue with the other advocacy groups that are in here. But we can only rely on the statistics we are given or the perspective we are given from members of the community. That is why it has been very difficult and which was why the point of our submission is to "let's get to the bottom of what the problem is". There is a lot of debate out there in the community that there is some insufficiency within the health services. But a lot of people are putting forward solutions that may or may not be right. So let's get to the bottom of what the problem is so we can have a clear action for growing our health services in accordance with what our community needs.

Mr BRENNAN: If I could just add to that, the operational management of the health system is not really the council's role.

Ms CATE FAEHRMANN: No, I get that. But you did get these figures from somewhere that were quickly corrected.

Mr BRENNAN: We got them in good faith.

Ms CATE FAEHRMANN: You got the figures in good faith. So it is all good? Deniliquin Hospital is treating children? There is nothing to see. Is that correct?

Mr STONE: I would not say that is right either. There are some people who we understand—I have not got the figures in front of me. Maybe some people from Murrumbidgee Local Health District might be able to provide some of those statistics.

Ms CATE FAEHRMANN: Maybe we will get some from future witnesses.

Mr STONE: But we get statistics that some people in the paediatric system are being treated at the local hospital and being referred. Then there are other perceptions and perspectives from people in the community that say, "We just couldn't have our child seen to." So there is a debate.

Ms CATE FAEHRMANN: I think that will unfold during the day.

The Hon. WES FANG: Thank you very much for appearing today. I know some of you have come great distances and some of you from not so great distances. It is really good to see you all. I know all of you are really strong advocates for your communities, as I work quite closely with all of you. I just wanted to touch on a few things. Ms Cate Faehrmann has sort of touched on the first one that I wanted to talk about, which was the issue around paediatric services at Deniliquin. Obviously we have seen the submission that you have made. I was about to note that in the Deniliquin Hospital component of your advocacy brochure you have hand ruled out that component around children. With issues like that, do you see that potentially putting out misinformation would fuel issues in the community to come up around paediatric services? Because, by all accounts, if you have a paediatric patient who needs to be seen, they will absolutely be seen at the hospital. And by putting that out there, you may actually have patients who do need to be seen feeling like they cannot go to the hospital. Can you see where that may create an issue?

Mr BRENNAN: That is why we tried to correct it as soon as we could. The other option was to withdraw all of them and get them reprinted. We thought the quickest and easiest way was to amend.

Mr STONE: Can I add, Mr Fang, that is very much a metaphor of the challenges that are going on across the board in Deniliquin health services. There is a lot of different perceptions and misunderstandings of what is available. I note that one of the submissions to this inquiry from the local area talked about just getting clear on what services are actually offered in the local health area to make sure it meets the needs and that people are better informed. It is human nature that where there is a lack of information speculation often permeates. We did pull these figures in this submission together in good faith with the information we had at the time, and when we were corrected we took the steps to make sure it was changed.

The Hon. WES FANG: Because I think within the community at the moment there is still that perception that children are not being treated at Deniliquin Hospital and that they are potentially going elsewhere. It is just untrue. We need to actually have that corrected because potentially what we could see is that a child who is unwell is taken by their parents somewhere else because they have read that children under 16 cannot be treated there. But they absolutely will be. And they will be given first-class treatment. Can you see that that is potentially—

The CHAIR: Mr Fang, I think you understand how we proceed.

The Hon. WES FANG: It is my questioning time and I am asking questions. I am making sure that this is—

Mrs HELEN DALTON: You are making a statement.

The Hon. WES FANG: Mrs Dalton, you be quiet, all right. You have created half of this issue—

Mrs HELEN DALTON: You are making a statement. You are not a witness. These people are.

The CHAIR: Mr Fang—

The Hon. WES FANG: You created this issue, Mrs Dalton, you and the rubbish that you put out there on social media.

The CHAIR: We know how this proceeds—back and forth.

The Hon. WES FANG: I am asking the questions. If the audience cannot be quiet then they can leave. They are not helpful, I can tell you that.

The CHAIR: Mr Fang, as the Chair I interrupted you because what you were doing—you may not appreciate—was quite a long editorialising of your position. I was trying to get you to come to the question. That is what I was doing.

The Hon. WES FANG: Sorry, Chair. I should be succinct, like you. My apologies.

The CHAIR: That is all I was trying to do. Pose the question—

The Hon. WES FANG: I am just trying to have this corrected because it is of grave concern to me—

The CHAIR: Order! This is not a forum for you as a member of Parliament or a member of this Committee to correct the record.

The Hon. WES FANG: What is it then?

The CHAIR: The way this goes—and you have recently experienced it, you are a chair of a committee—is you pose questions, as you know, and allow the answers to come back and forth. That is the way we go.

The Hon. WES FANG: As I have been doing. I guess misinformation feeds misinformation. What I will do, Mr Mayor, is congratulate you on your advocacy because we have just toured Deniliquin Hospital. Some of the things that you have been talking about advocating for, i.e. the oncology services, we have actually just had a tour of what will be the new oncology area in the hospital. Can you talk to us about how you have engaged with the local health district and seen a lot of those improvements in the hospital come about? Because no doubt it has partly been your advocacy on the issue, like the renal unit where you have now got nine chairs.

The CHAIR: Mr Fang, I am loathe to intervene again but we do not editorialise. We put the question and allow the answer.

The Hon. WES FANG: There was a question there. It was explicit.

The CHAIR: That is right. But then you continued on editorialising.

Mr BRENNAN: The advocacy for the renal section was done well before this new council was formed. Congratulations to all those people who did that. The main thing in our presentation here and what is an onus on this Committee is to take up the concept of getting the clinical services plan initiated so that we can set a new benchmark as to the way forward. I think that is critical so all the different questions that we have around can be answered. That to me is the way that you will stop the misinformation throughout the community left, right and centre.

The CHAIR: That is particularly in regard to the services available. That is the key.

Mr BRENNAN: Yes, and the level of services that should be made available.

The Hon. WALT SECORD: Madam Mayor, you made reference in your opening remarks about council becoming involved in attracting, assisting and supporting specialist medical professionals. We want to be constructive about this, we actually want to make recommendations to the Government to improve the health care that people in rural and regional areas receive. Can you tell us a bit about what the council has done and in what ways do you think the State Government can work with council to attract specialists to the region to work at the hospital?

Ms McRAE: I think the way health professionals are trained these days—and I will probably be shot for saying what I am about to say—is that everything is a specialised field. In rural and remote Australia we need generalists. We need generalist medicos that are well trained. Nobody says that they do not need to be really adequately trained, but they also need to be incentivised. Lots of professions, lots of organisations, lots of big businesses have really significant incentives to encourage people to get into the workforce, get the runs on the board and then move on with their professional development.

The Hon. WALT SECORD: But in your opening statement you made reference to council in the past. So what have you done in the past?

Ms McRAE: In the past we have provided an income guarantee for our general practitioner, to attract somebody. We had two periods where in Jerilderie we did not have a GP for up to 18 months. We lost our functioning pharmacist.

The Hon. WALT SECORD: Sorry, you were 18 months without a GP in a community?

Ms McRAE: Yes. It is a small rural community, but we were 18 months without a GP.

The CHAIR: How long ago was that?

Ms McRAE: A long time ago—15 years ago.

Ms CATE FAEHRMANN: A Labor government.

The Hon. WES FANG: I was about to make that point.

The Hon. WALT SECORD: Sorry, I want to hear the witness, please.

The CHAIR: Order!

Ms McRAE: But we learned a very valuable lesson from that. We realised that even though this is not core business for local government, we had to assist. We had an old doctor's surgery and an old residence. We built a doctor's residence and we built a surgery.

The Hon. WES FANG: Did the Labor Government at the time offer to help assist you?

The CHAIR: Order! I am a reasonably patient person, but I have limits. Interventions like that, you know, are completely inappropriate.

The Hon. WES FANG: It was a question. I was seeking elucidation.

The CHAIR: I will not keep doing this—pulling you into line. I am going to give you the opportunity to just reflect on the last 20 minutes and see if we can proceed as we know we ought to.

The Hon. WES FANG: I have been able to ask about three questions, but anyway.

Ms McRAE: Have I answered your question?

The Hon. WALT SECORD: Yes. I wanted to be constructive and I wanted to get some examples. You are on the front line; you have got experience. It may have happened in the past, but we want to make recommendations where we can improve health care for families in rural and regional areas.

Ms McRAE: At this stage we no longer have to provide an income guarantee for either of the doctors who work across our local government area.

The Hon. WALT SECORD: So they are functioning. They are self-sufficient.

Ms McRAE: They are functioning in very self-sustaining practices.

The Hon. WALT SECORD: Wonderful. Mr Stone?

Mr STONE: Council has recently adopted an amended financial incentives policy for our doctors. This actual calendar year council provided a $5,000 incentive to a local doctor to stay here as a registrar. Some of the personal stories—for me, I think, as a ratepayer of Edward River Council, the ratepayer should not be picking up the bill for those things. But it is seen as necessary to try and attract people here. So that is a bit of a symptom of the challenge we have. As a local resident—as I have just moved here in the last six months—I have tried to get seen for just a general ailment that I had at a local doctor and all of the doctors' surgeries told me that they were not taking on new patients. I could not see them.

The Hon. WALT SECORD: What do you do in that case? Did you go to the emergency department or did you—

Mr STONE: Yes, I went to the emergency department and was seen by a nurse practitioner. So that is a symptom of the challenges we have in resourcing the appropriate level of care.

The Hon. WALT SECORD: If you actually get on a doctor's books, what is the wait to see a GP in the region?

Mr STONE: It changes from month to month. This was back in November, so right on the advent of—still during border closures and so forth. I believe that the doctors' surgeries are now taking on new patients, but there was a period there where none of them did take on new patients.

The Hon. WALT SECORD: Madam Mayor?

Ms McRAE: I can answer the question that Wes asked. Council paid for the build of the house and the general practice, back when it was replaced. I can also add that since our council merger, we have spent $90,000 on the doctor's surgery in Coleambally and we have done improvements also to the doctor's surgery in Darlington Point. While it is not our core business, it is our social responsibility to enable and provide that access to medical care. In overall budgets people probably say, "It is not that much money." But it is a significant amount of money in a small rural council.

Mr SCARCE: Probably one of the telling issues—and it is with recruitment—is isolation. It is peer isolation to anybody that comes out. We see it in local government in just getting engineers and getting other professionals, but it is even more so for doctors that are working 12 hours a day five days a week and they have got, really, nobody. There needs to be something set up to support that isolation to ensure that they can, without closing the door, get a locum through or do something like that so they can have a week off or they can go and do their professional studies or something.

The CHAIR: I have two quick questions before we wind up. With respect to Murrumbidgee Council, in your submission on the top of page 2 there is reference to over 12-month wait lists to see a specialist. Is that a matter that has been raised with you by constituents as an ongoing issue?

Mr SCARCE: It was raised by constituents and it was primarily to do with the border issue—the locals from Victoria coming through to Wagga. That was the main thing.

The CHAIR: Finally, in the second paragraph on the second page of your submission, the last sentence says about seeking specialist attention, " … to give us"—presumably the community—"the option to go to Sydney if we can be seen within a reasonable period of time." I gather that is compared to the case of going down to Melbourne or some other location? Is that what you are saying?

Mr SCARCE: It does not really matter. It was not going to Melbourne. It is the same impost onto any location, which is the time to get the referral through for the specialist. Whether it is to Wagga—and if it cannot be to Wagga, then why not to somewhere else that can see us. Is it just stopped?

The CHAIR: The evidence from constituents is that there is like a blockage, they cannot get access to referrals to Sydney. Is that what you are saying?

Mr SCARCE: It is sort of like that they go, they get the referrals. Whether that is because the network only knows of those specialists in Wagga or Albury or whatever and they do not know of the others or it is an impediment, but it just seems to come back. Some do ask and say, "Can you go away?" Others that are more

informed actually get on and do some Google searches and find out what else and where it is and they actually go in and say, "Well, how about Mr so and so over here? Is he available?", or whatever, and get their referrals that way as well.

The CHAIR: Finally, quickly, the issue of ambulance wait times, you explicitly draw that out in your submission. That is a matter that has been raised by the community.

Ms McRAE: There have been instances of ambulances having to come out of Albury-Wodonga to meet an ambulance between Jerilderie-Berrigan on the way to Albury because it is the only ambulance that is left in the area at the time. So rather than leave the whole area without an ambulance, we have to wait for somebody to come and retrieve.

The Hon. WES FANG: How often does that happen though?

Ms McRAE: We only hear a minuscule amount of the instances where people have to wait. You know, when you have got somebody having a heart attack, 20 minutes might seem like two hours. So we have a four-person ambulance station in Jerilderie—we are on the Newell Highway—and sometimes there is not an ambulance there. We are very lucky because a lot of the time it is there. Some centres do not even have an ambulance. But I think the whole ambulance on-call rotation thing is a compounding issue added to access to, you know, expedient and critical care.

The Hon. WES FANG: The only reason I was asking was because it was one of those issues where it may have happened once but it is something that lives on in perpetuity. The reality is that the majority of the time you have got those ambulances at the station.

The CHAIR: Mr Fang.

Ms CATE FAEHRMANN: We are over time, five minutes late.

The Hon. WES FANG: This is not going to work if every time I ask a question the Labor-Greens alliance tries to block me.

Ms McRAE: Can I make one final comment. Our local member is aware of this issue and is advocating in that space for us. Justin Clancy is doing that out of Albury.

The CHAIR: Are there any final points you would like to bring together before we conclude?

Mr BRENNAN: There is one thing I would like to say in regard to ambulances. We are very poorly serviced with public transport. There is a tyranny of distance. The elderly might not have a licence, they might not have a vehicle, and therefore they are inhibited in trying to get to those services. That is another little chunk that needs to be put in the equation.

The CHAIR: Part of the puzzle.

Mr BRENNAN: Yes.

The CHAIR: The time moves so quickly when we have such robust questioning. There will be supplementary questions on notice from the Committee members. The Committee secretariat, after providing you with the opportunity to have a look at the transcript, will follow through with further questions. There is normally a 21-day turnaround. On behalf of the Committee, thank you very much. It is very important to have a baseline set by the council.

(The witnesses withdrew.)

DAN SALMON, Secretary, Deniliquin Health Action Group, sworn and examined

MARION MAGEE, Chair, Deniliquin Health Action Group, sworn and examined

The CHAIR: With respect to the submission from the Deniliquin Health Action Group, as you would be aware, it has been received by the Committee secretariat and processed and stands as submission No. 95 to the inquiry. Thank you very much for putting that together. Take it as read by all Committee members in preparation for this hearing. There is no need to go through it line by line. There will be some questions coming from members after providing you with an opportunity to make an opening statement.

Dr MAGEE: I have been elected to give the opening statement. First of all I would like to pay our respects to the Wemba Wemba Perrepa Perrepa people who are the traditional owners of the land upon which we meet and work today and pay our respect to the Elders past, present and emerging. We represent the Deniliquin Health Action Group. I am the chair, Marion Magee. Dan Salmon is the secretary. We were formed in 2019 in response to a growing community concern over what we felt were health needs in our community that were not being met by bureaucracy in government. We decided to form a committee to try and see if we could find our own local solutions to the problems that were facing us. First of all we conducted a survey of our community. We got over 400 responses to two simple questions. They were just: How do you think the health services can be improved? And, what are you concerned about in your community at the moment? As a result of that we got a lot of responses. We collated the responses and a copy of those responses are available to you, if you wish. We came up with four main areas which we felt were a priority.

The CHAIR: Could you just pause. You have a summary of the work done?

Dr SALMON: I have 10 copies here.

The CHAIR: Thank you, the secretariat will distribute those. Sorry to interrupt.

Dr MAGEE: There were a range of areas, but we met and decided upon four areas that we thought were the most pressing and where we could make the most headway. One of them was recruitment and retention of staff. Another was returning paediatric services to the level that they were before. Another was access to health services and the fourth was improving oncology services. We put our heads together and we had a good think about why people come to the country and we decided that they come for love, money or fear: Love of relationships, love of family, love of country, love of adventure, love of lifestyle; fear because they are running away from another country—such as international medical graduates; or remuneration. And we all know that remuneration is not that fabulous in the country.

We collaborate with the local hospital, with the Murrumbidgee Local Health District [MLHD], with the Murrumbidgee Primary Health Network [MPHN], the council, our local member of Parliament—we collaborate with anybody we can. Our solutions for staff recruitment and retention have been quite successful. We have managed to get another four doctors to the town, we have managed to get a nurse practitioner to staff our emergency department [ED] and we have just been approved for funding for a further nurse practitioner to cover in our emergency department.

Our recruitment and retention strategy had two streams. Stream one was to grow your own. So people who were already here and already committed to the community, we sought to educate them and upskill them so they could improve their range of services. Three midwives have been grown that way, which is nice. The other stream was to recruit and retrain. The recruitment and retention package included accommodation, tenure, remuneration, opportunities for career development and mentorship. It turns out that accommodation has been very crucial. We have gone from no houses to nine houses that we can now offer staff who come into the town.

The CHAIR: Are they on a nominal rent basis or a no rent basis?

Dr MAGEE: I am trying to keep my opening statement brief, but I can go into further detail on how we achieved that. An oncology unit has been set up. I am not saying these are our achievements but these things have happened while we have been active and advocating for the community. We set up to provide the community with a voice and to try and take back some responsibility and to use local know-how to come up with our own solutions.

The CHAIR: I will commence with one question and then pass on to my colleagues. In your submission, halfway down the first page, it states:

> Services delivered in Victoria to NSW residents are rarely reported to the NSW health authorities unless there is a charge for public hospital services.

This issue of not having clear eyes into what is the provision of health services to New South Wales residents by an outside provider, namely the State of Victoria, do you think that is an issue?

Dr MAGEE: Yes, we know that millions—

The CHAIR: Why do you say it is an issue?

Dr MAGEE: For instance, we tried to get some data on how many oncology patients were going from our town into Victoria and it was a huge secret squirrel business and we had to be—basically they would not tell us.

The CHAIR: "They" being?

Dr MAGEE: The Victorian health department. They have the numbers. They have the stats. There are millions and millions of dollars going across the border but we cannot get the stats. We cannot get the numbers.

The CHAIR: How did you seek that information? Through a freedom of information application? Or writing a letter to Vic Health?

Dr MAGEE: Virginia Lang, who is the manager of the hospital, sought the information.

The CHAIR: Made a request?

Dr MAGEE: By request. She got the information but then she was told she was not allowed to pass it on to the community.

The CHAIR: Sorry, the person you just mentioned—what is her responsibility?

Dr MAGEE: Virginia Lang. She is the manager of the local hospital.

The Hon. WES FANG: She took us around the—

Ms CATE FAEHRMANN: That's who we saw.

Dr MAGEE: You met her today.

The CHAIR: For the purpose of Hansard—Hansard needs to have a record of names we refer to. So thank you very much, Wes.

The Hon. WALT SECORD: Your very first recommendation is a bit surprising to me. It says, "Produce a list of services available from Deniliquin Hospital." Why would such an obvious recommendation—I am not insulting you. I am just asking you a question.

Dr SALMON: I was listening to your interview with the councillors and one of the issues raised was the lack of clarity on what is available.

The Hon. WALT SECORD: Yes.

Dr SALMON: The other thing that concerns me as a fairly substantial consumer in my broader family of health services is the continuity of supply. They have one nurse practitioner. That one nurse practitioner is not able to provide a continuous service—he or she gets sick, takes a couple of days off. The same with oncology. There is one oncology nurse at various stages, which means that if he or she gets sick there are no oncology services. There is a combination of nobody really knows what happens because being a small community, it is a hotbed of gossip and much of it is not completely correct, shall we say—

The Hon. WES FANG: Sorry, can I just jump in there? Doctor, can you direct—

The CHAIR: Order!

The Hon. WES FANG: Sure, you guys do what you want. We will not have a committee. I could try and tease stuff out—

The Hon. WALT SECORD: I want to hear firsthand from them.

The Hon. WES FANG: No, you're alright. You go.

The Hon. WALT SECORD: Please. I apologise for my colleague.

The CHAIR: That's not helpful either, Walt. Let us just continue.

Dr SALMON: That's alright. I have got five kids.

The Hon. WALT SECORD: Please explain to me why there is concern. People just do not know what services are available at the hospital?

Dr SALMON: That is correct. And the discussion about paediatrics is the case in point. There are some paediatric patients which are transferred out of town because there are not the specialist surgeons or physicians or

facilities for them. That is then translated into no paediatric patients are dealt with in Deniliquin, whereas the statistics produced by the hospital indicates that something like, what was it, 90—

Dr MAGEE: Some 1,134 children were seen in the ED, of which 31 were transferred out, which is the 3 per cent.

The Hon. WALT SECORD: Dr Magee, how long have you practised in the community here?

Dr MAGEE: Thirty-two years.

The Hon. WALT SECORD: Have health services in the community improved over those 32 years?

Dr MAGEE: It has remarkably deteriorated.

The Hon. WALT SECORD: So what areas have deteriorated and what do you see as the cause of that deterioration?

Dr MAGEE: For instance, we used to have 10 visiting specialists. We now have three. We have always had difficulties attracting and retaining GPs. The level of what people expect is higher. Patients are presenting with more trivial issues, which stretches us. It is much, much harder to do what I do and to become what I am now. There are layers and layers of difficulties and I am more than happy—I know you are keen to find out what is different and I can certainly give you some input about what is different and what has put the barriers up for us. For instance, in the 2000s our three-page application form to be a doctor at the local hospital, which I had had for 20 years, suddenly became a 30-page form. I was informed by the medical director at the time, Dr Banga, that of the 700 doctors employed by MLHD 350 had decided not to reapply because the reapplication process was so onerous. So they lost 350 doctors—boom. And no-one said boo, nothing.

The Hon. WALT SECORD: Three hundred and fifty doctors walked out of the door?

Dr MAGEE: Three hundred and fifty. Anyway, that is one example that the process has become much more—

The Hon. WES FANG: I wanted to pick up on a point that you made earlier, Dr Salmon. You said that if, say, the oncology nurse was unavailable because he or she was sick, that service would stop, or if the nurse practitioner was unavailable, that service would stop. Dr Magee, do you agree with a statement like that?

Dr MAGEE: Yes, that is exactly what happens. It has happened right now. Our nurse practitioner is not available right now.

The Hon. WES FANG: We have just been to Deniliquin Hospital where we, for example, have been talking about the training system of new nurses and how they have multidisciplinary training. There are nurses that are trained across multiple disciplines within the hospital.

Dr MAGEE: So a nurse practitioner is a specialty—

The Hon. WES FANG: I am aware of that.

Dr MAGEE: Yes. They function kind of between a nurse and a doctor.

The Hon. WES FANG: I understand that.

Dr MAGEE: They are a fairly rare thing and we only have one.

The Hon. WES FANG: I understand that, but what—

The CHAIR: Wes, the doctor is answering your question.

The Hon. WES FANG: My point is what service stops.

Dr MAGEE: The nurse practitioner in the emergency department was provided as a solution for us doctors so that we were not continually being pulled away from our practices to see patients in the emergency department during the day. He works nine to five, or nine to six, and he sees the category triage three, four or fives that otherwise we would be having to race backwards and forwards and trying to see. He is currently not there.

The Hon. WES FANG: My point is that if the nurse practitioner is not there, the service still continues. A patient that attends ED will still be seen by a medical professional, most likely a doctor instead of a nurse practitioner.

Dr MAGEE: Correct, so last year's—

The Hon. WES FANG: So the service does not stop. That is my point. So when a statement is that the nurse practitioner is not there the service stops—

Dr MAGEE: Oh, I see.

The Hon. WES FANG: The service does not stop and that is how misinformation happens. By saying that the service stops, there is a perception that the service stops. Whereas what will happen is a doctor like yourself will actually take up the slack. Is that correct?

Ms CATE FAEHRMANN: Point of order: If you could please direct the honourable member to ask questions of the witnesses as opposed to making statements. That is not the purpose of us being here today.

The CHAIR: I accept the point of order.

Dr MAGEE: I take your point, Wes. It makes everything a lot more onerous and difficult. I am afraid Deniliquin doctors are at a tipping point where we are actually at the point of saying, "No, our service stops" to the hospital because it is so onerous we cannot do it anymore.

The CHAIR: Doctor, could you repeat what you have just said again please?

Dr MAGEE: We are at a tipping point. The doctors in town—

The CHAIR: This is right now?

Dr MAGEE: Right now. We are actually having a meeting about talking about resigning en masse.

The CHAIR: Right. And I presume that has not come about without very careful consideration?

Dr MAGEE: We are in the process of our careful consideration right now.

The Hon. WALT SECORD: Thirty-one doctors—how many doctors?

Dr MAGEE: There are 11 doctors in town, of which five provide services to the local hospital as on call.

The Hon. WALT SECORD: And you are considering walking?

Dr MAGEE: We are considering resigning en masse.

The Hon. WES FANG: Dr Magee, if you did that—

The CHAIR: Just hold it.

The Hon. WES FANG: No, it was my question time and Walt just jumped in. I did not make, you know—Greg, you have got to fair about this, mate. Seriously.

The CHAIR: Listen, Wes, I am not your "mate" for the purpose of this hearing. I am the Chair. This has not been a particularly good start for these country visits—the first couple of hours this morning.

The Hon. WES FANG: No, it really has not, because the way that you guys are trying to uncover all this is terrible.

The CHAIR: No, not "you guys". I am not "you guys". I am the Chair of the Committee. If you cannot cooperate with the way I am trying to reasonably run this hearing, you can leave.

The Hon. WES FANG: No, I am not going to leave. I am going to stay here and ask the questions.

The CHAIR: Okay.

The Hon. WES FANG: I am going to be afforded the opportunity to do so.

The CHAIR: Okay. Well, you are not going to talk over me and tell me how to run this hearing. It is up to you, Wes. Dr Salmon, you were wanting to say something?

Dr SALMON: I just wanted to make a clarification that, with the case of the oncology nurse, when the oncology nurse was not available people were driving to Albury for their therapies.

The CHAIR: Right.

The Hon. WES FANG: Thank you for appearing today, I just want to start by saying that. Dr Magee, if the doctors were to resign en masse, as you said, the local health district would employ doctors to actually come in. The services to Deniliquin would not stop; is that correct?

Dr MAGEE: I will answer your question in a roundabout way. Virginia Lange, manager of the hospital, recently tried to find a locum service to get a locum to come to our hospital. Twenty eight locum services were contacted but no-one replied.

The Hon. WES FANG: I am going to re-ask the question. If the doctors resigned en masse, as you are threatening to do—

Dr MAGEE: There would be the potential for doctor services to stop at the hospital, yes.

The Hon. WES FANG: Potential for it to stop?

Dr MAGEE: Yes.

The Hon. WES FANG: Can you elucidate on that? Can you explain further how the hospital would not be able to supply doctors?

Dr MAGEE: We would not be able to deliver babies. We would not be able to do anaesthetics. No-one would be seen in the emergency department by a doctor.

The Hon. WES FANG: I think on that issue though the Murrumbidgee Local Health District [MLHD] will provide doctors to that hospital if you resign.

Dr MAGEE: How?

The Hon. WES FANG: I am sure they will find doctors.

Dr MAGEE: They will contact 28 locum services.

The Hon. WES FANG: So you are threatening to leave the people of Deniliquin without a service?

The CHAIR: Order! I would strongly advise you to withdraw that last statement.

The Hon. WES FANG: It was a question.

The CHAIR: I will say it again. I strongly advise you to withdraw that statement.

The Hon. WES FANG: I will rephrase.

The CHAIR: No, I said to you—

The Hon. WES FANG: No, I have—

The CHAIR: No, you put a position which was quite clear and unequivocal. You know the word you used. I would ask you to withdraw that statement.

The Hon. WES FANG: To aid the Chair, I will withdraw. Let me rephrase.

The CHAIR: Proceed.

The Hon. WES FANG: The MLHD will provide the hospital with doctors should you resign. What services will not be able to be provided for? Can you identify what you think will not be able to be provided for?

Dr MAGEE: In-patient services, theatre services, obstetric services and emergency services.

The Hon. WES FANG: Okay.

Ms CATE FAEHRMANN: Thanks for appearing today. I would like to get to the obvious questions based on what you have just said in relation to the doctors resigning en masse. I am sure you thought about this before you came before this Committee today and you wanted to announce that today. I am you sure thought about—

Dr MAGEE: No, I did not, actually.

Ms CATE FAEHRMANN: Okay, so it has happened.

Dr MAGEE: It has happened.

Ms CATE FAEHRMANN: That is okay. It has happened. I want to ask you to expand upon the reasons as to why you have reached this tipping point. Of course it is very concerning. This is why we are here; to talk about the issues in relation to reduced health services. A lot of the submissions clearly state, over time, as you said, how much the services have deteriorated. There is no doubt we have, in some ways, the evidence before us and you are a witness here to this inquiry. I suppose you are saying that is the straw that broke the camel's back, in some ways, by your evidence today. My question is: Would you care to expand upon more of the reasons as to why you have reached this situation as a group of doctors ready to leave? Are you okay to talk to us a bit about that?

Dr MAGEE: Sure. I must stress this decision has not been made. It is a proposal that has been put forward to us as a group and it certainly has been received favourably. There are 11 of us in town. Five of us

provide on call services to the hospital, which means we are doing one in five 24 hours. I do not work 12-hour days five days a week, I work 120 hours a week. I provide continual anaesthetic and obstetric cover. It is rare for me to get a full night's sleep.

The CHAIR: Sorry, 120 hours a week?

Dr MAGEE: And I have done that for 32 years.

The CHAIR: Right.

Dr MAGEE: That is just how it goes.

The CHAIR: You are quite an extraordinary person.

Dr MAGEE: I am continually on call for anaesthetics. I am continually on call for obstetrics. It does not stop, and then there is the one in five at the hospital as well. We are finding that the new doctors who are arriving in town are looking at our workload and just going, "No way in hell. I'm not doing that. I'm not joining in." So that is why there are 11 doctors in town and five are the only ones who are participating in the on-call roster. Three of us who are doing on call are over 60; we are not going to survive for long. The other two are a married couple. So if the phone rings for one of them, it wakes the other one. One of those has just indicated she wants to go to one in a fortnight and another doctor has just indicated they want to reduce their services. That will leave us three doctors to cover 24 hours. It is not sustainable. It is clearly a broken system and we are currently brainstorming to see how we can possibly fix it. It is a morally outrageous situation to leave a hospital without cover. It is part of the reason why I do work such long hours because I cannot stand the thought of someone going to the hospital and not being seen. So we are going to throw around some proposals.

Ms CATE FAEHRMANN: When you say "we"—

Dr MAGEE: As a collective doctor—we are having a meeting this Sunday. We are going to throw around some proposals and see what can come out of it. There has been a range of proposals that have come out of it. One of them was that we resign en masse but then we rehire ourselves to the hospital as either locums and get a locum rate. At the moment we cannot get a locum rate because we are visiting medical officers [VMOs]. We actually lose money by going to the hospital during the day. The other proposal is that we split our shifts into 12-hour shifts instead of 24-hour shifts. If we were paid at locum rates then that would be remunerative enough that we could perhaps take the day off the next day.

Another proposal is that when we are on call we actually sit at the hospital and see patients as a GP clinic but we are available to see emergency patients as well. If we were paid locum rates that would be remunerative enough to be able to do that and it was thought that then—and several of the other doctors who are currently not participating in the roster have said that if it was a 12-hour roster and locum rates that they would participate. We also think that new doctors coming to town would look at our workload and go, "Okay, yeah, we could do that", whereas at the moment they are coming in and going, "No, I can't do that."

Ms CATE FAEHRMANN: You said you have a 30-year history of working as a doctor, and Dr Salmon you as well for a number of decades.

Dr SALMON: Well, yes, but I am a vet so it is different. I go into the outback and look at dead things.

The CHAIR: Can I just make sure that Hansard has captured that poignant phrase by Dr Salmon? Hopefully you keep them alive, Dr Salmon.

Dr SALMON: I keep the survivors alive.

The CHAIR: Yes.

Ms CATE FAEHRMANN: Dr Magee, you mentioned that things have been deteriorating quite rapidly over the last few years, but you did say that you have been working 120 hours most of your life. Why has it gotten so bad now, do you know? Why has it deteriorated so quickly, I think you said? If you have been working 120 hours most of your life, what is the relationship like with the local health district, the primary health network? What is the catalyst for getting to this? It is a big question.

Dr MAGEE: We are getting into some dangerous territory here. One of the solutions that we came up with was finding and hiring a nurse practitioner to our staff now, which took a huge load off us. It made life livable. The other thing is we have secured sessional services for a locum who comes quite regularly. He does a weekend, he does the nights for us in that week and then he does the weekend after. That was workable. That was okay. The nurse practitioner was suddenly removed from his position, temporarily. It was a solution that was working for us and all of a sudden it was taken away. Plus there are more doctors saying, "We cannot do this, we

need to do it less", and the young doctors saying, "No, we will not come on a roster like this", because they have got these crazy ideas about work-life balance and sleep. I do not know.

The Hon. WALT SECORD: What is it like after working a 120-hour week? How do you function? This is not a criticism of you, but how do you feel about the quality of care and your judgement calls after 120 hours?

Dr MAGEE: We know if you have been awake for 18 hours or more, it is equivalent to driving 0.05. We know that. How do we do it? I have become a sleep addict. I grab it whenever I can. I have an untidy house and no social life.

The Hon. WALT SECORD: What about the care that you provide to patients?

Dr MAGEE: The care that I provide, I do the best I can. It is a type of fitness, if you like. I find that I do not know. You would probably have to ask my colleagues and other people what the quality of my care is. I know I make—last night I was called out late and I could not remember the name of the drug that I had to give.

The Hon. WALT SECORD: Oh my goodness.

Dr MAGEE: But that was okay. I knew where it was and I knew what it look like so I went and got it. But I think little things like that—

The Hon. WALT SECORD: That is extraordinary.

Dr MAGEE: I definitely notice that I am not functioning as well as I should.

Ms CATE FAEHRMANN: One of the four areas that you identified through the survey that you undertook of 400 members of the community, one of them was paediatric services, which I asked the former witnesses about and you said that you wanted basically to get it back to the level it was before. Can I firstly just check on the population in this region and the numbers of children in this region and whether that has reduced or increased, roughly?

Dr MAGEE: I am sorry, I know we draw about 14,000 or 15,000 people. The number of children—

Ms CATE FAEHRMANN: Has it roughly stayed the same? Has there been a boom? Has it reduced?

Dr MAGEE: I honestly could not tell you. I think it has been pretty stable, actually.

Dr SALMON: I think it is drifting down, but slowly. The demographic is like most country towns of this size. We have a huge void in the demographic between about 14 and 30.

Dr MAGEE: I have personally delivered about 3,500 babies, so we have made a contribution to the town.

Ms CATE FAEHRMANN: When you are saying what it was before, talk us through those changes.

Dr MAGEE: In 2013 there were three policy directives directing paediatric healthcare sent up by the ministry. Apparently those three policies do not align but there was a new policy brought out in 2013 where they came up with this idea of level one, two and three facilities and they basically did this blanket: You are level two; you cannot do "blah". We had been doing "blah" safely for 30 years but all of a sudden we were told: You cannot do blah anymore. It did not actually filter through to us until 2018. The directive was made in 2013 but our hospital did not actually realise what we were doing until five years later and that happened because, all of a sudden, I got in trouble for doing something that I had done for the last 30 years safely. It was like, "What the hell are you doing giving a general anaesthetic to a 15-year-old to put his arm back in place?"

Ms CATE FAEHRMANN: Are you going to explain what that "blah" is—the word "blah", the services?

Dr MAGEE: The "blahs" that we used to do in town safely and that we are no longer allowed to do. One is called the general anaesthetic manipulation procedure [GAMP]. So if a child comes in with a grossly deformed arm, we used to be able to give them a brief anaesthetic, put their arm back in place, bundle them up and send them off to their orthopaedic surgeon. We cannot do anaesthetics on children anymore. We also used to give anaesthetics for dental extractions. There are lots of dental health issues. We used to be able to give anaesthetics for children. Say if you wanted to burn off some warts, we used to be able to give an anaesthetic for that. We cannot do that anymore. Say a kid came in with big laceration—a big cut—that needed a general anaesthetic to stitch it up, we cannot do that anymore. We are allowed to do what is called procedural sedation in the ED but that is not always suitable and is sometimes a very risky and dodgy procedure.

The Hon. LOU AMATO: How long ago did that come in?

Dr MAGEE: In 2013. There is a paediatric capability framework ministry directive.

The Hon. LOU AMATO: And the reason why they brought it in?

Dr MAGEE: Apparently there had been some adverse event in another hospital, not ours, and so there was a knee-jerk response to—we are going to take these facilities away from all hospitals.

The Hon. LOU AMATO: It seems to be a common problem across a wide range of issues, but thank you for that.

The Hon. WES FANG: When you said that it had come in from another incident in another hospital, if they had not implemented any changes around that would you think that that would be an appropriate response to an incident that has occurred?

Dr MAGEE: I think every hospital needs to be looked at on a case-by-case basis and to see what facilities that hospital has and what capabilities the practitioners there have. I do not think you can just go blanket: You are all level two. You cannot do this anymore. If we have been doing it safely for 20 years and we have got experienced practitioners, why are we not allowed to continue doing it?

The Hon. WES FANG: It just seems to me a bit incongruous that, on one hand, there is criticism that the department applies a requirement on hospitals because there has been a recognised incident where they perhaps have had, say, a paediatric general anaesthesia issue and then have not had the ability to do something about it when something goes wrong. But then, on the same side, you have got criticism of the department if there is an incident and they go, "That was an incident in this area. We are going to look at other places", and say that that service is different because of XYZ, how do you correlate those two things? Because it almost seems like there is criticism of the department if they respond to an incident but then, if they do not, and look at everything on an isolated basis, how do you see Deniliquin being different to other areas for that paediatric level two service?

Dr MAGEE: I think there needs to be an independent health body set up that is independent of the electoral cycle and they need to have general attitude of risk management rather than risk aversion. The current mindset is risk aversion. A bad thing happened, you cannot deal with that anymore and it has to be sent out. So that is my answer to that. If you have got a ministry that is tied to the electoral cycle, you are going to have politicians worry that they are going to lose their popularity, and they are going to have a knee-jerk reaction and say, "We better do a big thing to make a big fuss and make the voters think that we are doing the right thing." If you had an independent health body that was independent of the electoral cycle, they would have the long view that you guys do not necessarily have.

Successive governments come in, they make policy changes but they do not hang around to see the effect of the implementation of that. Hospital boards were disbanded in the 1990s. So the government took away the local voice. You also took away—you disempowered us. There was no longer any local responsibility or decision-making. They have retained them in Victoria and Queensland. No-one has hung around to see the effect of taking away hospital boards. We were in the black and Griffith was in the black at the time. We were told that Big Brother would look after us at the time and Big Brother has not looked after us, to be the honest. The hub-and-spoke method of hospital administration does not work. You give all the money to the hub, the people spend it on the hub. They do not spend it on the spokes and there have not been upgrades or changes since the 1990s when hospital boards were removed because there is no local advocacy and no local responsibility.

The Hon. WES FANG: But, again, the ED is about to be upgraded. You have got the oncology upgrades, you have your CT scanner, for example. I think if we get into the situation where we are talking down areas when there are actually investments happening here, can you see that that—

Dr MAGEE: Federal money of $4.6 million, and in the meantime Wagga Base hospital spent $200 million on a car park.

The Hon. WES FANG: No, that is incorrect, actually.

Ms CATE FAEHRMANN: Point of order—

The CHAIR: A point of order has been taken.

Ms CATE FAEHRMANN: Thank you, Chair. I am really interested in the witness's responses, if the member could allow the witness to respond without interjecting.

The CHAIR: A proposition was put that you made a mistake in terms of that figure of four-point-what million. Is that the question?

The Hon. WES FANG: No, no, no, because it is predominately State money; $1.2 million of it was Federal money, I believe, but the majority of it is State money.

Dr MAGEE: Okay, I stand corrected.

The CHAIR: That is fine. The record should reflect what the facts are. Careful with that.

The Hon. WES FANG: We had this issue in one of our previous inquiries where people begin to start talking down health in their area and then they find it harder to attract doctors. Can you see that it is potentially an issue, not only for here but across the State, where we have people talking down the services that are provided at a hospital? You are effectively making it harder to attract people to actually come here, which is creating part of the problem.

Dr MAGEE: Well, that is why we put together our recruitment and retention package that has some very good parts to it. It has been very successful and it has worked, so we have in fact been able to attract people here and retain them. For the first time in 10 years, we have a functioning and fully staffed midwifery unit. We have an oncology unit; we have attracted four doctors.

The Hon. WES FANG: And was that in partnership with the local health district?

Dr MAGEE: Yes. We work in partnership MLHD, MPHN, council, and the wider community, to make Deniliquin an attractive place that people actually want to stay. We have developed a very warm, collegial atmosphere amongst the doctors. We have regular educational meetings. We support each other. We are consciously going about making Deniliquin a nice place that people want to come and stay.

The Hon. WES FANG: The picture you just painted there seems to be quite different to the one that you were painting earlier. Certainly the latter one you just painted is more of what we saw when we just toured the hospital recently.

The CHAIR: Is that a question? Mr Fang, you have got to pose a question.

Dr MAGEE: Is there a question in there?

The Hon. WES FANG: Yes. The question is: Do you see the differences in the position you were painting earlier to the position you are painting now?

Dr MAGEE: I get your point. If we say it is all terrible and horrible here, no-one will want to come. I get that point. But by the same token, we should neither say, "It is blissful and wonderful here, please come," because that is not the truth.

The Hon. WES FANG: I understand that. I guess I am trying to tease forward how the council got the wrong information around paediatric services because they are part of the health advisory body that you chair, and yet they still managed to get the wrong information and put it in their advocacy brochure. Do you know how that would occur?

The CHAIR: Mr Fang, that is a question for the council.

The Hon. WES FANG: No, no. I believe that—did the information come through the health advisory?

Dr MAGEE: Council did not consult us and we were the ones to draw it to their attention that that was incorrect.

The Hon. LOU AMATO: Dr Magee, do you think if international medical graduates were able to go to regional areas like Deniliquin, it would help increase the size and scope of medical coverage for your community?

Dr MAGEE: Our experience with international medical graduates is that they will come and they will stay for their allotted five years, but then they will go because we cannot cater for them culturally. For instance, three of them were devout Muslims; there is nowhere for them to worship. They tend to come, stay their five years, and then they will go to where they can be culturally catered for. Another main concern is around education. A lot of health professionals who come to town want a good level of education for their children. That is another thing we often find—that once the children get to high school age, they may leave town in order to seek educational opportunities for their children.

The Hon. LOU AMATO: So that is another issue, as well.

Dr MAGEE: Yes, so I do not feel that international medical graduates have worked very well for us.

The CHAIR: Just to wrap up, your recommendations which are found on page three of your submission—the Hon. Walt Secord referred to the first one, which is this production of a list of services available from the Deniliquin Hospital ancillary services and to make that publicly available. That seems to be an obvious proposition. One would have perhaps even anticipated that the hospital's website for New South Wales for this

particular hospital would have, in fact, quite a comprehensive scoping out of what the services and ancillary services are. That is not the case, as you understand it?

Dr MAGEE: We work in collaboration with the LHAC, which is the Local Health Advisory Committee, and they have been working very hard in this space across all the media to provide a very—to the extent that that is being addressed. The trouble is, as Dr Salmon pointed out, it is a very fluid thing. It changes from week to week and day to day, but the Deniliquin LHAC work very hard in that space to keep the community advised.

The CHAIR: To effectively have, dare I say, a register or list of services—

Dr MAGEE: A living, week by week discussion—

The CHAIR: Okay, so that is a work in progress.

Dr MAGEE: —and the LHAC do that.

The CHAIR: Finally, the third-last point: It is said that the principles of the New England Virtual Health Network be extended to all regional communities in New South Wales. That is a big call. Why would you be advancing that proposition? Is there something particular about the New England Virtual Health Network that invites some close scrutiny and support?

Dr SALMON: It is a startup that is encouraging medical graduates and interns to work more in regional hospitals. We were hoping that, with the opening of the Charles Sturt University medical school, that could be extended into the southern half of the State too. We see it as a way of, as Dr Magee said—

The CHAIR: But it is something that has impressed you. You have obviously seen it and you are impressed and that is why you have put it here.

Dr SALMON: I am a big of a tech fan, so—

The CHAIR: No, that is okay. I am just teasing this out, so thank you.

Dr SALMON: Yes. There is a submission from the New England network in your documentation, so you are probably familiar with that.

The CHAIR: Thanks, Dr Salmon. That is good. Listen, as always, we have run out of time—

Dr MAGEE: Can I make one last point?

The CHAIR: You sure can.

Dr MAGEE: Just as a suggestion for incentivisation for people to come to the rural—make it a tax break. The more rural you are, the less tax you have to pay.

The CHAIR: You mean income tax?

Dr MAGEE: Yes, income tax. I know that is not necessarily a State issue.

The CHAIR: That is why I am just checking, in terms of income tax.

Dr MAGEE: A way of incentivising where you are actually throwing [inaudible].

The Hon. LOU AMATO: It is a good point.

Dr SALMON: There is that, but unfortunately Deniliquin, in the Modified Monash Model, is considered to be inner regional.

Dr MAGEE: No, not under the Modified Monash.

Dr SALMON: Yes, on the current one. So what chance has Moulamein got?

The CHAIR: To both of you, thank you very much. Thank you, Dr Magee, for the work you have done in this community over an extended period of time and for your advocacy. I do hope you get a bit of sleep tonight. Dr Salmon, in terms of the secretarial support, advocacy and speaking on behalf of the community about their concerns—much appreciated. Thank you both very much.

(The witnesses withdrew.)

LYN BOND, Chair, Deniliquin Mental Health Awareness Group, affirmed and examined

LOURENE LIEBENBERG, Vice Chair, Deniliquin Mental Health Awareness Group, affirmed and examined

SUE HARDY, President, Can Assist Coleambally, affirmed and examined

MONICA WHELAN, Member, Can Assist Coleambally, affirmed and examined

The CHAIR: I invite a representative from each organisation to make an opening statement. I can confirm that both your respective organisations' submissions have been received by the Committee and have been processed. For the Deniliquin Mental Health Awareness Group, your submission to the inquiry stands as submission No. 181 and for the Can Assist Coleambally your submission to the inquiry stands as No. 344. Thank you very much. You can take the submissions as read by the Committee members so you do not have to refer to them in detail in your opening statements, but set up your position over a few minutes and then we will open up the hearing to questions. Ms Bond, are you delegated?

Ms BOND: Ms Liebenberg and I have just got a little bit to say each. Is that okay?

The CHAIR: Absolutely—as you see fit.

Ms BOND: First of all I would just like to pay our respects to the traditional owners of the land on which we meet today. That is the Peerepa Perrepa and Wamba Wamba people. I would like to thank you for the opportunity to talk to you today and for coming to the district to hear these submissions. I am currently the chair of the Deni Mental Health Awareness Group we are known as Deni MHAG. We have been in operation for 15 years. Ms Liebenberg is with me today. She was the chair at the time the submission was put in. The aim of our group is to increase awareness of mental health to all the users of the services whether that be the consumers, the service providers, their families and just the general public. We signpost the way to mental health services and resources in Deniliquin and we initiate wellbeing activities. We are not for profit. We are volunteers. We do this because we recognise there is an actual need to try to coordinate the services that are in our community. We are here to try to fill the gaps and we are here to listen to what the consumers have to say.

Ms LIEBENBERG: What is clear to us is that three key issues remain a constant determinant around the level and quality of care as well as timely delivery of services, workforce shortage, funding and fragmentation of service delivery. As long as we have a workforce shortage this will remain a key issue to better outcomes for consumers in this space. With regards to funding, we have a range of services of programs being delivered across a very large geographical area. This in itself is a challenge. We are here to have a conversation, though, with the service provider, who does not acknowledge that more funding would make a significant difference to the delivery of service as well as to the reduced burnout in our workforce. Secondly, still on the funding issue, there appears to be many different pockets and streams of funding, such as State, Commonwealth, commission, services and crisis funding. In our opinion this contributes to both duplication and gaps in service delivery. We believe a more coordinated oversight is needed so specific communities get their specific needs met.

This leads to the third key issue—the fragmentation of services. Some commission services, contracts and projects last only two to three years so just when you think you know which door to knock on the door changes or closes. This affects continuity of care. We believe work needs to be done on a co-location model of all mental health services in Deniliquin, regardless of whether there be early intervention, clinical or psychosocial services. In closing, we not only do this work because we are passionate about our community. We do it because there is a gap in the wellbeing, the promotion and the early intervention space. We believe the model our group follows and the work and projects we do should be incorporated into models of service, funded appropriately across the Murrumbidgee Local Health District [MLHD], the Murrumbidgee Primary Health Network [MPHN] and local government. As volunteers, we have been filling this gap for 15 years. We are asking for this gap to be addressed effectively so our communities can find the help they need. Thank you.

The CHAIR: Thank you Ms Liebenberg. Who has been delegated? Ms Whelan?

Ms WHELAN: That is me, thank you. As representatives of the Coleambally community and Can Assist, we would like to address the following terms of reference that we feel impact our community. "Access to health and hospital services": This includes a lack of transport, both community and public, limited community nursing services and the lack of outreach services including psychology, drug and alcohol, mental health, and all areas of allied health. It is common for our residents to have to travel two or more hours to access health care. We are fortunate in Coleambally to have ambulance services but we believe access to programs such as Paramedic Connect and Extended Care Paramedic will improve the care of our residents with chronic and palliative health conditions.

Regarding oncology services, a radiation centre for Griffith has been promised but this would also require a commitment to provide accommodation for the centre so it can be accessed by its patients for whom it is intended. Local health nurses need the necessary skill sets to care for the various access devices used in oncology so that patients do not have to travel long distances back to Griffith and Wagga Wagga for these procedures. Regarding the lack of palliative care services within our community: we have now out of hours or weekend community nursing or specialist palliative nursing services to assist families with end-stage palliative care so our residents have no option but to be admitted to hospital, away from their homes and loved ones, if they cannot access adequate symptom control, such as pain relief, and their families should be provided with the care they need to care for their loved ones at home.

Our final issue is a lack of partnership between the health services that are available in our town. In rural centres we need to be looking at the existing services and how they can be adapted to meet the needs of the community—so looking at a grassroots approach rather than an all-over LHD approach. We need State and Federal government as well as private providers to work in partnership to find local solutions to improve health outcomes in our communities. Most importantly we need a model of palliative care that will give our residents and their families the choice to die at home with dignity. Thank you for the opportunity to appear before this inquiry. We hope the information we provide is insightful and relevant to your inquiry. Thank you.

The CHAIR: Thank you, Ms Whelan and no doubt Ms Hardy you were involved in the preparation of that very good opening statement, which has laid it out very well for us. We will now commence questioning. Members of the Committee will share the questions. The parties represented here are the Labor Opposition, the crossbench and the Coalition Government. The members will have roughly 10 minutes each. We will begin with the Hon. Wes Fang and we will proceed.

The Hon. WES FANG: Thank you very much. It is a shame we have only got 10 minutes because I have heaps of questions for you, but I will start with the Deniliquin Mental Health Awareness Group first. I have read the submission and thank you very much for highlighting a lot of issues that you see in the community. I guess I was hoping to start by touching on the COVID that we have had, the border issues and the anxiety that that may have created for people on both sides, but particularly here in Deniliquin. How did you find the services were here to support people through COVID? Did you get the additional services here? Was there extra support for those who already have mental health issues as well as for people who were finding it more difficult?

Ms LIEBENBERG: I am a private practitioner and I have had my own private practice in the mental health space. I am an occupational therapist so I see people every day. What has been really helpful through COVID and which I thought was something that we had been waiting for to happen was the introduction of the telehealth Medicare items. That enabled a lot of people to access a service that they had not previously been able to access. In the midst of COVID, if you want to talk about the public mental health services, I guess a lot of people got the help that they needed but they were not able to get it before. Therefore, in our submission, we advocate that telehealth services continue, purely for being able to access ongoingly. As far as COVID services through the public mental health services are concerned, we know that that funding for COVID is now being rolled out, so in the midst of COVID services were delivered as well via telehealth where they could not do outreach. My understanding is that those services continued as normal.

The Hon. WES FANG: In your own practice, did you see an increase in people seeking help because of issues around COVID or just with the increase in anxiety?

Ms LIEBENBERG: There was increasing anxiety. It was a really interesting time because what I actually saw in my practice is, for a lot of people their mental health improved because we stayed home, we stopped rushing around and we all took a breather. Yes, there was a lot of anxiety in the community around cross-border issues. Did that require counselling? No. What that required was a lot of information being coordinated through community groups and organisations to keep our community informed because it was a really complex process. I do not know if that answers your question.

The Hon. WES FANG: It does; it was wonderful. In the brief time I have got left, I want to turn to Can Assist and thank you very much again for your submission. I wanted to talk about regional oncology services and the like. Can Assist has been well known for providing accommodation services to rural and regional families, normally in Sydney, when they have had to go for services. Like you identified in Griffith, what would be the model of accommodation that you would advocate for in Griffith?

Ms HARDY: In Wagga there is a facility called Lilier Lodge. But in Griffith, being a smaller centre, something similar but on a smaller scale would be beneficial.

The Hon. WES FANG: Being from Coleambally, which is not far from Griffith, do you see that you would have people from those sort of areas prefer to stay in rural and regional communities as opposed to

travelling elsewhere? Or do you think they prefer to go to some of those larger areas? What is the experience you have had with the people who have stayed at your locations?

Ms WHELAN: I would say that most people, particularly if they are experiencing cancer treatment, definitely want to be home or as close as possible to their family. When we think of cancer treatment, we have got to look at the whole spectrum. We have got to look at mums with young children and we have got to look at elderly parents that want to stay in contact with their extended families. Definitely, somewhere like Coleambally if we had a—I personally had radiotherapy 10 years ago and that meant me travelling. I had three children; the youngest was only eight. That required me to travel to Wagga weekly, stay in Wagga by myself while my husband, who luckily was a farmer and could look after the children, looked after the children at home. If we had something similar in Griffith, I would have been able to travel in and out daily. The idea of the accommodation at the Griffith one, it needs to be there because we need to look at the people west. We need to look at Hay, Hillston, those areas. They need to have the opportunity to have those services.

The Hon. WES FANG: From Coleambally itself, would people would normally travel to Wagga?

Ms WHELAN: Depends on what services they are accessing. There is an oncology unit in Griffith and most locals would have their oncology there. If they need radiation therapy, at the moment the closest centre is Wagga.

The Hon. WES FANG: The last question I have got around accommodation is: If you had been able to have your friends and family come with you at the time, do you think that would have helped you through your recovery?

Ms WHELAN: I guess in my situation it was a little bit different because I was a nurse and I had a really good understanding of what was happening and my treatment, and I actually felt better knowing that my children were at home, going to school, doing those routine things. It depends on the circumstances, is my answer, and I think you would agree, Sue.

Ms HARDY: Agree.

The Hon. WES FANG: So for rural and regional people it is quite important to have those support networks with them.

Ms WHELAN: It is, yes, but it has to be individualised. Everyone will have different needs and circumstances.

The Hon. WALT SECORD: Thank you for your evidence and thank you for your opening statements. What happens in Deniliquin at the moment when there is an acute mental health incident? We saw this morning that there was telehealth. If you have an acute mental health incident, a person with unfortunately suicidal tendencies, how do they fit into the system with telehealth?

Ms LIEBENBERG: Anybody who has a presentation will present to ED, so are you asking if they come through ED?

The Hon. WALT SECORD: I guess I am asking, what is the patient experience and how do you feel about telehealth?

Ms LIEBENBERG: Any patient who presents to the ED will receive a service and that assessment is done through the Mental Health Emergency Consultation Service [MHECS]—the TV that you are talking about—and that is delivered out of Wagga by specialised mental health clinicians. The experience for the consumer is not always that great. They will get a service, they will be seen, but sometimes there can be a wait for that assessment to happen depending on the acuity and the stress level of that particular consumer. They could be needing a lot of intensive support while that process is going on. The feedback that we get from consumers is that that is not always what is experienced.

They are supposed to be supported through that process when they are doing that interview or being assessed. Sometimes, because of a whole lot of other reasons for what could be going on in ED at that point, that does not happen. I deliver mental health first aid across the region. I am a Mental Health First Aid facilitator and there is not a training that I deliver where I do not hear about an experience that has not been a great experience for the consumer. By that I am not saying that is everybody's experience. It all depends on what is happening in ED on that particular day and what can be given. They will get the assessment, but the level of support and their experience is determined by a whole lot of other external factors.

The Hon. WALT SECORD: Can you give examples of how long people have waited in the ED? You are nodding, Ms Bond.

Ms BOND: They can wait up to hours depending on the time of the day that they arrive and depending on whether or not it is an after-hours call to the MHECS line. Is that correct, Lourene?

Ms LIEBENBERG: Yes.

Ms BOND: They would go through central intake—Accessline. They would have to go through Accessline and then someone would get on the phone to them. That is trying to fit in with the normal emergency department.

The Hon. WALT SECORD: What is your experience, Ms Liebenberg?

Ms LIEBENBERG: It depends on a number of things. The person will be seen when they walk into ED, so they are not not seen and not not attended to. They can wait up to four hours, five hours for a MHECS assessment. It depends on what else is happening. I walked over from my clinic the other day, supported somebody and they had their MHECS assessment within 90 minutes. They were supported by the nurse practitioners in ED. But we have very different experiences depending on the time of day, the availability, how backed up the MHECS clinicians are in Wagga.

The Hon. WALT SECORD: Several years ago we heard that there were no mental health support workers in the local government area of Wentworth Shire. Is there a lack of mental health support in southern New South Wales?

Ms LIEBENBERG: I am not exactly sure what mental health support workers—are you talking about specialised clinicians or just in general?

The Hon. WALT SECORD: I will defer to you. People who would provide assistance to people who I guess would have acute mental health problems.

Ms LIEBENBERG: If a person has an acute mental health problem they will either ring Access Line or they will proceed to MHECS. Those people will be seen within the Murrumbidgee mental health team. We have specialist adult and youth workers. Depending on the triage that is given to that person once they have made contact with Access Line, that service or that follow-up will happen according to the triage. If we are referring to the workforce, we know that there are positions that are incredibly hard to fill and that they struggle to fill.

The Hon. WALT SECORD: Such as?

Ms LIEBENBERG: I am not in the service myself and I cannot remember the exact wording of that position. It was an ED nurse specialist position within the ED department, primarily responsible for training of ED staff at the hospital et cetera. That position has not been able to be filled for several years now. That same position in Griffith took a number of years to fill. I met with the mental health manager the other day. They are able to provide us with the evidence of how they are advertising. There is a lot of advertising and a lot of recruitment going on. It is a real issue that there is a lack of workforce for specific positions because of the specific qualifications needed.

The Hon. WALT SECORD: Because we have to have recommendations that we put to the Government to consider, what steps could the Government take to increase those workers and to get them to come to the region?

Ms LIEBENBERG: I think it is beyond the capacity of our group to answer that question, in all honesty. That is such a complex issue. A couple of things that we think could be helpful is within the Medicare system—so within Better Outcomes in Mental Health Care—at the moment we can get provider numbers for psychologists, occupational therapists and social workers who are suitably qualified. We would like to see that expand to specialist mental health nurses to be able to deliver. But of course, those better outcomes deliveries are only as good as having a clinician on the ground who is registered with Medicare. That is one way of increasing the workforce. Apart from that I really do not know.

Ms BOND: We also talked about continuity of programs. Programs come into the area and they are on limited tenure. They may be a three-year contract, so clinicians will come out not knowing whether or not the contract will be continued and whether the funding for that particular program will continue. They have to then go looking for other work, so do you make a big move to rural areas with a program that only has three years' funding?

Ms CATE FAEHRMANN: Thank you for appearing today. I want to focus firstly on mental health. I want to know whether you have information or data around the prevalence of mental health issues in the community or the region. Has it increased in recent years? I understand that data is sometimes hard to come by.

Ms LIEBENBERG: It is a really interesting question and thank you for that. I have tried to get the data. The question I wanted answered was how many of the people in our community are actually travelling out of our

community or using telehealth to access the Medicare Benefits Schedule [MBS] item numbers—seeing psychiatrists or psychologists outside of our community. It appears that data is almost impossible to access. I have left that with the MPHN and they will be looking at that data. But to give you an honest answer, I am sure that Murrumbidgee and the MPHN will be able to provide that answer but we do not have those answers. I cannot answer that question, I am sorry, but we know that the data is hard to come by.

Ms CATE FAEHRMANN: That is often the situation when we have witnesses pretty much on any issue. I think the data is often hard to come by for their advocacy. Because you are the advocacy group for mental health awareness in Deniliquin, particularly in the past year or two, do you think there is an increase in young people with mental health issues in the area? Have you received that anecdotally? Are people talking about it, if you do not have the data?

Ms LIEBENBERG: What we know is that—we have an early intervention service in Deniliquin. That funding sits with Intereach, which is a non-government organisation, and the program is called Reach Out and Relax [ROAR]. We know that the waitlist for that service can take up to six to eight months. That is an early intervention service for youth. What that is telling us is that, whatever the data is, there are not enough services there in that space.

Ms CATE FAEHRMANN: That is for young people experiencing mental health issues. There is a service but they have to wait six to eight months before they are able to see somebody.

Ms LIEBENBERG: That is an early intervention service, so not necessarily with a diagnosed mental illness. There might be an indication that some early intervention could be helpful so that we could prevent their escalation or a possible mental illness developing. I will not say that is the only early intervention because the space changes all the time. It is really hard to know. I know there is another early intervention program that is just busy rolling out. I have not got my head around it yet. What is it called, Ms Bond, the one that is going into schools?

Ms BOND: The Got It! program.

Ms LIEBENBERG: Yes, the Got It! program. But for this ROAR program, we know that almost since inception there has been a long waitlist. We know that in our headspace centres, which our kids do access—and once again I do not have the exact data. But we have to travel to Shepparton as our closest, which is 150—

Ms CATE FAEHRMANN: This is for headspace?

Ms LIEBENBERG: This is for headspace. We know that the waitlists are significant. What it tells us is that there must be an increase. Otherwise, what I would like to believe is that the work that is being done in the early intervention and the promotion space is actually working, that we are making people aware and that they are starting to look for services earlier. It is really difficult to ascertain if it is increasing or if it is because our help-seeking behaviour has improved.

Ms CATE FAEHRMANN: Are there waitlists for other general mental health services in the area, do you know? I specifically asked before about young people, but just generally.

Ms LIEBENBERG: We have a MyStep program, which generally is a cognitive behavioural therapy [CBT] counselling program that fits into the stepped care model. We know that there are waitlists for that. It varies at any particular time, but we know that service now sits with Murrumbidgee. It previously sat with Marathon Health. That changed over as well, with its own issues that came with it. That service has been waitlisted since the day it started because it took over a waitlist that was significant from the previous provider. So yes, the services are waitlisted and it is across the region.

Ms CATE FAEHRMANN: I want to talk you through a scenario in relation to the new hospital. You have mentioned here in your submission—and thank you, it is a very good submission—what happens with someone who is in crisis or suicidal when they present to the emergency department. Specifically, given that you have highlighted the fact that there are no staff available over weekends who have specialised mental health training, I want you to explain to the Committee what would happen if for example a 15-year-old girl who was having a mental health episode—perhaps suicidal—presented to the emergency department at 8.00 p.m. on a Friday afternoon in Deniliquin. What is she presented with? How is she helped? When does she get a mental health bed?

Ms LIEBENBERG: I just need to clarify that statement. Since making that statement I need to revise some of that information. I mistakenly thought that during the week there might be a face-to-face MHECS assessment. There is not in fact a face-to-face MHECS assessment. The MHECS assessment is the emergency assessment and there are in fact no face-to-face MHECS assessments; it is all done by a telehealth. That young person walking in will be triaged by the ED nurse practitioner. Our ED nurse practitioners are emergency nursing

specialists, so they have training across a range of things. But they are not specialist mental health practitioners—just like none of them are cardiac specialist practitioners. So they will be seen and they will be supported by that nurse. The experience will be very similar to what I said before: The person will be connected with MHECS, an emergency assessment will happen and, depending on the risk that has been determined—whether that person is at risk of suicide and the level of that risk—it will then be decided whether she is able to be supported in the community or whether she needs to be transferred to a specialist mental health unit.

Ms CATE FAEHRMANN: And where are those specialist mental health units?

Ms LIEBENBERG: It depends on where you are, which town you are in. I think we are from Deniliquin; that arrangement is with Box Hill. I stand to be corrected, once again—

The CHAIR: Box Hill being in Victoria?

Ms LIEBENBERG: In Victoria, yes. And, once again, we are just a volunteer group; we do not carry all of this information, so I guess if there is anything that needs to be clarified—

Ms CATE FAEHRMANN: You are able to clarify that on notice.

Ms LIEBENBERG: Thank you. So we go to Box Hill if you are in Deniliquin. My understanding is if you are in Mathoura I think you go to the Austin, or Moama you go to the Austin.

The CHAIR: That is in Melbourne, is it not?

Ms CATE FAEHRMANN: Yes. Box Hill is in Melbourne. I just looked at the map—

Ms LIEBENBERG: Yes, it is Melbourne.

Ms CATE FAEHRMANN: —just to check it was not just some town on the border I was not aware of. But you are talking Melbourne.

Ms LIEBENBERG: So depending on the postcode, you could also be going to—

Ms BOND: They also can go to Sydney, to Westmead.

Ms CATE FAEHRMANN: So beds for young people who are experiencing—

Ms BOND: Someone who needs an inpatient admission.

Ms CATE FAEHRMANN: —acute mental health episodes, you are saying close to Melbourne, close to Sydney, or around Sydney?

Ms LIEBENBERG: Yes.

Ms CATE FAEHRMANN: Do you think that is satisfactory for this community?

Ms LIEBENBERG: No. That is why we have asked for a mental health inpatient facility within our local health district.

Ms CATE FAEHRMANN: How long have you been asking for that for?

Ms LIEBENBERG: I really cannot answer that question. It is an ongoing conversation. In the submission that is what we have asked for.

Ms CATE FAEHRMANN: I see in the submission as well it says that "Institutions were abolished 20 years ago and we are still waiting for adequate supports in regional and rural areas to support people with persistent and severe mental illness." So there was something—maybe 20 years ago they were not ideal. I do not know what was around 20 years ago here, but—

Ms LIEBENBERG: We did not have that here. That was a general statement about the way that mental health was managed in the past. The idea of abolishing those institutions was that we would have significant supports within our community, because essentially we would really like to keep people out of hospital and we know that the best outcomes are to be where you have family support.

Ms CATE FAEHRMANN: I have got one more question—I actually have a lot of questions.

The CHAIR: Some might have to go on notice.

Ms CATE FAEHRMANN: Drug and alcohol facilities, you have mentioned as well that there are no addiction services apart from "one drug and alcohol worker in our specialised mental health team". That seems extraordinary, I would think, given even the NSW Health submission states the increase in addiction to meth—

just one example: ice—in regional areas. I am sure there is a huge demand for that in not only this region but all regions. If you would like to talk to that?

Ms LIEBENBERG: Once again, it is actually 1.5 positions. I thought I would just clarify that. But we know that there has really not been any significant increase in funding for our drug and alcohol services over a significant period of time. People are able to access a drug and alcohol service, an inpatient service, in Wagga, but that is not a free service and, to be honest, I am not exactly sure what the intake in that looks like. On the ground what we are funded for is 1.5 drug and alcohol positions to work across a large geographical area and we would advocate that that is not enough.

Ms BOND: Can I just say something? Our organisation does not provide a service, but what we try and do is to coordinate the information that is going out to the community about the services that are available and I think the fact is that it is so hard to actually find accurate information on what is actually available, where it is running, what the referral process is, how do you actually get into that? We are both professional people and even we find it very difficult to navigate that system.

The CHAIR: That is your website you refer to.

Ms BOND: And that is our website. This is just a volunteer organisation trying to coordinate an enormous amount of services—and some of them are excellent, but how do you get into it? How do you access it? Is it here? Who is running it? And then we are trying to keep that up to date and it is just an evolving space. It is uncoordinated; organisations are working in silos. We get funding for programs because there has been a crisis but it is already being delivered. So there is a duplication of that sort of service.

The CHAIR: The Hon. Wes Fang?

The Hon. WES FANG: Just noting the time, Chair, I know you have an interest in palliative care and I know that you have got some people here who have got a very keen interest as well, so I will save my time to allow you to ask about some palliative care issues.

The CHAIR: Thank you very much. Thank you very much for your submission. It addresses points in a very systematic fashion and I am grateful for that; it makes it all very clear. On the specific matter of palliative care, can I just commence my comments by saying that I have nothing but the highest regard for the level of palliative care that is currently provided by obviously clinicians, volunteers, palliative care specialist nurses, RNs, whatever. But in addition to that though, the substance of your focus on palliative care is there is more to be done, perhaps is a way to describe it—arguably a lot more to be done.

Out of this "more to be done" or "a lot more to be done", are there particular priorities that you would identify as the ones that should be sort of started first and then work down in terms of dealing with this issue of enhancing and improving palliative care, or, as you loosely do, you have got a number of dash points that we need to concurrently try and deal with them and raise all the boats on the rising tide? This is perhaps an opportunity to sort of express your views about how we can enhance the general provision of it by looking at the points you made or elucidating particular ones which you think need priority.

Ms WHELAN: That is difficult to separate a lot of things out really. Looking at our community, there are some great palliative care services out there in towns, the bigger towns, and the bigger towns have great opportunities for people to die at home: They have access to the palliative care nurse specialists, they have access to GPs. It is once you get a geographical distance from those services that you come across problems in service. For example, when we are looking at end-stage palliative care, we are looking at symptom control. And one of the most common symptoms in palliative care is adequate pain relief. So if you live in Coleambally and you have cancer and you are at the stage that you need a syringe driver, you can no longer stay in Coleambally because there is no-one that can look after that syringe driver out of nine-to-five hours and over weekends.[1]

So the only way that can be done is—and this has happened in the past, it was an amazing family; they had a 50-year-old man who was dying at home and his wish was to die at home with his children around him. So what we did, because we were not able to work out of hours or on weekends—and, of course, it was Easter; these things always happen when there are public holidays—what happened was the GP filled the syringes for the syringe driver and we taught the daughter how to operate the syringe driver. That man did actually die at home with his family around him, but that was all due to a very compassionate GP who actually travelled from Griffith

[1] In correspondence to the committee dated 30 April 2021, Ms Whelan corrected her answer to "It is now possible for a Community Nurse working within MLHD to negotiate with Managers and Palliative care team to change syringe drivers on weekends if required".

to Coleambally to do that. The problem is I think there are great palliative care services. There are great palliative care nurse specialists. There has been a lot done in the area, but it focuses on those larger towns. Once you get out into the regional areas there is not that support, and it is very difficult for a family to be at home on their own with no-one and watch that person die.

The CHAIR: Yes, that is terrible.

Ms WHELAN: My father passed away 12 months ago. I have been a nurse for over 30 years; I have been a community nurse for 10 years. I have done a lot of palliative care training. I chose to have him stay in a palliative care room in Griffith because I did not believe that I could adequately look after him at home. We need to look at ways that we can utilise services that we already have in our little towns to allow palliative clients to stay at home. That can be done through using the services of the ambulance, if you do have an ambulance service in town, and also working across Federal and State and utilising any aged-care facilities that might be there as well.

One of the ideas that Coleambally is working on—I am also a member of the board of the local aged-care facility. Because this is such a concern for our community, we are looking at some way of developing a model of care where we can have a palliative room in that aged-care service. There are two registered nurses that work in that service. There are two registered nurses that work in the community, plus if we could have ambulance officers who are prepared to work under the Paramedic Connect program, or also the extended care paramedic system, that would provide enough health professionals to care for that client's pain relief care—

The CHAIR: Pain relief and distress relief, yes.

Ms WHELAN: It is not as good as being at home, but at least they would be in their communities. Obviously, at the moment this is just a dream.

The CHAIR: Well, it looks like you are giving some pretty serious thought to some of the possibilities, which is hopefully part of what we can do with this inquiry. We find it so engaging. In fact, it is very fulfilling to find people at the grassroots level coming up with innovative thinking and ideas like that which, if you actually overlay with each other, creates sort of a tapestry that, if it all comes together, can provide that enhanced service of palliative care. It is a credit to you.

Ms WHELAN: I think the other issue we have is that because we have limited community nursing services we are stretched so thin that it is difficult to keep up because of the health services requirements. They are wonderful—you have got to have protocols in place—but it is very difficult in a small community where you might go six months or 12 months between actually caring for a palliative client to keep those skills current and then be able to upskill quickly. That is where some educational telehealth and things like that can be useful.

The CHAIR: Very good. That is a lot of food for thought there, so thank you very much. On behalf of the Committee, I thank you all very much for coming along. I also express our gratitude and thanks for the work your organisations do—very much grassroots driven and grassroots run—and for having the community at the very centre of what they are all about. It is what makes our civil society decent, that we have people in these groups between, dare I say, the big bureaucracies—and I am not talking about NSW Health—but the big bureaucracies and big organisations and the people on the grassroots with these intermediate organisations such as your own, these not-for-profit community groups that really nourish our society so much and do such great work. Thank you very much.

Ms HARDY: Can I just make one more comment?

The CHAIR: Please, Ms Hardy.

Ms HARDY: Ms Whelan, I do not know if you want to mention about the lack of—

Ms WHELAN: That was mentioned in the opening statement: that lack of everyone working in silos, which I think is the same with mental health, and the inability to interact with different levels of government and private providers.

The CHAIR: Thank you very much. We will now break for lunch. We will be back at 1.45 p.m.

(The witnesses withdrew.)

(Luncheon adjournment)

TIMOTHY BURGE, Private citizen, sworn and examined

SHIRLEE BURGE, Private citizen, affirmed and examined

IAN DUMBRELL, Private citizen, sworn and examined

The CHAIR: I appreciate our next witnesses coming along this afternoon. You are all very busy with your commitments and responsibilities, and I appreciate not just the fact you have made your submissions but that you have made the time available this afternoon to come along. Thank you very much. Your submissions have been received. For the record, Dr Dumbrell, your submission stands as submission No. 354 to this inquiry. Mrs Burge, yours is submission No. 484. Mr Burge, yours is submission No. 625. To be clear, both of you are appearing separately in your own right. Dr Dumbrell, I invite you to make your opening statement of a few minutes.

Dr DUMBRELL: The Hon. Greg Donnelly, thank you very much, and thank you to the members of the Committee for inviting me and giving me this incredible privilege of speaking to a parliamentary hearing. I just want to clarify that none of my remarks are meant to reflect on Murrumbidgee, who I think are trying desperately hard to improve the situation here, and I have been very happy working at Deniliquin Hospital.

The CHAIR: Sorry, Murrumbidgee being the local health district? Is that what you are—

Dr DUMBRELL: I just want to say that my remarks are of a general nature and not specifically about the situation in Deniliquin.

The CHAIR: Thank you.

Dr DUMBRELL: My submission has outlined three broad streams of action to improve the health outcomes and access to health and to hospital services in rural, regional and remote areas. Those streams are increased personnel, increased efficiency, and diverting presentations through better chronic disease management and raising the population health. I just wanted to go back a step in my opening statement to talk a little bit about what we are doing in general practice. Not to delay too long, but we have got four things that we are doing in a consult: the acute management; the chronic disease management; the opportunistic health promotion; and modification of health-seeking behaviour, otherwise known as health literacy, patient engagement and self-care. This happens in primary care as well as in the emergency department.

Of course, in the emergency department it will be more the acute, but we are still doing some of the chronic disease management, opportunistic health promotion and modification of health-seeking behaviour. But on the GP side of things we are doing more of the chronic disease management. What we need to do is we actually need to have more clinicians so we can have more consultations. We also need to delegate these four factors: the acute, the chronic disease management, health promotion and increase the patient self-engagement and self-care. We need to delegate that through team care in our various structures.

There are well-known, well-established socio-economic gradients in health. You cannot really see these from a distance but there is a graph. Poor people have an increased burden of disease. There is a dose response, if you like, going down to rich people with a reduced burden of disease. That is relevant to our situation because very, very disadvantaged postcodes are where we have much increased chronic disease, mental health, drug addiction, cancer, infectious disease and behavioural problems. That is part of the problem. It is going to take a couple of generations to fix that, but that is part of the problem—the background population health. In terms of these three streams, I am proposing a bachelor of general practice degree.

In 2008 the Garling report, which had major changes to the health system, talked about how long it took to train doctors. We are talking 15 years to train a GP. Now we have got postgraduate training as well—another four years. My experience of working in the Northern Territory in Aboriginal health was that within six months, people with year 12 or year 10 standard were performing as clinicians. I do think that with the right targeted training we could produce medical graduates or general practitioners. This is, I suppose, breaking the mould. This is thinking outside the square. Most doctors think, "Well, we have a traditional medical training. Let's stick with that." But I would like to break that and change to a much shorter targeted training. I also think that most of what we learn as GPs and in the emergency department we learn on the job. Ten thousand cases in 10 years was one of my GP trainings. I think this is feasible and possible.

The reason why I am recommending it is because there is a certain amount of friction. If people learn here, they will stay here. Not all of them, but we will keep a lot of them here if they train here. I can see that in Albury; I can see that when we have regional medical schools. There is friction. People do not move out of there. They have been there for five years and they stay there. They have set up lives. They do not move out of Albury.

There is a new round of universities being set up. I think they are all going to stay in Gippsland; they are going to stay in those large regional centres.

Moving on a little bit, I also think that we need more regional networking of our ward and emergency department. At the moment I am at the top of the tree in some ways, which is ridiculous. As a GP in the emergency department or in the ward, the only person above me is Director of medical services at Griffith, who is an administrator. If there is an ICU problem, of course we can call the ICU. But there is no real structure there and I think that we could operate more efficiently if we incorporated more structure. What I am proposing is that we have regional emergency department medicine doctors more embedded—not actually locally in the emergency department—in our structure. And the same with general physicians embedded in our ward structure.

I am also recommending—I hope you do not get fatigued with all this—a chronic disease virtual hospital. I do not think we are managing chronic disease as well as we could do. I have outlined the concept of a shared action plan, which is a list of problems that the GP and the integrated care coordinator handle together. Some of that is happening already but I think we could do better than that. I also think that all this is not enough. I think that we need regional specialists. Some sort of incentives and disincentives have to be applied in a health economics way to the supply of regional emergency medicine specialists and general physicians. I have said at the end of my statement that we have got some early targets.

I think the early targets would be increasing the Medicare rebates for nurse practitioners to make them viable. They are not economically viable at the moment. We also need to improve the team care structure and the action plan. Longer term I think other things will be needed. I think that at the moment recruitment happens separately. GPs and hospitals recruit separately to GP positions. We share these people. I think that we need to integrate the culture of the hospitals and the GPs much more closely. I do acknowledge that the primary health network, which in some ways represents the GPs, does work with the hospital. But I think more integration is needed. Thank you very much for listening to my opening statement.

The CHAIR: Thank you, Doctor. It is very pleasing to have a witness come along who brings some fresh thinking and ideas to feed into this inquiry because it is key to what we are trying to do to pick up new thinking, new ideas and new ways of improving the way in which we provide and deliver health in regional, rural and remote New South Wales. Thank you for that. There will be some questions, I am sure, that will follow from your presentation. I presume you are going to have separate opening statements. Mrs Burge, we will start with you.

Mrs BURGE: I would just like to say I have tabled a document. It is the Murrumbidgee Local Health District Strategic Plan 2021-26, just for your information. I would like you to indulge me a bit. I know I swore an oath, but I am about to tell you a fairytale, if that is all right. The fairytale is called "The Right Care in the Right Place at the Right Time". The story starts in 1980 with a 109-bed hospital, with a geriatric ward, a 10-bed maternity ward, a coronary care unit, a 23-bed children's ward, 12 visiting specialists and surgeons, a women's clinic, an infant welfare centre and numerous allied health services. We never expected brain or spinal surgery, but we were able to look after ourselves to a high degree. We had a full kitchen and laundry facilities and we were self-sufficient. We ran at a profit. Darkness swept across the Riverina in the form of amalgamation and a governing board from a place far away. It came, bringing with it massive debt and famine. The darkness continued and the kitchen, laundry and all good things relating to service vanished. The local people hardly noticed until one day they woke and there was almost nothing left of their once grand building. People then had to drive hundreds of miles to seek help—into another land run by angry people who really did not want them and yelled, "Go back to your own land. You are taking up 35 per cent of our resources."

In 2014 a white knight appeared called Peter Dutton. He rode in and told the crowd he would remove the administration glut in health services and replace them with hands-on frontline workers. Five more years passed and nothing happened, so two bad elves named Joy and Shirley started an underground revolution about trying to reinstate service for the dying people of the region. They created havoc, amassing a team of revolutionaries. In 2016 the leader of the dark force met with the rebels and promised change, but still nothing happened. In 2019 the leaders found another white knight—a consultant to lead the community in a crusade to get better local health services. He described a land far away called Christchurch and an earthquake.

He said, "The city's rebuilding was achievable because of resilience and what a community coming together can achieve." We shouted at him, "Forget Christchurch. There is nothing you can teach our rural nurses or local medical officers about community spirit and resilience. They are the most resilient in the world. They are understaffed, under-resourced, overworked, often abused and unrecognised for the superb effort they produce every single day to keep us safe and alive with little or outdated equipment and inadequate backup and support. They go above and beyond and they are underpaid and under-acknowledged. In any other workplace in Australia they would be pursuing a Fair Work claim. Days off were taken from them when workmates fell ill and they had

no time to ride horses or play with children. There was no-one to replace this ancient society of frontline health staff."

We said, "Worn out before their time, scared to leave or retire and abandon their patients because they know there is no replacement available, frustrated and exhausted with no time for ongoing education, extra study or personal development, or horseriding." We yelled, "This is why we have a shortage of healers wanting to work in rural Australia, because they have been treated appallingly by the dark force and it was too hard to get permanent contracts. Sometimes it took two years. And they were threatened with exile if they revolted. They were accused of scaring prospective employees off by their bad behaviour." No relief came. So the citizens grew angry and they knew that for the cost of the consultant they could have employed round-the-clock midwives and always kept maternity open or provided a registrar on a full-time basis. They already knew about resilience.

And so the fairytale gets worse. For almost two years, the last of the consultant-based group asked the leaders for a full description of paediatric services provided at their now crumbling building. And lo, two weeks ago, they sent a CN paediatrics expert out to speak. We asked outright, "Would we ever again have a children's ward in Deniliquin?" She answered, "No," because the population did not warrant it and because of safety and specialised care requirements. She proclaimed that a child could escape from the ward and enter the kitchen area, open a cupboard and swallow a dangerous substance. This had obviously occurred elsewhere, so let's close all children's wards. But I think she had forgotten we had no kitchen. The nightmare was now reactive rather than proactive. I shook with rage when the spokeswoman also maintained it was safer to make a child suffer with no adequate analgesic and transfer them out, maybe hours later, to a distant land than for an LMO to administer pain relief and attend to the injury—like a dislocated shoulder—quickly and efficiently here.

The traveller was obviously unaware that the hospital she was referring to once had the 23-bed children's ward and now nothing, yet the population was the same and increasing. I tried to calm down because in the back of my mind was the absence of thrombolysis treatment if I had a stroke and the fact that I might suffer permanent injury while I waited for the ambulance, if they could find one, to get me to the distant land for treatment. It was night and the ambos were abed, the kangaroos were afoot and driving was a very unsafe practice. My mind wandered to 1996, when my 14-year-old son had an emergency appendectomy at Deniliquin Hospital. He is still alive today. 25 years later, in 2020, a young man of a similar age presented late in the afternoon. His father was advised by ER staff to drive him to Shepparton. They arrived at 11.00 p.m., were admitted at 1.00 a.m., given the all clear re the appendix at 5.00 a.m., were released at 11.00 a.m. and the father drove the boy home the 150 kilometres through the deadly kangaroo gauntlet. The father had been awake—

The CHAIR: Mrs Burge, just to help me figure through, how much more have you got?

Mrs BURGE: Not much. The thing there is—

The CHAIR: It will creep into question time, that is all.

Mrs BURGE: Sure, okay. The father had been awake for 30 hours. He was lucky to survive. The leaders continued to not find staff but began to produce costly strategic plans, which have been tabled, that really said nothing substantial and failed to save lives. When asked for public comment the town went wild and yelled, "It is fictitious, meaningless nothingness that beggars belief and probably costs millions in man hours and production." What we do need it did nothing to alleviate—the urgently required saving of lives, prolonging of lives and to provide basic health services to the people. I will just make this brief because there is no time. In effect, the Deniliquin Health Action Group asked for two years for Murrumbidgee to give us a correct ruling on children's services. There has been a bit said about that today. The reason the council had the wrong figure—the 2,063—was the document I produced saying how many children were at school in Deniliquin. They misinterpreted it and they put it into their document.

The CHAIR: I do not want to have you compromised in terms of information you want to transmit to the Committee so I am wondering, and I will take some guidance from the secretariat here, if this might become—I know it is an opening statement, but if you are about to truncate it and parts will be left out it might be a supplementary submission, which will enable us to capture all of it.

Mrs BURGE: Yes. I would like that because it refers to children's services. I would just like to say about that, if that is okay, that they can be admitted up to 24 hours in the ER, but a paediatrician must be consulted by phone and the child must be fully assessed at the end of the period. They do minor procedures—they carry out the odd stitch without adequate pain relief, removal of splinters, no orthopaedics and no anaesthetics. It is simple. It needs to be documented so the whole town knows exactly what happened. I would just like to say, in children's services—this is a true story: A nine-year-old boy fell from his bike, his helmet was smashed and he developed a severe concussion with dizziness and vomiting for over 30 hours. He was discharged from emergency after only 90 minutes. He was concussed. He could not tell them he had a broken arm; it was missed. Parents were told if

they wanted to they could take him across the border through to Shepparton—this was during COVID. The mother would then drive the sick child on her own with the father remaining with the other children.

This happens all the time. On return they would have been in isolation—the whole family—for two weeks. That is not treating children. It is actually quite a serious thing. The boy was given Panadol for a severe concussion, a broken arm and other injuries. How did the parents deal with this? They found an off-duty nurse and kept vigilant at their home all night and the next day and the day after, until five days later when they could get in to a doctor. I think that what we need to say here is the strategic plan, my reason for tabling it, needs to address the reality of parental risk management because that is where we are today. The risk was put on the parent to decide whether to drive across the border for help because what we have here is inferior and inadequate. We have thousands of children and they break arms and they hurt themselves—it is natural for children to do things like that. We do not have a service that adequately deals with them. Yes, they can go to the hospital, but more often than not they are told to move on to Shepparton or Echuca or wherever.

The CHAIR: Can I invite you—

Mrs BURGE: Yes, I will table it.

The CHAIR: —if you wish to do so, to hand it to the secretariat. My proposition will be—Hansard has taken down much of that as your opening statement, but we want to have the fullness of that considered so we will treat it as a tabled document and thus be incorporated as evidence to the inquiry. Sorry for cutting you off; we have just got limited time.

Mrs BURGE: No, that is okay. It is very hard to get the attention so that you take it away and understand how desperate it is.

The CHAIR: You have done the best thing possible, and that is to reduce it in writing with some significant detail. So that is very good.

The CHAIR: Mr Burge, did you have an opening statement or are you going to double up on the one that has been made?

Mr BURGE: No. I have got—sorry, I am as nervous as all Christ.

The CHAIR: You will be okay, but can I indicate that we have only got yourselves and, importantly, we are only asking question of you till 2.30 p.m. It is about eight minutes past now.

Mr BURGE: I am a haematology patient and I believe that I represent 1,000 people in this area.

The CHAIR: Can I just say I invite you to do the same thing—to perhaps give a very short opening statement and table that.

Mr BURGE: I have tried to.

The CHAIR: Please proceed.

Mr BURGE: I have been relying on treatment in Victoria for the past 11 years. In that time I have only received treatment at Deniliquin Hospital once. With COVID-19 the borders closed and it made treatment as good as impossible. Visits were limited and specialists stopped taking appointments. My treatment went from monthly to three monthly. To access treatment we would leave Deni at 6.00 a.m. and drive to Melbourne. My wife was not allowed in the hospital so she waited outside for six hours while I had my treatment and then we would drive home. This would take 14 to 16 hours with driving at night. So we have got driving through roos and all of that. It is creating a stress problem. I am trying to keep this as quick as possible.

The CHAIR: That is okay.

Mr BURGE: Last year NSW Health paid something like $56 million for reciprocal border rights and donated $1.5 million to Echuca Cancer and Wellness centre. This single year's donation alone would have rebuilt the Deniliquin Hospital and financed their own cancer wellness centre. Last year the opportunity arose for Murrumbidgee health to partner with Peter MacCallum in Victoria by means of a pop-up clinic here at Deniliquin. That would have serviced this area and maybe become a permanent fixture. It was stomped on by Murrumbidgee health, who maintained that we had to follow procedure and abide by current State guidelines. They said that it could not be done, yet the rest of the world was bending and changing rules due to COVID. To me it was a failure of care. Patients there gave up treatment.

My wife spoke to the head of oncology at Murrumbidgee health yesterday and there is still no plan 12 months later as far as oncology goes. My treatment is currently in Echuca. They said they are struggling with the influx of patients from New South Wales. They are concerned how they will cope in the future as the need keeps

escalating. At the moment we are building a three-chair oncology wing. The problem is we have 100 times more than that. The renal services centre has nine chairs. Because people are going south across the border there is no footprint so they have not got the data. I will skip a couple of lines. Murrumbidgee health years and years ago stated that there was no need for renal services as there was not enough people here but the local community fought tooth and nail and now they have a nine-chair service. The same thing has happened with oncology. They said there is 41 when in actual fact Peter MacCallum Cancer Foundation, Can Assist and cancer Victoria say there are 1,000 to 1,500 oncology patients in this district.

The CHAIR: Just a couple more minutes.

Mr BURGE: Don't worry. Because of COVID what has happened is that I have had to transfer from my specialist that I have had for 11 years to an unknown face on a telephone because the provider in Echuca could not accommodate my professor and as a private patient. I have to pay both the one that I have never met from St Vincent's who supervises me in Echuca for $450 a phone call and my original professional at $250 a phone call as well because he requires the information as my condition is rare and he needs to oversee it. The oncology services in rural areas need to allow all providers access, not just one. We are isolated and we cannot be treated under the same guidelines as city facilities.

The CHAIR: Thank you, Mr Burge, that is very helpful and adds to the content in your submission. Are you agreeable that your statement and that of Mrs Burge be incorporated as evidence to the inquiry?

Mr BURGE: Yes.

The CHAIR: That ensures that anything you skipped over we will have.

Mr BURGE: I am quite happy with that because there was other stuff there that was relevant.

The CHAIR: We do not want to not to deal with it, we are just conscious of time. We will commence the questioning.

Ms CATE FAEHRMANN: Thank you all for appearing today. Your extensive submissions contain a lot of useful information for us. Mr Burge, I want to ask you a quick question. What you are saying is the local health district vetoed at every stage a suggestion that there be a Peter Mac clinic, is that right?

Mr BURGE: Yes.

Ms CATE FAEHRMANN: These are the facts as you stated but what is your opinion as to why that was happening? You said something about a policy at a State level, but why would they veto such a thing? What in your view is behind it?

Mr BURGE: I do not know. I just think that New South Wales have their own oncology set up here closer to Victoria. Peter Mac is the cancer centre that everyone knows about, that we feel safe with. I do not know why Murrumbidgee health—

Ms CATE FAEHRMANN: Mrs Burge, do you have an opinion?

Mrs BURGE: Yes, I do. I have spoken to the head of oncology several times. The issue lies in the credentials of the service. It is based on city and Wagga Wagga guidelines and it refers to the further up part of New South Wales. We all come under the one umbrella so it cannot change. My argument to them for years has been: Look what we did, we had people dying, they could not access services in Victoria. Can we change it, can we have Peter Mac come in? They were agreeable and you have the documentation. But it was vetoed. People did die because of that. There were too many people that wanted border oncology and we could not all get there. That is why we had to drive to Melbourne under those circumstances. It is in their policy. This is the whole problem, we are treated like a city or a metropolitan area and we are not. We need our own different guidelines, we need to be governed by people like Dr Magee, like Dr Robert Campbell, who have lived 30 or 40 years here and they know what we need. That is the problem: it is policy and it needs to be changed.

Ms CATE FAEHRMANN: You attached correspondence to your submission that verifies that they said there are only 41 patients in the area. Yet in your evidence today and in fact your submission, Mr Burge, suggests that it was through cancer Victoria that they suggested there were 1,000 to 1,500 oncology, immunology and haematology patients.

Mr BURGE: Cancer Vic, Can Assist.

Ms CATE FAEHRMANN: Cancer Victoria.

Mrs BURGE: And Can Assist New South Wales because they dish out money to help those people travel. They knew the figures were wrong. We went to the hospital and we tried to argue it. Murrumbidgee are correct in saying that they only have 41 but they could not service any more.

Ms CATE FAEHRMANN: I am just very conscious of time and in fact I am aware that there is somebody in the audience from Echuca hospital very keen for us to try and sort this issue out so that more patients are dealt with here in New South Wales. He did tell me that at the end of each year the services provided to New South Wales patients are billed to the New South Wales government by the Victorian government. So the New South Wales government should actually have a record of exactly what patients are going into Victoria for what, is that correct?

Mrs BURGE: No, I do not think that is correct for private patients. I do not think they are accounted for. I do not think Tim's footprint at Cabrini or Epworth was ever accounted for, we never claimed from the Isolated Patients Travel and Accommodation Assistance Scheme [IPTAAS] and it is not in the travel records. We could ring cancer New South Wales and ask but he is not a cancer patient he is haematology. So they are not accounted for.

Ms CATE FAEHRMANN: Do you think the New South Wales Government is essentially abrogating their responsibility to people in this part of the world?

Mrs BURGE: That is correct, give it to Victoria. We class ourselves. We have a rule to get in the car and race children across the border to get a decent service—with broken arms or anything.

Ms CATE FAEHRMANN: One very quick question to Dr Dumbrell. Thank you for your submission, I think you have another potential career as a policy adviser. It is a very good submission with lots of excellent suggestions. I do not think we are going to cover this enough during this whole inquiry, to be honest. But, I think the whole point of prevention is a really important one and you raise it in your submission. Would you care to expand on that for the Committee just so this inquiry captures how important it is.

Dr DUMBRELL: Acute care is very much affected by preventative care. I can notice anecdotally on a Sunday when I am in the ED that presentations rise, even in that few days where people have not seen a GP. All of our acute care is affected. Emergency departments are being swamped to a certain extent by the complications of unmanaged chronic disease. That is where people will end up, they will end up in flooded emergency departments. There is only so much you can do to manage chronic disease but people are going to get sick and that is a human biology, but we can do better in fine tuning our chronic disease and in prevention.

There are two aspects of chronic disease prevention. There is secondary prevention, that is when somebody has got sick. Somebody has already had a heart attack and we talk about secondary prevention, that is preventing a second heart attack. Primary prevention is all those factors which have been proven to start in the early years and people are set on a behaviour and trajectory for life and it is very hard to change. It will be 30 or 40 years for any changes, but that has been seen in the United States in studies in child care in the United States in Chicago. Obviously we cannot wait 45 years for improvements in health care, but prevention ultimately is going to take pressure off our emergency departments. It is the right thing to do as well, basically.

The Hon. WALT SECORD: Dr Dumbrell, in your proposal you talk about shorter training.

Dr DUMBRELL: Shorter training, yes.

The Hon. WALT SECORD: What is the view of your colleagues about that?

Dr DUMBRELL: I think they are shocked by it. I think they are affronted. Medicine has grand traditions and it is affronting grand traditions. We do a bachelor of medicine, a bachelor of surgery. All that was appropriate when you were going out and you were setting limbs or doing appendisectomies. We are not doing that anymore, so I think there would be opposition to that basically.

The Hon. WALT SECORD: Are you proposing a two-tier system? One for country practices—

Dr DUMBRELL: Yes, I am.

The Hon. WALT SECORD: You are proposing that. Mr Burge, you mentioned in your opening statement $450 for a teleconference call.

Mr BURGE: Yes.

The Hon. WALT SECORD: What did you get for $450? How long did it go? How did you feel at the end of that?

Mr BURGE: I will not say ripped off.

The CHAIR: You just did.

Mr BURGE: Yes. It is every phone call every month when I am speaking to my professor and this other guy. With my professor it is a FaceTime and it is just not quite the same. When you have been with someone for that long, you develop a relationship and he says to me, "So how does it feel?" or, "How does it look?" and all that. I say, "Well, I cannot see. Since I have taken my glasses off, I cannot see." And I cannot feel what he feels. When you are talking telehealth, there is telehealth and there is telehealth. When you are in the private system, you have just got to roll with the flow.

The Hon. WALT SECORD: So is it telehealth for public patients and do private patients get face to face? What were you actually referring to when you said—

Mr BURGE: As I said, it is not telehealth. I am on FaceTime when I speak to my professor and he can make views of it. I do not know how he can. It is a camera but I think it is the same with telehealth. I mean, that is just a simple layman's idea. As far as medical people go, it would be a different tool—a worthwhile tool.

The Hon. WALT SECORD: Excuse my intrusion. You have received cancer treatment for 11 years now?

Mr BURGE: Haematology, yes.

The Hon. WALT SECORD: What does that involve?

Mr BURGE: Infusion.

The Hon. WALT SECORD: And does that occur here in Deniliquin or do you go across—

Mr BURGE: Only once in Deniliquin and that was in September, I think it was.

The Hon. WALT SECORD: Why did it occur once here but 11 years across the border?

Mr BURGE: I mean, I asked a question about—when it first happened—going to Albury and my professor said no. For some reason and I cannot remember why but he said the service was not—he was not happy with the oncology set-up. There was some reason. I cannot tell you exactly why.

The Hon. WALT SECORD: Okay, but why did you have the one here?

Mr BURGE: Because of the COVID. When it came on we were fairly well forearmed. We had been down twice when COVID was first happening and in the end I rang him up and said, "Look, I do not want to come down to Melbourne. Is there any chance?" And he said yes. So he spoke to my GP and she was actually really excited. And so to say we finally got it.

The Hon. WALT SECORD: You received the one-off treatment at Deniliquin Hospital?

Mr BURGE: Yes.

The Hon. WALT SECORD: In your experience as a patient, was it good?

Mr BURGE: Well, it was the same as, you know, any other thing.

The Hon. WALT SECORD: What I am saying is: Was it comparable to what you got in Melbourne but you did not have to travel?

Mr BURGE: There was a bit of a headache initially. Everything was right and then all of a sudden—and I do not know why it was but then we were told that we could not have any more infusions here. So then that is why I have gone to Echuca. I am going down there. I am not seeing my professor. I am seeing this other guy that you are talking about. He is from St Vincent's, the haematologist down there. It is a bit of a—I will not say a rat race. I am not saying you are going with the flow but that is what they want me to do.

The Hon. WALT SECORD: The $450 consultation—how long did it go for? The telephone one.

Mr BURGE: Telephone calls do not go for long, do they?

Mrs BURGE: Ten minutes.

Mr BURGE: It would have been at the most 10 minutes. And out of that then it was possibly the initial call but, yes, as it is, I am under him as well as under my professor.

The Hon. WALT SECORD: Dr Dumbrell, you work at Deniliquin Hospital in the emergency department?

Dr DUMBRELL: I do.

The Hon. WALT SECORD: Do you do long hours?

Dr DUMBRELL: Yes, I do.

The Hon. WALT SECORD: What would be a typical work week for you as a doctor in Deniliquin?

Dr DUMBRELL: I will say something like about 80 hours basically. That would be a combination of clinical administration, so checking letters and specialist letters—it is very important to do that, so out of hours—in-hours consultations in the rooms, then emergency department work and ward work as well. I admit patients to the ward. I would say something like a full-time is not 40; it is probably about 80 hours or something like that.

The Hon. WALT SECORD: And how long have you been doing that?

Dr DUMBRELL: I have been here for 14 years.

The Hon. WALT SECORD: You have been doing 80-hour weeks for 14 years?

Dr DUMBRELL: Yes, that is correct.

The Hon. WALT SECORD: How long can keep doing this?

Dr DUMBRELL: You need a holiday. It is hard to get a holiday.

The Hon. WALT SECORD: What happens when you take a holiday? Do you feel that you are letting down the other doctors and the patients?

Dr DUMBRELL: I do. They do as well. They say, "Look, I have to justify my holidays to my patients and they know exactly when I am gone." Yes, I do.

The Hon. LOU AMATO: Mr Dumbrell, how do we help lower the use of illicit drugs such as ice in the community?

Dr DUMBRELL: I think we acknowledge the problem. This morning one of my patients informed me of a drug home invasion of one of his friends. I am regularly buzzed past when I walk back from the hospital at four o'clock in the morning by drug runners. We have had drug dealers sitting on the front steps of our surgery. We can see them through the glass window. I think we acknowledge the problem. I think we have a combined approach of council, the New South Wales Government, and we measure wastewater. We go back to the early years study, learning behaviour and health. Often unemployed people, difficult to employ people—we give people better alternatives than drug use and drug dealing. We give them hope and things like that.

The Hon. WES FANG: Dr Dumbrell, I want to get your opinion on the model that you propose versus some of the other models which are currently being looked at, that is, rural clinical schools and rural training of doctors in order to try and have them stay. Is there some similarities there? What is your opinion on, say, a rural generalist scheme, which has been proposed and to be looked at in greater detail?

Dr DUMBRELL: I am not sure if it is Federal or State but there has been a round of 100 places, I think—a round of new universities, one in Bairnsdale or Gippsland and that was postgraduate. I will address all the issue parts of your question. My experience of these is that people will stay in Albury and Wagga and Bairnsdale. I have had medical students for the past 20 years, or 15 years while I have been here, and I can see their names coming up as the trainee doctors. They are now orthopaedic registrars. They are staying in Albury but they are not going any further than that. That is what I think is the problem with the current round of regional universities. I think they are not going deep enough into the country.

The rural generalist program, the problem with that is that the numbers of GP trainees are going down. There is a very good submission from GP Synergy and it talks about leakage along the pipeline. People are leaking out and each year we are getting less. So out of those 77 trainees this year—not Australia wide but I think GP Synergy wide—they have got to go into that rural generalist pool. I also think, to be honest, the whole rural generalist idea is going back to a VMO model that we are familiar with. When we are threatened we think let us go back to the Board, let us go back to an independent Deniliquin. I think that is a natural thing to do, but I think the VMO model is broken and I do not think that we can go back. I think the rural generalist is more of "let us do more of what we did in the past".

The Hon. WES FANG: When you say the VMO model is broken do you mean as in for a hospital, for example? So say that you have a GP who is also a VMO into a hospital or has admitting rights—

Dr DUMBRELL: Yes, I do. I do think so.

The Hon. WES FANG: So you think that the GP should—so a local GP operating in their own medical practice, for example, and then have a staff specialist employed in the hospital under a—

Dr DUMBRELL: It sounds extraordinary but I think we have come to that point now. There was a time when there were enough doctors and then when—what has happened, I think, in the 30 years or say 35 years since the introduction of Medicare in 1985, is that the number of presentations to doctors has grown and the system needs more doctors than it used to. There is more chronic disease and there is a different style of medicine. So it is not possible—I am doing three roles in one. I am the general physician on the ward, I am the emergency physician in the emergency department and I am the GP. Those doctors even have underlings. They have junior doctors under them.

The Hon. WES FANG: Registrars.

Dr DUMBRELL: Yes, they do. I am doing three roles wrapped up into one and it is becoming increasingly unsustainable because you just generate work like a squirrel. You see a patient in ED, then you take them to the ward, then you have got to take them onto your books. There is not enough of us to do that.

The Hon. WES FANG: Do you think your opinion is shared amongst your colleagues?

Dr DUMBRELL: Yes, I do. I do.

The Hon. WES FANG: Do you think they all feel that this needs to be—

Dr DUMBRELL: They do feel that it is unsustainable. But they do not know—unlike me, I think they want to go back to the VMO model of the past where we had doctors here for 60 years delivering babies, very revered doctors. I just scratch my head and I do not think we can do that. Modern reality is not going to—I do not think we can do that.

The Hon. WES FANG: Thank you very much for your insight. It is valuable to actually hear those thoughts from you, so I really appreciate it.

Dr DUMBRELL: Thank you.

The CHAIR: Any other quick questions?

Ms CATE FAEHRMANN: Maybe just to hear from Mrs Burge in relation to midwives.

The CHAIR: You have got two minutes.

Ms CATE FAEHRMANN: You have written extensively in your submission about the lack of midwives in Deniliquin. Do you want to expand on that for a minute?

Mrs BURGE: Yes. The unit was cut down from a 10-bed ward to a two. We still have the same population. A lot of our women go across the border to Echuca. They may present here and if there is not enough staff—we have been told for years that it is up and running and adequate and there is a new midwifery unit manager [MUM] in charge.

Ms CATE FAEHRMANN: Because you have been advocating for more midwives?

Mrs BURGE: I have. It is very important to me. I was able to have my children here with no problems. My daughters-in-law are having a pretty bad time and they are not monitored properly. There is not a midwife on at night. My grandchild was born last year in October. It was a difficult birth and under New South Wales guidelines that baby should have been monitored every 40 minutes through the night. A tea lady saw him and the mother was left alone all night because the nurses out on the main ward were not midwives. What they do is they expect the midwives to cover for the general nurses and the general nurses to cover for the midwives. We have had the case where a general nurse has refused to pick up a baby to hand it to the mother, who has had a caesarean and is lying in bed, because she is not trained to do it.

Ms CATE FAEHRMANN: And your daughter's example, just one thing, would not be the only example of babies—I am just checking whether that is a unique example that you are giving of a baby being born and then having no midwives at night to check on that baby and the tea ladies having to check on a baby.

Mrs BURGE: That would be normal, yes, I am afraid. That would be normal. That needs to be changed. Because we did make ourselves a bit too smart by generalising everything into a specialist thing. So a midwife cannot really go and look after someone who is having a stroke or whatever. That is where the rural generalist stuff comes in. We have begged the Government for a big facility here. Our hospital—four million is nothing, we need 60 to rebuild it. It is absolutely pathetic the amount that has been given to us. I know how much it is and how it came, I helped to get it, yet I am not consulted on what we should have when I have got the history of what is available. I have worked for government; I understand those things.

We need to have that rural generalist training centre. Deniliquin is put between Adelaide, Melbourne and Sydney. We are right in the centre. We would get graduates coming up here if we had that training facility. We

have got a good airport. The tutors could come in from Melbourne or Sydney. They could also operate while they are here. This is the ideal location for a rural generalist facility and I think it should happen as quick as possible. Our population is booming. People are moving out of the cities because of COVID. We are inundating Echuca; 35 per cent of their intake is from Deniliquin. It is hard for us, yes.

The CHAIR: Just to be very clear, so that your position on this is unambiguous, the answer you gave to the question about the tea lady keeping an eye on the new mum and the baby, is that something that you have been told about or you have firsthand knowledge of because you have observed it? This is evidence in the inquiry, so I just want to be very clear.

Mrs BURGE: Be very clear this was my—not daughter-in-law—son's partner. It was her second baby. She was left alone. When the midwife left and the doctor left, after an extremely difficult birth, no-one opened the door to her room all night. He should have been checked. It was a difficult delivery with instruments used and he also had another complication. She saw no-one until the next morning. I was at the birth; I saw how difficult it was. The staff were amazing. We have the best people, but they are not backed up at night-time. My other daughter-in-law was a midwife here. She waited 2½ years for a contract to be signed. She left here because she felt it was an unsafe place to give birth to her child, so that tells a lot.

The CHAIR: I just wanted to make sure the evidence was very clear.

Mrs BURGE: Yes.

The Hon. WALT SECORD: So a midwife thought it was unsafe to give birth at the hospital?

Mrs BURGE: Absolutely correct.

The Hon. WALT SECORD: Say that again.

Mrs BURGE: The midwife, my daughter-in-law, was frightened to give birth here at the Deniliquin Hospital.

The Hon. WALT SECORD: And she was a midwife?

Mrs BURGE: She was a midwife.

The CHAIR: Thank you very much for your frankness and also the thoughts and ideas that will now feed into the inquiry, particularly Dr Dumbrell your thoughts and ideas. I do appreciate it. It is this firsthand information which provides us with the insights which hopefully will inform not only the content of the report but, importantly, recommendations that will go back to the Government and the health Minister in particular, so thank you very much.

Mr BURGE: Mr Chair, can I just say, there are a lot of people who are very sceptical about this inquiry outside and they think that it is going to be too hard and it is going to be swept under the carpet. I think it is up to you to prove the sceptics wrong.

The CHAIR: Well, we are very committed. This is our first trip to regional and rural and remote New South Wales. We have started. We have got a number of places to visit but there is a determination, and I have to say my experience with respect to upper House committees is although there are members drawn from a range of parties here—Opposition and Government, both Liberal and Nationals, Cate Faehrmann from The Greens—we want to bring our eyes to this and produce the best report we can with the best recommendations we can. Ultimately it will be up to the Minister and the Government to make a decision though in terms of their position with respect to those recommendations, but we are going to do our darnedest to put together the best report and the best recommendations we can. So that is what we intend to do.

Mr BURGE: Okay, thank you.

(The witnesses withdrew.)

JILL LUDFORD, Chief Executive, Murrumbidgee Local Health District, sworn and examined

LENERT BRUCE, Senior Visiting Medical Officer in Anaesthesia and Executive Director, Medical Services, Murrumbidgee Local Health District and Professor of Medicine, Charles Sturt University, sworn and examined

JULIE REDWAY, Acting Chief Executive Officer, Murrumbidgee Primary Health Network, affirmed and examined

JODI CULBERT, Chair, Murrumbidgee Primary Health Network Board, Murrumbidgee Primary Health Network, sworn and examined

Dr CULBERT: I am a GP in Wagga Wagga, working clinically. I also work at the university teaching students and as a medical educator and supervisor. My role here today is as the chair of the Murrumbidgee Primary Health Network Board. I have done my training here in this area for 14 years.

The Hon. WES FANG: Chair, I should just declare that I know Dr Bruce—our children go to school together. And Dr Culbert and I have been at social events together. So I know both of them.

The CHAIR: Thank you for doing that. That is a normal thing that we do in a hearing if we have associations. It is perfectly normal and thank you for doing that. That is quite appropriate. I will provide an opportunity for both organisations to make an opening statement. You would be aware, of course, that your respective organisations have made submissions. The Murrumbidgee Local Health District is under the umbrella of the New South Wales Government submission, which is specifically produced by NSW Health, and that stands as submission number 630 of the inquiry. We have got that and I am sure you are familiar with that. With respect to the Murrumbidgee Primary Health Network, your submission stands as number 452 of the inquiry, so that has been processed and forms part of the evidence to the inquiry. Please proceed.

Ms LUDFORD: I will make an opening statement, which is short, on behalf of the Murrumbidgee Local Health District. Let me first acknowledge the traditional custodians of this land on which we are meeting today—the Wamba Wamba Perrepa Perrepa people—and I pay my respects to the Elders past, present and future. We welcome this opportunity to participate in the hearings of the inquiry. Rural people are asking us to hear their stories and improve their experiences. Murrumbidgee Local Health District covers 126,000 square kilometres, and many communities have unique health needs locally. One-third of our 33 hospitals are positioned along the Victorian border, and patients should have access to the closest available service. The border should not be seen as a barrier and, to support this, NSW Health has ensured that the health funding follows the patient.

It is important that we work collaboratively with other healthcare providers and local communities to establish clear clinical pathways for patients. We see this with the Deniliquin Renal Service, where we work in partnership with the Royal Melbourne Hospital. Royal Melbourne clinicians oversee our patients on dialysis, provide education for our nurses and support local GPs with early detection of kidney disease. Clinical pathways can also be virtual and can be life saving for time-critical conditions. The cardiac reperfusion service supports immediate treatment for patients having a heart attack. From the emergency department [ED] we digitally transmit their electrocardiogram [ECG] to be immediately read by a cardiologist—a specialist. This doctor initiates immediate treatment, which can include medication to reduce clots in the heart.

It is also recognised that health and social outcomes are interdependent. We can achieve improved health outcomes through integration of acute and primary care systems. General practitioners, as we have heard, have had a vital role in coordinating care for patients with chronic illness. But fragmentation occurs when the hospital system responds to patients' care needs after hours, without access to the patient's current care plan. A consumer-led care plan and intraoperative systems could bridge the gap. Murrumbidgee Local Health District has developed a consumer-led app for palliative care patients where their families, patients and carers can document, plan and record care.

A rural generalist trained workforce can better provide rural services and improve access to care. We have taken action to skill our doctors, nurses and allied health clinicians to be trained and recognised as rural generalists, working at the top of their scope. The Murrumbidgee Rural Generalist Training Pathway, for trainee GPs, is a trial of a single employer model for GP trainees—a first for Australia. More than an employment model, this is a training pathway that enables doctors to obtain the advanced skills that we need for doctors to work in rural hospitals and in primary care. In 2016 we developed a GP teaching program called WESTEND for GPs to gain the required ED experience to work in our hospitals. Five years later the program, about to be presented to the Australian College of Emergency Medicine in July, has not only reduced the contraction of the workforce but progressively built the number of permanent doctors and reduced dependence on locums.

The Allied Health Rural Generalist Pathway has also been piloted and has successfully attracted new graduates to our region and filled vacancies. These clinicians have now been retained at the completion of the program and have formed a professional network. We are also training and credentialing nurses and nurse practitioners to work at the top of their scope. Nurse Delegated Emergency Care accredited nurses are authorised to undertake assessment, intervention and discharge, all following detailed protocols. I would just like to recognise our dedicated staff, our volunteers and our carers, who play a vital role in these communities. They care for our patients with kindness and compassion at the most vulnerable times of their lives.

The CHAIR: Thank you very much and I ask on behalf of the Committee that you extend our thanks to those wonderful people you have just mentioned. We had the privilege to meet everyone this morning and no matter what role they play—as full employees, volunteers, they could be a specialist, they could be a cook, they could be on the wards, whatever—they all play a vital role in providing the best possible health for the people of their area. So I would ask you to pass our thanks on to them for the great work they do.

Ms REDWAY: I would like to acknowledge the traditional custodians of the land on which we are meeting today and pay respects to Elders past, present and emerging, and I extend that respect to traditional owners here today. Thank you for the invitation to appear before you. As you would be aware, there is a decline of socio-economic status that corresponds to remoteness. The health effects of income and educational disadvantage can be additionally compounded in rural and remote communities by poor access to a range of goods and services, including affordable healthy food, high-speed broadband, mobile phone coverage and public transport. People across our communities are impacted by many of these factors, resulting in poorer health outcomes.

Health workforce supply and sustainability is one of the greatest challenges we face to ensure that we have healthy communities into the future. In the Murrumbidgee region we have a population of 242,000 with 243 GPs and registrars, 184 practice nurses, 89 general practices and three Aboriginal Medical Services, with a GP to population ratio of 1 to 1,350 residents. There are 67 residential aged care facilities and 33 public hospitals, many of those staffed by GP visiting medical officers [VMOs]. While 25 new GPs were successfully recruited to the region last year, we currently have 37 vacancies. We know that professionals in our region are extremely committed to their rural communities and we have certainly seen that this morning; however, they also face many challenges.

Potentially preventable hospitalisations, or PPH, is a proxy indicator measure for the effectiveness of a primary care system. PPH are specific hospital admissions that potentially could have been prevented by timely and adequate health care in the community. The Murrumbidgee region ranks amongst the worst in New South Wales and nationally for total PPH, specifically for chronic heart failure, chronic obstructive airways disease, diabetes complications and hypertension, with Aboriginal people disproportionally represented. GP mental health service encounters are estimated to be half that of metropolitan cities, with fewer referral options. Recruitment and retention of qualified and experienced clinicians—and consideration of coordinated models of care, including telehealth—is critical to addressing the workforce shortages.

Murrumbidgee Primary Health Network [MPHN] and Murrumbidgee Local Health District [MLHD] share a boundary, which provides us with the opportunity for shared engagement, prioritisation and joint response as a regional health system. We work with the MLHD on many initiatives to improve integration, coordination and workforce optimisation at a regional level. While we have made some progress, we are limited in what we can achieve in a system that is not designed or funded to facilitate and support integration. Improvements in health outcomes for regional, rural and remote communities can only truly be realised through a coordinated State and Federal system response and a place-based approach which partners with communities to co-design and implement an effective, integrated health care system. We ask that the Committee consider this in the final report.

The CHAIR: Thank you very much, Ms Redway. We will open up to questions now. We will share them around between the parties represented here at the table. The Hon. Walt Secord?

The Hon. WALT SECORD: Ms Ludford, in February a parliamentary hearing heard that Griffith hospital had BYO bandages. There were a lack of bandages at Griffith hospital, which is under your jurisdiction. Has that been rectified?

Ms LUDFORD: Thank you, Mr Secord. The Griffith Base Hospital has a budget that has increased year on year. I am able to say to you, Mr Secord, that the hospital does have access to all consumables that are needed to treat patients.

The Hon. WALT SECORD: So it now has bandages?

Ms LUDFORD: It absolutely has bandages.

The Hon. WALT SECORD: This morning—thank you for the tour of Deniliquin Hospital. You were rather proud of the dialysis chairs. There are nine renal dialysis chairs. Is that correct?

Ms LUDFORD: That is correct.

The Hon. WALT SECORD: You said that there was quite a bit of demand for those chairs. Is that correct?

Ms LUDFORD: That is correct.

The Hon. WALT SECORD: So why were there no patients in those chairs today?

Ms LUDFORD: Thank you. So you are asking about why we have some days that they are not currently utilising?

The Hon. WALT SECORD: Yes.

Ms LUDFORD: Okay, thank you.

The Hon. WALT SECORD: There was no-one there. You could have tossed a ball down there.

Ms LUDFORD: Sure, thank you. I think you are aware that renal patients dialyse three times a week.

The Hon. WALT SECORD: Yes.

Ms LUDFORD: That means that there is always opportunity for us to expand services. When we were planning for the renal unit, we always knew that there was going to be a projection of increased activity over time. We have built that unit to be able to open additional sessions as the activity grows in the region. That activity has only just occurred now, and I think that was explained to the Committee this morning. It is only in relatively recent months where we have had an increase in the activity. We will now go ahead and look at the activity and make sure that we can plan additional sessions in accordance with the rising activity.

The Hon. WALT SECORD: How many days a week of the seven days a week are all nine of the renal dialysis chairs vacant?

Ms LUDFORD: They are used three days a week, which means that there are four days a week that they are not used. That is additional expansion opportunities as the service grows.

The Hon. WALT SECORD: Okay, so they are used three days a week and empty four days a week?

Ms LUDFORD: Yes.

The Hon. WALT SECORD: So why do you not open them another three days a week?

Ms LUDFORD: Because we do not currently have the activity to support that additional activity. Once we do, we will be able to commission additional sessions.

The Hon. WALT SECORD: I understand that this morning there were one or two patients of Aboriginal descent. Did you say one or two?

Ms LUDFORD: The nurse unit manager identified that there were one or two patients, correct.

The Hon. WALT SECORD: I understand that there is quite a bit of demand amongst the Aboriginal community and that if you actually alerted the community that there were renal dialysis chairs, the community would take it up.

Ms LUDFORD: I think we need to understand that chronic renal disease is more than just renal dialysis. The work that is happening with the Royal Melbourne Hospital is in collaboration with the local GPs, who would be caring for those patients.

The Hon. WALT SECORD: But do you not think it is a bit ridiculous to have nine chairs empty four days and only used three days a week?

Ms LUDFORD: What I am saying to you is that we have commissioned the chairs in accordance to the need and activity. As the need grows over time, we will open more chairs.

The Hon. WALT SECORD: Do you think it is acceptable for a tea lady to check on an infant baby patient who has just been born?

Ms LUDFORD: Clearly I do not think that is appropriate, but I would like to correct the record to say that there is 24-hour midwifery cover at Deniliquin Hospital.

The Hon. WALT SECORD: Did the tea lady have any health training?

Ms LUDFORD: I do not know, Mr Secord, because I do not—

The Hon. WALT SECORD: Do you think she maybe would have had basic—

Ms LUDFORD: I do not know when this—

The Hon. WES FANG: Point of order—

The CHAIR: A point of order has been taken.

The Hon. WES FANG: Ms Ludford is being very responsive and providing very thoughtful answers. The Hon. Walt Secord should allow her to conclude her answers before he starts badgering the witness.

The Hon. WALT SECORD: Fair enough, Mr Fang. Thank you.

The CHAIR: Yes, we know how this goes back and forth, so—

The Hon. WALT SECORD: I am mindful of the time. What is the situation at Deniliquin Hospital if a child presents at the emergency department?

Ms LUDFORD: The situation is that if a child presents at the emergency department, the child will be triaged, assessed—

The Hon. WALT SECORD: Yes.

Ms LUDFORD: If I can just finish my answer, Mr Secord?

The Hon. WALT SECORD: Yes.

Ms LUDFORD: Thank you. Depending on the triage category, that designates the time period before that child is assessed by a medical officer.

The Hon. WALT SECORD: Okay, so they are triaged?

Ms LUDFORD: Yes.

The Hon. WALT SECORD: When do they get admitted?

Ms LUDFORD: Let us be really clear here: It depends on what is wrong with the child. If there is a child in the emergency department, when the doctor assesses the child, he will determine whether that child is stable or unstable, depending on their clinical condition. If the GP is concerned about the clinical condition of the child, he will consult a paediatrician, which is appropriate. Children can deteriorate very, very quickly, and we need to make sure that we have got an appropriate care plan. If the GP and the paediatrician agree that the child is stable and could warrant some observation in the hospital, that child can be admitted.

The Hon. WALT SECORD: Can be admitted?

Ms LUDFORD: But the child—if they are unstable, the paediatrician will recommend that that child is then transferred to either Shepparton or a base hospital.

The Hon. WALT SECORD: So if a child is determined in the emergency department at Deniliquin hospital to be unstable—and that is your word, "unstable"—they are then sent to Victoria.

Ms LUDFORD: I am saying—and I will get my medical colleague to answer because this is a medical question that you are asking.

The Hon. WES FANG: I think you have—

The Hon. WALT SECORD: It is a pretty simple question.

Dr BRUCE: Well, the child is then transported to the closest appropriate hospital.

The Hon. WALT SECORD: But are they not in a hospital?

The Hon. WES FANG: Point of order—

The Hon. WALT SECORD: But are they not in a hospital?

The Hon. WES FANG: Point of order—

The CHAIR: In anticipation of the point of order, I indicate that all witnesses must be provided with the proper respect and opportunity to answer questions.

The Hon. WALT SECORD: I apologise.

The CHAIR: Dr Bruce?

The Hon. WALT SECORD: So can they—

The Hon. WES FANG: I think Dr Bruce was actually going to finish his answer.

The Hon. WALT SECORD: Sorry, Dr Bruce.

Dr BRUCE: So patients are transported on a regular basis even from large hospitals.

The Hon. WALT SECORD: I understand.

Dr BRUCE: We call that process retrieval.

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

Dr BRUCE: The level of retrieval and support that is provided during transport is determined by the clinical condition of the patient. As someone who has done retrieval work myself, I think it is a misconception that the child is essentially placed in the back of an ambulance and not cared for appropriately while they are being transported. So it is not uncommon, even from the Wagga Wagga Base, for patients to be retrieved to Sydney.

The Hon. WALT SECORD: Yes. I understand.

Dr BRUCE: So it is an occurrence that happens internationally and not just in regional areas. While I have the floor I can probably just comment because there has been a lot of concern about paediatric services at the Deniliquin hospital in terms of activity. Between 2018 and 2021 there were 170 patients that were transferred, in total. Some of those patients could have been transferred to tertiary facilities.

The Hon. WALT SECORD: Yes. I accept that.

Dr BRUCE: All right. During that time there were 74 admissions so we are looking at quite small numbers of patients that are being transported but they can actually admit patients for 48 hours. There is a proviso to that: There has to be consultation with the specialist, which is appropriate because, as pointed out, children can actually deteriorate very quickly, and it is a misconception that children are small adults. That is not the case.

The Hon. WALT SECORD: Dr Bruce, you said 74 were admitted.

Dr BRUCE: That is correct—between 2018 and 2021.

The Hon. WALT SECORD: And 170 were transferred.

The Hon. WALT SECORD: To other hospitals. That is correct.

The Hon. WALT SECORD: So the likelihood of showing up at the Deniliquin hospital with a child means that you have the likelihood that you will be sent to another hospital because—

The Hon. WES FANG: No, because it does not count presentations.

The Hon. WALT SECORD: Or 74 admissions.

The Hon. WES FANG: That is not presentations.

The CHAIR: Order!

The Hon. WES FANG: You cannot construe—

The CHAIR: Order, please! I think if you can just pose the question, the doctor will be able to respond to it.

The Hon. WALT SECORD: I guess I want to get to context. So 170 retrieval/referrals to other—

Dr BRUCE: That is correct, yes.

The Hon. WALT SECORD: —which I understand could occur. Something major happens and you have to fly them to Sydney, to Westmead.

Dr BRUCE: Yes.

The Hon. WALT SECORD: I understand that. But, during that three-year period, only 74 children were admitted to Deniliquin hospital.

Dr BRUCE: That is correct, yes.

The Hon. WALT SECORD: Is that not almost a *Yes Minister* scenario?

The Hon. WES FANG: Point of order: That characterisation is just—

The Hon. WALT SECORD: Well, I have not posed my question. You are actually saying that it is quite rare to be admitted to Deniliquin hospital if you are a sick child.

Ms LUDFORD: If I could just provide some clarification in terms of the data: What you are looking at is number of patients admitted and number of patients transferred, but what we have not looked at is the number of patients presenting.

The Hon. WALT SECORD: Can you—do you have—

Ms LUDFORD: Yes, I do. There are 134 children. That is zero to 16 years of age.

The Hon. WALT SECORD: One hundred and thirty-four children.

Ms LUDFORD: Yes, present to the Deniliquin emergency department each month and, of those, only one to two are transferred.

The Hon. WALT SECORD: How many are admitted?

Ms LUDFORD: Dr Bruce is giving you the data.

The Hon. WALT SECORD: Yes, 134 times 12, so we are talking about a thousand or maybe 1,400.

The Hon. WES FANG: And over three years, that is over three and a half thousand.

The CHAIR: Order!

The Hon. WALT SECORD: And 74 were admitted.

Dr BRUCE: That is correct.

The Hon. WALT SECORD: Well then, I let the figures stand. So it is very rare to have a child admitted to Deniliquin hospital.

Ms LUDFORD: If I could also just say, Mr Secord, that it—

The Hon. WALT SECORD: The figures show that.

Ms LUDFORD: I think it is also worthwhile noting that the children—

The Hon. WALT SECORD: So what—

Ms LUDFORD: With contemporary medicine—

The Hon. WALT SECORD: Can we get the—

The CHAIR: Order!

Ms LUDFORD: The best place to care for children is actually in the community.

The Hon. WALT SECORD: In a hospital, is it not?

The CHAIR: Order!

Ms LUDFORD: Children are only admitted to a hospital—

The Hon. WES FANG: Point of order—

Ms LUDFORD: —if they really need to be.

The CHAIR: You have to let the witness answer the question.

The Hon. WALT SECORD: Doctor—

Dr BRUCE: Yes?

The Hon. WALT SECORD: Those 74 that were admitted—

Dr BRUCE: Yes.

The Hon. WALT SECORD: What does it take for a child to be admitted to Deniliquin hospital? Of those 74, what is the affliction, the ailment, the illness that says, "Okay, we'll admit this child to this hospital."?

Dr BRUCE: In a lot of cases it is children that are admitted for observation—

The Hon. WALT SECORD: Right.

Dr BRUCE: —and that is why there is a short period. One thing could be a baby that is unwell. They are reviewed. There is no clear indication necessarily for admission or a clear diagnosis. There is then discussion with a paediatrician who will then provide advice to say, "Yes, you can observe the patient", or sometimes they are concerned and the patients are retrieved to where it is appropriate. So the decision to care for the patient is made by the most appropriate people who are the paediatric specialists.

The Hon. WALT SECORD: This will be my last question.

The CHAIR: That is fine and then we will switch over.

The Hon. WALT SECORD: Ms Ludford, the doctors at Deniliquin hospital at their meeting on Sunday, one of the options before them is that they were going to walk out because they were doing more 100 hours a week. Are you confident that they will not walk out?

Ms LUDFORD: Well, what I would really like to do is to be able to speak with the doctors because as yet they have not come to us to talk about their decision to walk out, but I think—

The Hon. WALT SECORD: Were you unaware of their workload?

Ms LUDFORD: I am absolutely aware of their workload, Mr Secord, and we are fully appreciative of the work that they do with us. I think one of the things that I will mention here is that the doctors, who I greatly respect in Deniliquin and who are hardworking and committed to this community, have a way of working where, when a patient of theirs presents at the hospital, they like to come and see their own patients. Now, we have been talking with the doctors around the way that doctors are rostered in our other hospitals—in our other 33 hospitals across the district—which is that we have a doctor on call and that doctor looks after the patients for the day, or two days, or whatever the doctors decide. So how we roster and look after our emergency department and the wards makes a big difference to the fatigue level of the doctors.

So we have spoken with them about we can help you re-roster so that you have less impost on your surgery, less impost on your fatigue levels, and I am very happy to go back and talk to them about we have offered them additional nurse practitioners, we are offering them sessional time in the emergency department so it does not impact on them in their rooms. So I really would be very keen to talk with the doctors to see what we can do to really lessen that load for them and reduce their fatigue.

The Hon. WALT SECORD: So, Ms Ludford, we come to my final question: What do you say to medical observers that the Murrumbidgee Local Health District is the most under pressure local health district in its hospitals and medical staff in the State?

The Hon. WES FANG: Who says that?

Mrs BURGE: Me.

The Hon. WALT SECORD: Well, members of the audience, clearly.

The CHAIR: Order!

Ms LUDFORD: Thank you very much, and I appreciate the communities are feeling overwhelmed.

The Hon. WALT SECORD: The communities tell me this.

Ms LUDFORD: Yes, I appreciate communities are but I would see things differently that we are not the only local health district in this situation, Mr Secord. I think what the Committee will hear over the coming months throughout the whole year is that the whole rural sector is actually under pressure and that we really need to look at different ways of how we structure and provide our services, particularly our medical cover for hospitals. The existing structures that are there, as we have heard today, need some work, some alignment and I think that is a very important message for us to hear, but we have a very, very strong commitment to improving services for our region and I would not agree that we are the only district.

The CHAIR: The Hon. Wes Fang?

The Hon. WES FANG: Thank you, Chair. Thank you very much for appearing before us today. Thank you very much for the tour you gave us of the hospital this morning. It was fantastic to actually get some context. I want to start by addressing some of the points you raised in questioning from the Hon. Walt Secord. As I have just run the numbers, the figures would indicate that there is less than 3 per cent—you know, two point something per cent—of the total number of paediatric presentations that are actually being retrieved out of Deniliquin and then around one per cent that are actually being admitted. Is that around the figures as you would have them in that region?

Dr BRUCE: That is the data that was provided to us and we know that the most appropriate place for children to be cared for, if it is safe, is at home with their parents. Children find hospitals a scary place, but once again if they have to be admitted, the aim is also then to admit them in the best possible facility with the most appropriate resources for them. That is why we consult with the paediatricians to make sure that every child gets the highest level of decision-making. Even though the paediatrician might not be in the room, at least there is paediatric support and discussion, and then if retrieval is required, the paediatrician knows the patient understands the situation. That is a very elegant way of doing it.

The Hon. WES FANG: You said you worked in retrieval medicine around a number of areas.

Dr BRUCE: That is correct, yes.

The Hon. WES FANG: would you say that those numbers are reflective of, say, hospitals in metropolitan areas as well where for example a child might need to be retrieved from Liverpool Hospital to Sydney Children's or the like?

Dr BRUCE: It is difficult to know because obviously I do not have their number of presentations, but it would not be uncommon for patients to be moved around in Sydney to children's hospitals.

The Hon. WES FANG: I spent half my degree doing that.

Dr BRUCE: That is correct and I think that is part of the paediatric services capability framework, and really the aim of the framework is to ensure the safest possible care for children. I would just like to comment on when it was spoken about paediatric anaesthesia. I was the clinical director of anaesthesia for Wagga Base and by default for the district since 2010 and this was discussed quite significantly in terms of wanting the safest way to provide anaesthesia for children. A fallacy that exists is that if it is a small procedure, it is only a small anaesthetic. Emergency anaesthesia, in other words children that have a broken arm that needs some manipulation and anaesthesia, is a high-risk procedure. Dental cases are shared airway procedures which are extremely high risk for patients, and there would be a certain minimum volume of practice to make sure the staff more so is capable of looking after children because as anaesthetists we are but part of a team. I can put an experienced paediatric anaesthetist in a facility where the staff does not do paediatric anaesthesia. That is a significant risk for the children.

If we look at Deniliquin before the changes of the service capability framework, between 2010 and 2017 there were 31 cases below the age of 16. Considering that that was three paediatric anaesthetists, you were looking at 10 cases in a seven-year period. That would probably not be considered an adequate volume of practice to maintain currency. What we have put in place in the Murrumbidgee from a credentialing point of view is that we are happy for anaesthetists or GP anaesthetists to anaesthetise children over the age of eight and over 20 kilograms as long as they are fit and well but that would also depend on their facility. The reason for that is you do not need special paediatric equipment for children of that age. In terms of retrieval, I have done paediatric retrieval. It is very common for children to be moved to specialised hospitals. We know and appreciate that it is an impact for children. I have retrieved children where I have taken their baby in a plane and they would have to travel hours to get to the hospital. We appreciate that impacts families, but our responsibility there is the safety of the child.

The Hon. WES FANG: You may be able to answer this or not, but in your experience do you think some of the community advocates who are championing for this to occur would be the first to criticise you should something go wrong? That is, a procedure that is not done that often is allowed to be done in a hospital where the work effort is not allowing currency and proficiency in that procedure to occur.

Dr BRUCE: I will answer the question in a different way. If I am asked to review a case that was done in a facility electively where there is not the necessary infrastructure, currency and capability and there is an adverse event, I would be critical of the decision to provide that service there. In an emergency it is different, but once again if there is a different option, the safest option is what I would pick as an anaesthetist.

The Hon. WES FANG: Safety of the patient is the priority.

Dr BRUCE: That is correct, and I think it is really important that we are here to serve the community. We are not in opposition to the community. We appreciate that they want their children treated closer to home. We appreciate that it is difficult. I will give you an example. I am going to do a telehealth pre-op consultation on a 102-year-old patient in Temora tomorrow, but he does not have to travel to Wagga to come and see me. It is not that we stand separate from the community. We feel what they feel because we are part of the community. My children go to the hospital if they are sick. It really is important that we are there to work with the community to provide the safest possible care. I think our paediatric network with the district director of paediatrics—you have very capable GPs in Deniliquin. You have a doctor with a Diploma in Paediatrics and they can provide care as long as it is done in consultation and support. I will give another example. I regularly consult even with some of

the GP anaesthetists in Deniliquin to provide advice about cases. There really is that network of support for our GP colleagues.

The Hon. WES FANG: Thank you very much. Ms Ludford, I just wanted to turn to you for a minute. Like the Hon. Walt Secord was asking questions around some of the evidence we heard earlier, Dr Magee spoke about 350 VMOs resigning. Do you think you might be able to provide some insight on that? I find that surprising.

Dr BRUCE: I will answer that question. I chair the appointments committee for Murrumbidgee Local Health District as the executive director of medical services and we have actually clarified that information with our workforce unit. Visiting medical officers are essentially appointed in five-year cycles. There was a five-year cycle that finished in 2015. At that stage, the total number of VMOs in Murrumbidgee was 297.

The Hon. WES FANG: How could there be 350 less?

Dr BRUCE: Yes. Of those doctors, 83 decided not to continue with their contract. In 2020 we have 425 VMOs of whom 39 decided not to proceed with renewing their contracts.

The Hon. WES FANG: You have actually been able to recruit additional VMOs to the—

Dr BRUCE: Yes, we are almost 130 more VMOs than we had in—

The Hon. WES FANG: But the evidence was that we had lost 350, so that cannot be correct. Is that right?

Dr BRUCE: Our evidence is that since 2015 we have lost 83 and 39 VMOs who did not decide to renew their contracts.

The Hon. WES FANG: That could be for a number of reasons. They just reached the age that they want to retire or—

Dr BRUCE: That is correct, and we have a number of visiting specialists. It is not uncommon for younger doctors to start out with us and they work for us for a while and when their practice builds up where they live, they come less frequently and they are replaced by other staff. I think the other component about the documentary requirement for appointment—that was actually a special recommendation after the Garling report and I am sure I arrived in Australia shortly after the Dr Patel case, so I know all about providing paperwork.

The reason why we have such a rigorous credentialing process—and I follow exactly the same credentialing process as Dr Magee has discussed this morning—is to ensure that patients can have confidence that the staff that look after them are appropriately trained, have appropriate qualifications and have currency of practice and meet a number of other legislative requirements. It is there to ensure patient safety. It is not in any way or form designed to make it difficult for doctors. One of the great improvements is that we are moving to an e-credentialing system where it is electronic, so once I have uploaded my information once, it is there and I can use that information. All I really do is, every year I update my medical indemnity, my professional registration and then one or two mandatory training requirements like basic life support and fire training.

The Hon. WES FANG: We heard about the workload on some of the VMOs and there was a range of answers. I noted one response was around 80 hours a week for obviously the period they are on call and time in rooms and letters. That I guess is balanced against the 120 hours which we were given by another witness. In your opinion, is there something we can do to assist with workloads and their bearing on VMOs in hospitals?

Dr BRUCE: Most definitely. It really is of grave concern to the Murrumbidgee Local Health District that our doctors are working such long hours. Apart from the wellbeing of themselves and their families, we risk burnout. The last thing we want to do is to lose doctors because they cannot keep up with the workload, so we have a number of initiatives in place. If we look at the emergency department presentations at Deniliquin Hospital, 75 per cent of those presentations are low-acuity presentations—category four and five. Those are the types of presentations that can be managed very well by nurse practitioners. We have employed a nurse practitioner at Deniliquin Hospital and we are in the process of expanding their hours because we thought that was extremely valuable. It supports our GPs.

The other component to the service is the Remote Medical Consultation Service, where we can use virtual care to manage the lower acuity presentations. That was put in place to support Deniliquin Hospital when the nurse practitioner could not attend work. It also means that the doctor is not called about everything at night. As Dr Dumbrell mentioned very eloquently, in a large hospital there is an intern, a resident and a registrar. If you are a rural GP then you are the intern, resident, registrar, consultant and sometimes the specialist. What they can do is for the low-acuity discussions or advice they can utilise the Remote Medical Consultation Service, the same way that we would contact an intern or resident in a base hospital and not call the consultant.

The Hon. WES FANG: On the last question on this similar topic, Ms Ludford, you talked about looking at different rostering.

The CHAIR: Wes, I have given you a fair crack of the whip. You have had almost 14 or 15 minutes.

The Hon. WES FANG: Okay, I will come back to it.

The CHAIR: You might, yes; You might not, either.

Ms CATE FAEHRMANN: I want to turn to the primary health care network's witnesses and ask a question in relation to your submission. On page 3 in the introduction you say:

> We urge the NSW Government to accelerate progress towards overcoming barriers to person-centred integrated healthcare by working with the Federal Government and PHNs to fast-track and implement new workforce models

Firstly, what are those barriers? You probably did not write this submission yourself.

Ms REDWAY: No.

Dr CULBERT: We have had considerable input into the submission.

Ms CATE FAEHRMANN: But are you aware of what barriers are being referred to?

Ms REDWAY: Looking at some of the joint incentives, a joint statement has been progressed between NSW Health and the New South Wales primary health networks around addressing some of those barriers. There are a couple of elements to this. Certainly to enter into general practice, so training into general practice. Dr Culbert can probably talk a little bit more about that because that is a part of the problem right across New South Wales. But then that is exacerbated as we become more rural and more remote, whereby there are fewer GPs training within the system and then fewer coming out. There was reference earlier today to the declining number of GP registrars.

Ms CATE FAEHRMANN: Yes, I suppose particularly the question is more focused not on the problem per se but the fact that the submission clearly seems to state that there may be some resistance by the New South Wales Government. The way it is worded—and this is obviously an inquiry into health services and if there are barriers then I think it is important for us to know—you urge the New South Wales Government to accelerate progress. It sounds like they have been slow, or would you care to—

Dr CULBERT: I will take a little bit of that question. I am not a policy expert, not as well as Dr Dumbrell. His submission is fantastic and innovative and I think that is what we are actually calling on here. We have spent a good part of the session this afternoon discussing some minutia, very important and very personal minutia if it is a child and those sorts of things, but it is really important that we have an appetite for significant structural reform. We have a difficulty when we have a Federal and a State component of funding. We work very closely with our colleagues in the MLHD to work on collaborative commissioning programs to provide services. Our preferred place program is looking at making it a very attractive environment for doctors to come and work here, but we are working with a very old and antiquated system. There are fee-for-service payments that do not suit chronic care management. In the past, your doctor visit was a transactional one. You came with an acute illness, you had a treatment and you went away. You might have seen them twice in a year.

We are now seeing in general practice that the average number of problems dealt with in one consultation is four at minimum. That is in a reasonably short space of time. Equally in the hospital system, when you are a GP VMO coming into the hospital, again it is a transactional system. It is reliant on the State services. This is not in reflection to my colleagues here at the table, but the structure of the State services relies on a private service run by private individuals to provide a service to the hospital. As Ms Ludford has mentioned, it is not really sustainable. Dr Dumbrell and Dr Magee have both mentioned that. When the doctor comes from their clinic rooms to address issues in the emergency department, they are not only working extra hours but they are pulled away from patients in their waiting room. They then go back.

I have had this experience. I have worked in a small town for 12 months. I would be called to chest pain while I was there dealing with a chest pain. The staff would have to deal with 15 patients in the waiting room to sort out where they were coming from. I might get back to them at 6.00 p.m. at night and try to deal with them. In the meantime that private entity does not generate revenue. They still have fixed costs for their service, they do not generate any revenue to pay staff and it is a continuous cycle. We need to look at some real structural reform. Some of that will be allowing sessional services for GPs to be treated as the equivalent of staff specialists in a rural generalist setting in a hospital, where they can do that for a day during the week. That would reduce after-hours presentations because they are better managed during the day. It reduces the stress on the doctors from running backwards and forwards. The quadruple aim of health care is efficiency, safety, patient experience and practitioner experience.

Ms CATE FAEHRMANN: I have so many questions that I need to ask in a very short amount of time.

Dr CULBERT: Sorry, I have a lot to say.

Ms CATE FAEHRMANN: That was a very good response. Again In relation to that the same paragraph says, "to fast-track and implement new workforce models". You are calling on the New South Wales Government to accelerate progress and to work with the Federal Government and PHNs to do that.

Dr CULBERT: That is correct.

Ms CATE FAEHRMANN: When you say, "fast-track and implement new workforce models", is that being worked on now? Is there resistance to doing that? Are there models within the public service, within your respective entities, that you are actually working on to significantly change the structures that you are referring to?

Dr CULBERT: Yes, there are models being looked at. I am sure Dr Bruce and Ms Ludford could talk about the rural generalist program in more depth than I can. That is one of those problems and the funding for that is moving away from a fee-for-service program. That is a trial in this area. The resistance probably is not so much personal or institutional resistance but the funding models that drive them. We do not have the funding levers to be able to do this on a decent enough scale and we do not easily get reporting from other projects in different areas to look at scalability across regions.

Ms REDWAY: If I could add to that, I know this was raised in the first hearing by the NSW Rural Doctors Network. We are part of a regional sub-planning program called Collaborative Care, which is really taking a sub-region approach to looking at the health workforce that exists within the region. There were comments this morning that if you can create that environment, which is collegial and so on, then it may end up attracting workforce to the region. But the intention there is to look at the workforce that already exists and look at how they operate, working with that workforce and the community to look at how those clinical services might be delivered differently—more efficiently and more effectively.

Ms CATE FAEHRMANN: I could ask you more questions about that but I need to move on. To the representatives of the MLHD: How many maternity beds were there 10 years ago? It has been downgraded, has it not? We have reduced the number of maternity beds at Deniliquin Hospital, is that correct?

Ms LUDFORD: Thank you very much for your question. Ten years ago the maternity beds were situated in the building that you saw this morning, which was a standalone, separate building from the rest of the wards and there were 10 beds in there, as you have correctly stated. Looking at the data, though, and what we have ascertained is that years ago, 10 years, 20 years ago, when women had babies they stayed for considerable lengths of time; they stayed for five days, seven days. So their length of stay now is considerably shorter; the average length of stay is about 48 hours. Because we have seen that reduction in the length of stay we need less beds, so the upgrade to the maternity unit was made a number of years ago based on the activity.

Ms CATE FAEHRMANN: It is true to say, though, that women are driving hundreds of kilometres to other centres because those beds are not available in Deniliquin as a result of that downgrade.

Ms LUDFORD: No. The reason why women need to go to other services—and it is high-level services—is because Deniliquin Hospital, being a GP obstetric service, can only safely allow women to birth there who have normal risk. So women who have any identified risk who will need to have care from a specialist obstetrician are required to go to a high-level service for the safety of themselves and their baby. So that is the reason why they go there.

Ms CATE FAEHRMANN: Can I check again in terms of the cross-border issue, does the LHD have stats on how many people are accessing services all up, all the sorts of services for people across the border to access, whether it is an acute mental health episode service in Box Hill, as we heard this morning; whether it is Echuca hospital—I have got the submission here about women having to go to Echuca hospital for midwifery services—do you have statistics on that?

Ms LUDFORD: We have access to statistics on the Victorian data because, as I said in my opening statement, when patients from New South Wales access services in Victoria—public services—then the New South Wales Government funding pays for that. So because we have that funding data we have the Victorian data available to us.

Ms CATE FAEHRMANN: If we were, for example, somewhere where we did not have that border—say the border was water so we did not have that border—and therefore, potentially, had thousands more people needing treatment here in Deniliquin, that would make a difference to the services here, would it not? The New South Wales Government would have to suck it up, so to speak, and fund the services here instead. It is

extraordinary that there is just this expectation that people will go to something that is funded potentially better by the government just across the border, but you actually still do not know how many people are having to access that. Clearly it is unsatisfactory.

The Hon. WES FANG: So people from Queanbeyan should not go to Canberra?

The CHAIR: Order!

Ms LUDFORD: Thank you for the question. I think what we really need to clarify here is that the hospitals across the border are much larger centres. For example, Shepparton is a community similar to the size of Wagga Wagga, so that hospital is a specialist referral hospital that has a whole different range of services available. The district hospitals, such as Deniliquin, which service a smaller population are what we call district acute hospitals, and their role is, because they have the medical cover of the rural generalist, they care for acute patients. So we are talking about maternity, we are talking about acute admissions, we are talking about some surgery, but if people need that higher level of care and specialist treatment that is when they go to larger centres. It just so happens that here the larger centres are across a border.

The Hon. WES FANG: Or Albury.

Ms LUDFORD: Or Albury, yes.

The Hon. WES FANG: In New South Wales.

Ms CATE FAEHRMANN: Do those centres, which are hundreds of kilometres away still, say Echuca, do they factor in 35 per cent more additional services according to the fact that New South Wales residents will come to access those services? Is that factored into their business model and their strategic plan?

Ms LUDFORD: The way the health services are funded in Australia is to activity-based funding and, as I have suggested to the Committee, the New South Wales Government pays for New South Wales residents to receive their care in Victoria. So they will be funded for that care, so that should be factored into the work that they are providing. So they are saying that just because you come from across a river we are not going to include you in our community projections.

The CHAIR: Does that mean that it is a precise reimbursement based on that activity that is going on from the New South Wales Government to the Victorian Government—and if you do not know the answer to this feel free to say so—or, in fact, there is a contract, like an omnibus contract, that exists for the services to be provided by Victoria and it may or may not equate with what actually is the demand on those services from New South Wales?

Ms LUDFORD: I am happy to take that one on notice because I personally do not manage the interstate funding arrangements; it is managed by the Ministry of Health. They will have, I guess, the precise technical answer to your question, Mr Donnelly, but we are happy to take that one on notice.

The CHAIR: Okay, I will get that from you later.

Ms CATE FAEHRMANN: I have got one last question, and I am conscious we are over time. Just looking at the NSW Health submission, which I am sure you have read, there a couple of statements here which I just wanted to fact check, if you like. It says on page 5 of the submission at the top that "all LHDs are supported by NSW Health pillars, other health support organisations", blah, blah, blah, to point to the fact that "all these elements work together to deliver seamless, high-quality care for New South Wales residents regardless of location". Do you believe that statement? I know you have sat in the audience all day; do you believe that the LHDs, all of the elements working together deliver seamless, high-quality care for New South Wales residents regardless of location?

Ms LUDFORD: Thank you for the question. There are some benefits about working as a larger system and I do not want to downplay the role that some of those pillars, as they are called there, such as the Agency for Clinical Innovation, the Clinical Excellence Commission, in terms of the support that they provide for local health districts, are really fantastic—making sure that we have got all of the appropriate clinical guidelines for caring for patients, the telestroke service et cetera et cetera. I think we have heard from many people, and reading all the submissions across the State, that people who live in rural and regional New South Wales believe that it is harder for them to access services—they have the tyranny of distance; they have transport issues; they have higher rates of environment impact, such as drought; higher rates of mental health—so we really need to be working with local communities to make sure that we can really work to provide the services that they need. That is a very broad statement that has been made in the submission and I certainly support the system support that we get from NSW Health, but the reality is we have to work on the needs of the community and make sure that we can tailor those services to meet their needs.

The CHAIR: Thank you. Just finally, just two quick ones. With respect to the telehealth—I use the term in its generic sense—its various manifestations were seen by us this morning as we were taken through to the hospital and I presume that the amount of telehealth that is being done today out of that site is more than was done 12 months ago, which is probably more than was done 12 months behind that; in other words, the manifesting of telehealth to deliver health care and services is becoming greater and greater in terms of being made available.

My question is with respect to the adoption of telehealth services and care that the Murrumbidgee Local Health District does—in other words, to adopt them. Do any of them, that is, these care and services like telehealth, emanate out of the district; in other words, they are your own initiatives and own ideas around telehealth? Or are you effectively—and I do not say this in a disrespectful way—a top-down: This is what we are now doing and across all the districts around the State this will be integrated in this way? In other words, it is across-the-board, dare I say, adoption of what is a new, for example, niche teleservice that was not available 12 months ago? I am just trying to understand, is any of this initiative at a local district level or is it effectively the adoption of or the mandating of the use of it from NSW Health down?

Ms LUDFORD: The majority of it is the latter.

The CHAIR: I would have thought so.

Ms LUDFORD: It is emanated locally. There are only really a couple of examples where we have got that tiered network service, which is the cardiac, the heart attacks and the telestroke, but the rest of it—and I think the facility manager at Deniliquin today talked about the fact that their community care team, their community allied health team, they telehealth out to some of the smaller communities around Deniliquin, for example, to bring those services for people to save them from driving. Telehealth really should be only ever seen as an adjunct. It should never replace a face-to-face service. That is really important. The second part of virtual or telehealth is that it should bring additional services—

The CHAIR: I think that matter is in real contest. I understand the principle you have articulated, and it is a principle, but I think we are going to find this as a point of real contest as we work our way through this.

Ms LUDFORD: Yes.

The CHAIR: Finally on this particular question, with respect to doctors—VMOs—but also looking at all the staff who work at the hospital, irrespective of what position they hold, from the most junior to the most senior, there seems to be some evidence of people working what would seem, to those looking in, to be quite long hours. We heard some evidence today in that regard, particularly from some doctors working there. Is the Murrumbidgee Local Health District able to guarantee that all the hours worked in the hospitals that fall under your area of responsibility are actually paid for properly in accordance with the relevant awards?

Ms LUDFORD: Thank you very much for the question. I can actually guarantee that nurses, allied health and doctors are all paid in accordance with either their VMO contract or the relevant award. Agency nurses, if I could just clarify—

The CHAIR: Sorry, just before you move on: How can you guarantee that? On what basis can you be so confident?

Ms LUDFORD: I think it is all about the local leadership of the facility. There should be no circumstance where we expect a healthcare clinician to work in a hospital and not be paid. If there is something going on in the emergency department and they are required to stay back, it is the responsibility of the facility manager to ensure that they are paid appropriately through overtime provisions in accordance with their entitlements.

The CHAIR: And periodic audits and checks are done to ensure that that is the case?

Ms LUDFORD: Yes, absolutely. I think the way that we do that is by monitoring the overtime rates and the sick leave. The board looks at that; we all look at that. I just want to say there is no expectation from anybody in the Murrumbidgee Local Health District that people should be working without being paid.

The CHAIR: That is very good to hear. That is the way it ought to be. That is what the law provides for, so I am very pleased that is the answer. Dr Culbert?

Dr CULBERT: Mr Chair, I might just respond to one of the items you raised about telehealth. It is a strong feeling of the primary health networks that it is a key factor in going forward with health care but it should be a tool and a complementary factor, not an exclusive replacement, as others have said. But I just would like to draw the Committee's attention to some of the limitations for some of our patients in those. I just wonder if—

The CHAIR: Sorry, doctor—some of the what of your patients?

Dr CULBERT: Limitations.

The CHAIR: Limitations. No, that would be helpful.

Dr CULBERT: Limitations to telehealth. Particularly for rural and regional, there is an assumption that what works in metropolitan works in rural. It certainly does not. We conduct extensive data analysis in our region for our health needs assessment, which is mandatory for us to base our service on. Some 23 per cent of people in the Murrumbidgee region served by our LHD and the primary health network do not have access to internet at home. That is, they rely on mobile devices, perhaps, or shared mobile devices with fragility of supply to data if they are in socio-economic distress. They do not always have access to that in a reliable manner.

You may not know that there are, as you referred to, a raft of telehealth funding arrangements that were made during COVID to support both video and telephone consultations. General practices, other primary care institutions and hospitals have really moved very quickly to adopt this. We have been asking for it for a long time; it is some of that reform piece I was speaking about. It has taken a pandemic to do that, but it is piecemeal. It has been attached to the current systems and it has been changed often and always, which makes it very hard for us to keep up.

Just in the last 48 hours it has been announced by our health Minister, the Hon. Greg Hunt, that the telehealth would continue past 30 June, which is a big relief. But you may not know the detail in that, that it has been actually changed so that it will only apply to video consultations. In fact, the raft of telehealth by telephone, which is a very helpful method for people with mental health and chronic care, has been reduced to just two measures: a funding measure that applies to something under six minutes and over six minutes. If a general practitioner spends half an hour sorting out a mental health patient in crisis on the telephone who does not have access to video health—I use video health a lot; it often drops out and I switch to telephone. That is only funded—the Medicare is at the minimum rebate. It has been taken away for telephone for mental health care plans and other chronic disease programs. There is not enough good understanding of that for rural communities and I just would like that to be reflected.

The CHAIR: That is very valid evidence. Thank you all very much. You have been able to bring a rich amount of evidence—that is probably the best way to put it—to the contributions this afternoon. You are people with deep experience and long experience, and it is clearly shown not just through your submissions but through your oral evidence this afternoon. Thank you all very much, and thank you for the most important work you do for an on behalf of the local community.

Ms LUDFORD: Thank you, Mr Donnelly. There was something concerning me that I just wondered if I may be able to correct from some previous information that we were provided?

The CHAIR: Yes, sure.

Ms LUDFORD: It was just in relation to the midwifery cover at the Deniliquin Hospital. I just want to reassure the Committee that here, today there is 24-hour midwifery cover for women who are birthing in the Deniliquin Hospital. I am not sure of the case that was previously presented. A number of years ago there was a midwifery model that was a different way of working, where the midwives were called in on a case-based approach, but that was reviewed and has now been changed so that there are actually those midwives available on every shift at the Deniliquin Hospital. I just wanted to make sure that people were aware of that.

The CHAIR: I am grateful for that. Thank you very much. That concludes our hearing. To all the members of the public who have joined us today, I hope you have found it enlightening. Have a good evening and safe travel home.

(The witnesses withdrew.)

The Committee adjourned at 15:47.