REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

CORRECTED

At Dubbo RSL Club (Auditorium), Dubbo, on Wednesday 19 May 2021

The Committee met at 10:00 a.m.

PRESENT

The Hon. Emma Hurst (Acting Chair)

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

The CHAIR: Welcome to the fifth hearing of the Portfolio Committee No. 2 – Health 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 experiences, planning and capital expenditure in rural, regional and remote New South Wales. Before I commence I would like to acknowledge the Wiradjuri people, who are the traditional custodians of this land. I would also like to pay respect to the Elders past, present and emerging of the Wiradjuri people and extend that respect to other Aboriginals present. Today we will be hearing from a number of stakeholders, including local councils, private citizens, Aboriginal groups and health services, private health providers, the local health district and the primary health network. I thank everyone for making the time to give evidence to this important inquiry.

Before I commence, I would like to make some brief comments about the procedures for today's hearing. Today's hearing is being broadcast live via the Parliament's website. This is a trial and will be the first time the New South Wales Parliament has been able to broadcast a hearing held outside of Parliament House. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcasting guidelines, media representatives are reminded that they must take responsibility for what they publish about the Committee's proceedings. While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the hearing. I therefore urge witnesses to be careful about comments you may make to the media or to others after you complete 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 House in 2018. If witnesses are unable to answer a question today and want more time to respond, they can take a question on notice. Written answers to questions taken on notice are to be provided within 21 days. If witnesses wish to hand up documents, they should do so through the Committee staff. In terms of the audibility of the hearing today, I remind both Committee members and witnesses to speak into the microphone. That is particularly important because of the sound quality at the back of the room. Finally, I urge everybody to please turn their mobile phones to silent for the duration of the hearing. The broadcast of the hearing will cease during the allotted breaks.

KEN KEITH, Mayor, Parkes Shire Council, sworn and examined

KERRIE STEWART, General Practitioner, Ochre Health Medical Centre, affirmed and examined

MILTON QUIGLEY, Mayor, Warren Shire Council, affirmed and examined

HEATHER DRUCE, Councillor, Warren Shire Council, affirmed and examined

The ACTING CHAIR: I welcome our first witnesses. Do any of you wish to make a short opening statement?

Mr KEITH: Yes, I do. Thank you for the opportunity of appearing here today. I thought I would start with a little bit of history of the Parkes Shire, particularly the Parkes Hospital and the services from it. The hospital was built in 2014 after years of lobbying to get a new hospital. A $72.5 million new hospital was built following quite a few years of community consultation. There was also a $40.9 million upgrade of the Forbes hospital at the same time, and there are some shared services that now operate under the Lachlan Health Service covering both towns. The service level agreed to by the department of health and the Parkes community unfortunately has not been met. Two state-of-the-art operating theatres, for example, are underutilised.

The maternity service offered in Parkes is no longer operating there. There was also rehab for cardiac issues, and that service that was operating in our old hospital has now ceased. We had major public meetings, forums and protests in Parkes two years ago about the maternity issue. Despite a decade of warning about the retirement of three long-serving GP proceduralists, our maternity unit was closed in June 2019. A midwife-led model was proposed as an interim solution. Nearly two years later Parkes maternity still has not delivered another baby. This is not acceptable in a town of a population of 12,000 people and a shire population of 15,000 people.

As chair of the Country Mayors Association of New South Wales, with the support of my executive we surveyed all the regional councils as to their issues and priority needs. Water security and health services were the two top priorities in regional New South Wales, so we greatly appreciate the opportunity afforded by this inquiry. A motion to go to our next meeting in two weeks' time is to ask the State Government to create a Minister for regional health, just like what has happened with the road network with a Minister for the metropolitan road network and Minister Paul Toole who looks after regional road networks. We think that model should be applied to health as well, given the disparity between health services in the metropolitan area and regional areas.

One concern that has been expressed is that the allocation of resources to base hospitals—in our case that is Orange and Dubbo—has been done at the expense of the hospitals in regional towns. We are not saying that the wonderful services that Orange and Dubbo provide to the regional communities are not needed, but we should make sure that the other regional towns—medium-sized towns around that 10,000 population—need to be serviced as well. It is my pleasure now to introduce Dr Kerrie Stewart, who is a GP at Parkes, to talk about GPs and our crisis in that situation in Parkes, mental health, aged care support and allied health. Thank you, Dr Stewart.

Dr STEWART: I reiterate: Thank you so much for holding this inquiry. I bring appreciation from our healthcare providers in Parkes. I would like to acknowledge that today is actually World Family Doctor Day. There are four themes. One of the themes is building the future with family doctors and primary care teams. I am privileged to appear here today and represent GPs and primary carers in Parkes. I have lived and worked in Parkes since 2013. I completed my GP registrar training in Parkes and remained on as a GP. Parkes is my home, and I intend to live and practise there for the foreseeable future and raise my family. I love rural medicine, and I love the challenges of rural medicine. I acknowledge that there have always been issues around resources, scarcity and complexity within rural medicine, and it is with that knowledge that I have embraced this career path. I just want to celebrate that and acknowledge that rural doctors thrive on challenges and thrive in these environments quite frequently.

We have incredible dedication, skill, resilience and innovation, and we work really well quite often in these situations. I must acknowledge, though, that there comes a time when scarcity, limitation and reduction in resources is no longer a challenge but is in fact disabling. And there comes a time when critical resources are lost that make the continuation of a safe, quality service unsustainable and in fact unachievable when the gaps in resources make it unsafe for both patients and clinicians. It is at this stage that a health service can in fact become a disservice. I believe we are on the precipice of this scenario in Parkes. We are facing a huge shortage of general practitioners, in particular, and this has resulted in the inability of our current GP workforce to have the capacity to provide essential care to members of our community, including our aged care residents. It is also resulting in a reduction of our ability to have multidisciplinary collaboration with our colleagues within the community.

In preparation for this inquiry I have spoken with our three practices in town. In recent years practices that have had up to seven full-time equivalent GPs are down to two, three or less. Of our three practices in town,

one has three full-time equivalent GPs, one has 1.8 full-time equivalent GPs—and that is about to reduce as one of the GPs is moving to further part-time work—and the other practice has a variation from about 1.8 to three full time equivalent GPs. That practice has proceduralist general practitioners who work and provide services not only in a general practice clinic setting but also to the hospital. On different days it is not uncommon to have one or potentially no doctors in that clinic. With a maximum of eight full-time equivalent doctors serving a town of 12,000 people and its surrounding areas, it is no wonder there are really long wait times for appointments. There are almost zero, or there are zero, on-the-day or emergency appointments, and there is great difficulty in providing follow-up, which is causing great frustration for both the clinicians and, obviously, the patients.

Doctors are working weekends and extra days to provide COVID and flu clinics. Often in these clinics we are also putting out fires, so providing emergency scripts for patients, emergency referrals, organising medical appointments to get things like a driver's licence for farmers who live a significant distance from town. The situation is about to get significantly worse with three of our long-serving doctors indicating their imminent retirement. Very recently they have actually given information to our aged care facilities saying they are no longer able to provide ongoing GP services in person, or at all in fact, to those facilities. So that leaves us with literally 80 per cent of our aged care residents in Parkes without a GP post-30 June. We do not have the capacity, with the remaining GPs in town, to pick up that patient load.

Obviously this has a flow-on effect to our community health providers. There is pressure on pharmacies. There is pressure on our allied health colleagues as well. We love the fact that there are telehealth and remote health services available, but at this point that should be an adjunct and it should be supporting GPs who are able to fulfil services in the town. At the moment we do not have that critical mass of GPs to even offer that service to then be supported. Locums are great, and we really appreciate them. They bring a lot of skill and knowledge, and they work hard and they do fill a really important gap. The issue is once they leave they leave a backlog of results, investigations and patient care to follow up. The remaining GPs need to have some capacity to carry on that care, which we currently do not.

I like to celebrate that we do have amazing services. We have a lot of resources that are coming on board to address mental health issues and provide those services. What we do need is a directory that gives our community access to knowing what these services are and how to get to them without necessarily having to go through the bottleneck of getting an appointment with a GP at the moment. That is certainly something I would advocate for. There are some amazing technological innovations that our pharmacies and some of our other allied health professionals are putting into place that can help with reducing that bottleneck of going through a GP to get referrals and services. There is a lot of discussion around the collaborative care model, and I offer my absolute support and enthusiasm for that and would be incredibly excited and enthusiastic to be involved with that. Recruitment and retention of GPs is very challenging. One of the issues that has been identified is that Parkes is not classified as a Distribution Priority Area [DPA]. I think there has been a submission to this inquiry that indicates that. Is that correct?

Mr KEITH: Yes.

Dr STEWART: When you look at a map of western New South Wales, you will see the shocking or stark spot on the map that is Parkes that is not DPA classified, while areas such as Dubbo, Orange and Wagga are in fact DPA classified. In my conversations with the other two practices and my own practice it has been indicated that a reclassification would immediately have an effect on their ability to recruit and place doctors. Along with that, we do need to acknowledge that many of these doctors will be international medical graduates. We need to offer support for them to be able to get onto training programs because, as I hope you are all aware, if they are not on a training program or in fact vocationally registered or a GP specialist, they will have significantly lower Medicare billing, which then makes it difficult or financially less viable to have these doctors in our towns. That is something that is really important as well.

Looking at remuneration, I think this is certainly something that the State can contribute to—looking at, potentially, salary packaging of positions that would offer Rural Generalist but also general practice services to our community. There have been some suggestions from fellow GPs about looking at pools of doctors. We have amazing centres such as Dubbo and Orange where we have a supply of general practitioners but also some hospital-based doctors. That potentially would be a pool that we could use to provide some services to Parkes. This would have a great effect, both providing experience and communication from those larger centres to Parkes and offering that excellent education and upskilling for our local health providers as well. That would be a model that we would certainly be excited to explore.

We fully support the collaborative model and looking at establishing a local medical network and a collaboration, certainly with Parkes but within the greater Lachlan area, if that were able to be undertaken. Once again, we do support the establishment of the rural medical schools and the placement of junior doctors and junior

medical officers into general practice. One of our issues is that we need Fellowed GPs who can provide supervision for those junior doctors and medical students. Certainly remote supervision would be an option, but there is a lot of value in having peer support and in-person mentoring. Thank you again for the opportunity to talk and to represent Parkes. I am sure that there are definitely concerns and issues to be addressed in the hospital system, but certainly in the primary healthcare community we are really at a point where we need some immediate assistance. As I said, our top priorities would be around the review of the DPA classification, looking at potentially the remuneration or doctor-sharing options, and then the Collaborative care model that we welcome with open arms and great support.

The ACTING CHAIR: I remind witnesses to try to keep the opening statements short because we do have quite a few questions that we would like to ask the group as well.

Mr QUIGLEY: Certainly. Thank you very much for the opportunity to present to this inquiry into health outcomes and access to health and hospital services in rural and remote New South Wales. Councillor Druce and I represent a small council, in terms of population, but one with a large area. Warren Shire Council covers 10,760 square kilometres but we only have a population of 2,730-odd people. Our challenges are a little bit different to those of Parkes. We are very small and very remote. By way of background, Councillor Druce is a former registered nurse and has some expertise in that area. I am a practising dentist with a practice in Warren and have been there for 31 years. That background perhaps gives us some degree of credibility.

What I would say is that with our population being small, nonetheless 20.8 per cent of that population is 65 years or over. Some 17.7 per cent of that population is Aboriginal or Torres Strait Islander. Immediately we have got that challenge of probably a less mobile population in terms of accessing health services. Then of course there is the issue of geography. We are a long, irregular-shaped council, longer north-south than east-west. Those on the eastern end of our shire can travel 120 kays or so to Dubbo, but those on the north-west corner travel 300-plus kays. This is not news to your inquiry. Geography is a real issue in terms of people accessing health and getting the health outcomes that they want.

On the other side, one of my bugbears is that increasingly the burden for provision of health services is being placed on local government. To that end, Warren Shire Council has built a purpose-built medical facility that is able to house three medical GP practices as well as allied health people. We also subsidise some rental for doctors who are staying. But in my view often local government is being asked to step up to the plate when, in fact, the imprimatur of health services belongs in the State and the Federal spheres. Our communities, as Councillor Keith suggested, are really asking for the provision of health services as one of their top priorities. We need to overcome these sorts of issues and get on top of them. In many ways we are grateful for the opportunity to speak here today, but it is sad that it has actually become such a systemic issue that it needs to be addressed by an inquiry. We are seeing that these incidents are in the Parkes, the Warrens, the Cobars and the Bourkes of the world. We need to sit back and reflect on where we are, but then essentially move forward.

Our communities identified five areas that they see as the stumbling blocks in health. The first of those is the provision of GP services. The second is the recruitment and training of those working in health, particularly in the acute area of health in the MPS or the aged-care area. The third one is the ongoing provision of aged care within our towns so that people do not have to move out of their town—the area that they have known all their lives—to really have the health outcomes that they need. The last two pertain really more to allied health and, as Dr Stewart touched on, the idea that a significant number of allied health professionals come into our town on a continuing basis—but not often enough—to provide services.

Many of our community do not understand or are not aware of those services being provided. I think there is a serious shortcoming in terms of knowing about the allied health services that come in that could provide much better health outcomes. The final point is really just access to those allied health services. As Dr Stewart alluded to, people have to come in asking for a doctor to provide the okay for a driver licence or a medical intervention—a physiotherapist will come to the Warren MPS, but to access that service you have to see a GP. If there is no GP available then it all falls down, it becomes too hard and people do not follow through to get the health outcomes that they really need.

Those six areas really cover off on what we would like to talk about, and I think we will take the opportunity as questioning goes to elaborate a little bit more on those, particularly the recognition from Western NSW Local Health District that GPs provide the anchor for every health service within small remote towns like ours and even in bigger towns, as in the Parkes of the world we are talking about. I think anything we can do as an outcome of this inquiry to have GP services as that cornerstone—as Scott McLachlan and Shannon Nott presented to joint organisation of councils meetings suggesting that that is the cornerstone. We need to proceed along that way and get that in place. The more quickly that can occur, the better.

The ACTING CHAIR: Thank you. We will now have questions from the Government, the crossbench and the Opposition. Each group will have 6½ minutes. We will start with the Hon. Walt Secord.

The Hon. WALT SECORD: Councillor Keith and Dr Stewart, if we can talk about Parkes Hospital, in your submission you state:

> … state-of-the-art operating theatres which are largely unused …

You have a relatively brand-new hospital built in 2014; it is six or seven years old. What is actually happening with those operating theatres?

Mr KEITH: They are being underutilised at the moment. What has disappointed the Parkes community is that when we agreed with the department of health on the services that the new hospital should deliver we thought, "Oh, good, we will have beautiful health services moving forward." Seven years later it is not the case.

The Hon. WALT SECORD: What were the services that were promised? Just to prompt you, you were given the impression that there were going to be maternity services in a community of 15,000 people?

Mr KEITH: That is correct. Maternity services has been a huge issue for the community. There was a big rally and hundreds of people turned up wanting to retain maternity services in Parkes. At the moment Parkes and Forbes work together as the Lachlan Health Service and there are maternity services available in a level 3 form in Forbes but only a level 2, midwifery-led model proposed for Parkes—but that has not as yet eventuated two years later. The operating theatres are equivalent to Royal North Shore in Sydney—two operating theatres that are only doing very minor surgeries. They were there originally to support maternity, in the case of caesareans and so forth or any medical intervention that was needed. But we have had instances where somebody had a dislocated shoulder and they were not able to get that shoulder put in because the anaesthetist who used to service maternity was no longer available. So they had to be transferred to Orange to receive the anaesthetic to have that shoulder put back in. To me, for a simple operation like that we should have those services being able to be delivered in theatres like Parkes. Why doctors either from Orange or from Sydney cannot come up and utilise those theatres to do procedures in—there is talk of doing colonoscopies now in that Parkes hospital.

The Hon. WALT SECORD: You do not do colonoscopies?

Mr KEITH: Not yet. They are about to but that is the sort of problem that we have. The doctors are now not going up to Parkes and the danger for our theatres is that not only are the doctors not coming but then the theatre staff are not getting the experience and are not getting a career path to be able to utilise those facilities. If we do not start to get doctors coming up to Parkes—when we built the hospital we actually had an accommodation facility built as well so there would be somewhere for those doctors, registrars and different people to stay and come and help service the theatres and hospitals.

The Hon. WALT SECORD: What is actually happening in these operating theatres or not happening?

Mr KEITH: Dr Stewart might know more than I, but not a lot.

The Hon. WALT SECORD: Dr Stewart, what happens in the Parkes operating theatres?

Dr STEWART: I will lead by saying that I do not work at Parkes hospital.

The Hon. WALT SECORD: But you are a doctor in that community.

Dr STEWART: Yes. I am hoping the LHD would be able to give you exact numbers and dates et cetera. I spoke to one of my senior colleagues who does do procedural work at the hospital and in fact does some surgery, mostly advanced skin excisions, and he gave me a list of various specialists. We do have specialists who come. I believe there is one that comes from Dubbo once a month and does some general surgical lists, so very small procedures such as lap choles and some general surgical procedures. We do have a gynaecologist who comes across from Orange. I believe it is once a month but again you have to clarify this with the LHD or Parkes hospital directly. There is another general surgeon who comes across—possibly two general surgeons—from Orange, but they come essentially once a month. Then we have our local GP proceduralist who does his list once a fortnight, again doing minor surgical procedures. His comment to me yesterday was that on any given week there will be a maximum of two theatre lists. That is his information to me.

The Hon. WALT SECORD: For people who do not understand when you say theatre lists, you mean lists for a day, so two days.

Dr STEWART: Sorry, like a surgeon performing operations, whether it is a full day from eight until four or whether it is part thereof, I am unclear. It would depending on the bookings. On any given week, there would be two days that the theatre—a single theatre—is operating is my understanding.

The Hon. WALT SECORD: So three days a week the Parkes operating theatre would be vacant.

Dr STEWART: That is my understanding.

The Hon. WALT SECORD: That was my understanding too, but I wanted to get there in your words.

Dr STEWART: As I said, I do not work there but that is a direct conversation I had with the doctor who does work there and the hospital would hopefully give you exact details.

The Hon. WALT SECORD: So the ludicrous situation is that the Parkes operating theatre is closed more than it is open.

Dr STEWART: Absolutely. That would be correct.

The Hon. WALT SECORD: What about wait times for a GP in your community. What is the typical wait for an appointment. Not with yours but with all three—

Dr STEWART: A month, easily.

The Hon. WALT SECORD: A month?

Dr STEWART: When I say a month, that is if you were to ring wanting a standard appointment for ongoing medications et cetera. If it is urgent on the day there are essentially often zero appointments. So the answer is they go to the hospital.

The Hon. WALT SECORD: Does that put an extra burden on the hospital?

Dr STEWART: I imagine so, yes. I do know at different times depending on the availability of GPs—so certainly if there are GPs who are fully booked—there is a certain amount of time. Once you are filled up for essentially a month or so you cannot offer appointments further ahead because that just then blows that out to six and eight weeks. So sometimes when they ring they just say, "I'm sorry. There is no appointment." You cannot even book one for a month because if we start doing that we push it on. So we have a system whereby we say that if you can ring tomorrow—let's say today is Wednesday. So Wednesday for the next four weeks is fully booked but if you ring at 8.30 tomorrow morning suddenly Thursday in four weeks opens up.

The Hon. WALT SECORD: How does that make you feel as a person who is obviously connected to your community?

Dr STEWART: It is incredibly difficult and you feel a sense of—you are really torn because you would love to open the doors and say, "Everybody come in", but that is not possible. I can appreciate the patients' absolute frustration and anger and disappointment, but as a clinician you cannot offer good, safe medicine if you cannot follow people up. There is no point seeing someone today and then saying that I will follow you up for this urgent result or this urgent review but I have no appointments for four to five to six weeks. It is really difficult and it creates an environment of frustration and dissatisfaction in work that is otherwise absolutely marvellous work. So it is really difficult.

The ACTING CHAIR: I just have a quick question for Councillor Keith. In your submission it said that the council was having to often fill the gap and spend money on health service deficiencies. Can you give some examples where the council has actually had to step in to fill these gaps?

Mr KEITH: Yes. We had what we called a GP Cup and it has been running for a few years. We recognised the need for additional GPs to come to Parkes about four or five years ago. We had community sporting days, they competed for the GP Cup and they raised money. We raised over $200,000 to go towards the recruitment of GPs to subsidise their freight and their moving expenses to Parkes or their desire to come up and have a look at our town. We paid for their air flights and things like that.

The ACTING CHAIR: Do you think that that is a normal thing that councils should have to do—to actually fundraise for local health care?

Mr KEITH: It is not. Health is not a local government responsibility but our communities are telling us, "This is our biggest concern. We want you to voice our concerns about health care in our communities." We appreciate the collaboration we have with various health services, the local health network. Scott McLachlan and Shannon Nott and those people are always willing to talk. We have had some very constructive conversations about the new collaborative care model coming up. But we have been talking to them about the need for more GPs and some method of attracting those to our town for many years. But nothing has really been achieved and we are now hitting a crisis point.

The ACTING CHAIR: Has Warren council experienced something similar where you have had to raise money for health care?

Mr QUIGLEY: No, we have not been in that same situation as of yet, but our communities are enunciating that same degree of frustration that Councillor Keith has said there. We had two GPs resident in the town for quite some time. One resident has retired and one, who is actually presenting later today, has moved to a different location. But we have gone from two full-time GPs when the numbers would suggest that we should have had three anyway then. There were hardworking, diligent people and overworked. Now we are back to 1.5 full-time equivalents so we are really short at least 1.5 again. Then there are lies, damned lies, and statistics. That 1.5 sits back at one doctor during one week and then two during the next week, no visiting medical officer [VMO] at times and no-one particularly over weekends to see those accident and emergency things that happen in a rural landscape. There is a degree frustration from our community in terms of GPs on the ground.

Ms CATE FAEHRMANN: I just wanted to go to something you said in your opening statement, Dr Stewart, about here in Parkes. You said that we are on the precipice of health care in Parkes becoming a disservice not a service. What are you calling for from the Government right now to ensure that the Parkes health service does not become a disservice? What do you need?

Dr STEWART: We need a critical mass or a critical number of GPs, reiterating what both councillors have said. GPs in that primary care model are what hold the health of our community and stops that flow into our hospitals. In Parkes hospital my understanding is that a lot of the emergency services are being provided by locums but there are emergency services. We are able to see emergency patients so the hospital is doing its part. It is primary caring. If we could catch those people and service them in the community, we save that deluge going through to the hospital and it being our backstop. In short, the primary health—the number of clinicians—is what we need.

Ms CATE FAEHRMANN: Okay. Do you think that the advertising and recruitment process are adequate?

Dr STEWART: I think it can always be better. One of my colleagues who has recently done some interviewing for the Australian College of Rural & Remote Medicine [ACRRM] Independent Pathway—they are obviously doctors who are looking to do rural and remote medicine. Some of them had fantastic qualifications, including some emergency qualifications et cetera. Her comment to me was that some of them did not know where Parkes was or that it existed or that there were opportunities there. So there are avenues for improving our advertising and our awareness of medic needs in communities. My other comment would be around DPA classification and the comment that each practice has indicated that a reclassification of Parkes into a distribution priority area would open up some doctors or GPs—many of them not on pathway, is my understanding—to fellow. They certainly are doctors who could be mobilised and located into our practices in Parkes if that classification were adjusted.

Mr KEITH: Madam Chair, it might be an appropriate time to table a document that shows my correspondence to the Hon. Mark Coulton and to the Deputy Prime Minister, our local member, regarding that distribution area.

The ACTING CHAIR: Fantastic, thank you.

Ms CATE FAEHRMANN: Potentially specifically in relation to that as well—and this is possibly for the councillors—we have had some submissions that are essentially lobbying for a different way of treating the local health districts, specifically that there is a rural remote LHD. There should be, if you like, a metropolitan and a regional because the issues are so different. What are your views on that? Dr Stewart, I can see you nodding furiously, but I might also see if Councillor Druce has an opinion on that, perhaps?

Ms DRUCE: Yes, thank you. I believe that every community has their own needs and one size does not fit all. I think they need to separate the communities. They are all very different—demographics with ours with aged care. I just think they need to divide the services.

Ms CATE FAEHRMANN: Dr Stewart, did you also want to comment?

Dr STEWART: I completely agree. I think that the collaborative care model, which really looks at the discussion between the LHD, the Rural Doctors Network and the primary health network [PHN]. I think—I hope—that is what that will bring to the table.

The Hon. WES FANG: Thank you very much for appearing today and for sharing your experiences. I think it is really important that those of us who are in Parliament come out and hear your stories and experiences. I would like to start first with Councillor Keith. Parkes has advocated, as you have said, to the Federal member and Mr Coulton in his area around health. Obviously, they are both Federal so with primary health care being the Federal requirement, how do you see the State working in with that system to ensure that we have the health care being provided to all the communities, not just yours?

Mr KEITH: Look, the distribution area of need is something that is reviewed every three years. To me, that is probably too long. We probably had enough GPs at that particular point in time three years ago but that does not reflect what is happening now. So maybe that needs to be an annual review by the Federal Government based on the number of Medicare claims that are lodged through doctors and so forth. It does pick up locums and things like that are claimed through Medicare as well—it may not be a GP that is actually stationed in that particular community. So I think we need some liaison between State and Federal governments to straighten that out. I think there is the potential of creating more generous financial wage packages for doctors to recognise their training as a rural generalist in regional New South Wales and creating packages that actually remunerate them at an appropriate level for the risk that they have to take and the knowledge they have to acquire to be able to practice out there.

My understanding is that Queensland has more generous packages and they have solved their regional health problems as a result. I think creating a Minister for regional health would go a step further because he or she could actually be in Cabinet arguing the case for additional expenditure to be allocated to the local health districts in regional areas. At the moment Scott McLachlan and his team at the local health district provide some wonderful dialogue and some lovely consultation and we get positive vibes. We try to work with them in this collaborative model but, in the end, they are tied by budgetary constraints. I think at the end of the day the State Government has to have a serious look at whether they want to provide good regional health or not because it is at crisis point.

The Hon. WES FANG: I know we definitely do. As someone who lives in a regional area, I have a real strong advocacy for it. That is a bit of my next question because we have heard in recent inquiries that money is one part of the issue but it is not the only part—attracting people to regional communities is sometimes about the community. I think, Dr Stewart, you have actually alluded to that. We have to make those people who come feel welcome. Councillor Druce, I know particularly we heard yesterday that small communities like yours are very good at making people feel welcome and engaged. Do you think you could share a little bit about what you do to attract and provide a community that embraces doctors to get them to stay? Because we know that if people come they fall in love with the place and they want to stay.

Mr QUIGLEY: Yes, thank you for that. We certainly go out of our way to welcome those into our town, particularly those who are professionals. I believe there is a capacity for the movement of GPs into small country towns. We have seen evidence of that in Bourke, which has been able to secure the services of some GPs, and our near neighbour to the north, Coonamble, has been able to do the same thing. I think it is very much the idea that you can offer all the services that do occur in a bigger town. We go out of our way as a council to develop our town. We want to make it a town that our children will be happy to come back to. That means providing every service that we possibly can provide in terms of sporting facilities, clubs and facilitating everything that one can think of to make it an attractive town.

Anecdotally we have a number of graduate medical people from our area. One of those practises part-time—not in Warren, but locally, nonetheless. So we are gratified by that. But I think the opportunity to grow our own is the essential point here. I concur with Councillor Keith in that monetary value and making those people feel valued in your community is part of that. We would and do go out of our way to make people particularly welcome. That is why the GP who retired stayed in our town. He had the opportunity to move anywhere and he has stayed in our town. There is the opportunity to really be part of something, and I see that in my professional life. You can see a town grow. You can see community grow. It is an experience that goes with being part of a small country town. It is not something to be frightened of; it is something to embrace.

The Hon. WES FANG: No, it really is. Both of you have actually had that provision of health care in Warren, so you both understand it.

Ms DRUCE: Yes, and I will just add the need to try to get some incentive happening to get nursing staff because I am hearing on the local Bourke radio station they are asking for casual registered nurses [RNs] in about 15 hospitals in the western area. I think there needs to be something done about getting some sort of incentive happening to get nurses into our small hospitals.

The Hon. WES FANG: Nurses are just as important as doctors, so I could not agree more.

Ms DRUCE: Definitely, yes.

The ACTING CHAIR: We have one last very quick question.

The Hon. LOU AMATO: I had a few but I have one that has really raised concerns for me. I do not know if it is directed at you, Mr Keith, but it is in your submission. You mentioned mental health issues, particularly youth suicide, are increasing dramatically in regional New South Wales. Why do you think that is the case?

Mr KEITH: It is a combination of a couple of years of drought and mice plagues and things like that. Employment opportunities are limited in some areas. Certainly there has been an increase in suicides in the Parkes Shire area. The health department has recognised that and they are going to establish a health walk-in centre in the middle of town that will open in the middle of the year. So there is a recognition of that. It is very hard to put your finger on why that is happening. I think COVID has created a bit of isolation and not the opportunity to go into the metropolitan areas or the danger of catching COVID. So people are a bit isolated in rural communities. That is a combination of all those sorts of issues moving forward.

Parkes has a special activation precinct [SAP], as you would be aware as being with the government, that we have created. Our unemployment has dropped down, and the value of homes and rural land has increased quite dramatically over the last 12 months. We have had an employer that has to give medical certificates for people to be able to be employed to work on that new SAP. They cannot get an appointment to get the medical certificates, so therefore they are not meeting the obligations of their contract and it is making life very difficult for young people to get jobs the way they should be able to get them. So I think it is a combination of a range of things.

The Hon. LOU AMATO: So there is a lack of opportunities for young people.

The ACTING CHAIR: That concludes our hearing. Thank you all for attending today. We appreciate you coming and providing evidence.

Dr STEWART: Am I able to table a document?

The ACTING CHAIR: Do you want to table a document?

Dr STEWART: It is a letter from one of my fellow GPs. If you would be happy to receive that, I have 10 copies here.

The ACTING CHAIR: Thank you.

(The witnesses withdrew.)

(Short adjournment)

ANN-MAREE CHANDLER, Owner, Indidg Connect, affirmed and examined

JAMIE KEED, Practice Manager, Dubbo Regional Aboriginal Medical Service, sworn and examined

AMY PERRON, General Practitioner, Dubbo Regional Aboriginal Medical Service, affirmed and examined

The ACTING CHAIR: I now welcome our next witnesses. I will give each of you the opportunity to make a short opening statement. Ms Chandler, do you have an opening statement?

Ms CHANDLER: I am not sure exactly what an opening statement is, so I will just tell you a little bit of a background. I am a Wailwan woman from the Gulargambone area. I started Indidg Connect in December 2019 as an Aboriginal business for Aboriginal people to reduce our barriers and create an opportunity for financial independence. It started from my heart and we are still here today. We survived COVID and a few other different things but I have had to pivot the business a lot to be able to do that, and due to funding issues also. But we are still here, we are still going strong and we are building well. I am obviously here today from the things that I said in the submission that I made.

The ACTING CHAIR: We all have that submission and we have read it, so thank you very much. Ms Keed, do you have an opening statement that you wish to make?

Ms KEED: No, I do not.

The ACTING CHAIR: Dr Perron?

Dr PERRON: No.

The ACTING CHAIR: In that case, we will move straight to questioning.

The Hon. WALT SECORD: Ms Keed and Dr Perron, could you give us a bit of a perspective? We have heard in western New South Wales that there are lengthy waits and a lack of services in communities, particularly in MPSs, and a lack of doctors and the burden is falling on nurses. In some communities there are waits of up to, or more than, six weeks to see a GP. That experience must be compounded in the Aboriginal community with Aboriginal community members reluctant to see a doctor or delaying to see a doctor until it is too late to do so. Dr Perron, as a person who I think works in the Aboriginal Medical Service [AMS], could you give a perspective on that?

Dr PERRON: I agree with the statement that you have made. It definitely is difficult to attract doctors to our region and to retain those doctors. We personally have been trying to recruit for six months for extra doctors at the AMS. Currently it is just myself, a registrar and locum working in our service. I certainly have six-week waits for regular appointments.

The Hon. WALT SECORD: You have six-week waits?

Dr PERRON: Yes, six-week waits.

The Hon. WALT SECORD: So what do you do in an emergency situation? Because of the time constraints, I am going to jump.

Dr PERRON: We do have acute appointments for those emergency situations and I am prepared to see walk-ins on the day for those sick patients but, of course, there is only so much you can do in a day. It definitely is something that I do find difficult. Compounding that is the access to specialist services is quite lacking in our community, not only the specialist services themselves but also affordable specialist services. During COVID we lost a lot of cardiologists here in Dubbo, so we had upward of a 12-month wait for a private cardiologist. I was personally sending patients to Orange, to Bathurst, to Sydney, to Newcastle to try to see a cardiologist. In the time when we are waiting for specialists, the GPs have to hold the patient and keep them well.

We are seeing them a lot more frequently as well, which also compounds the increasing waiting list because we are not seeing those new patients with the new chronic diseases, we are also reviewing our prior patients. That goes across the board with a lot of specialists. It is not just cardiology, it is ears, nose and throat, it is paediatrics, it is rheumatology, dermatology—across the board. Waiting times for surgeries are also quite extended as well. Quite often they will max out those 365-day waiting periods for a category 3. During those times we are also managing the pain and the symptoms of those surgical conditions that require that surgery.

The Hon. WALT SECORD: I am going to have to stop you there for a second. You used medical terminology that is everyday usage for you. Could you explain category 3 maxed out for 365 days?

Dr PERRON: Category 3 is a non-emergent, elective surgery—something that needs to be done but does not need to be done today.

The Hon. WALT SECORD: So something that is painful but not life-threatening.

Dr PERRON: Like a gall bladder.

The Hon. WALT SECORD: Like a gall bladder, or a knee or hip replacement—things like that?

Dr PERRON: Yes. Tonsillectomies, grommets—those sorts of things.

The Hon. WALT SECORD: So waits are more than 365 days for those.

Dr PERRON: They will try and get them in by that period, but usually it will be up to that limit.

The Hon. WALT SECORD: What about people who need cataract surgery and things like that? What are the waits like for an Indigenous person out here?

Dr PERRON: We have been a lot more lucky with the eye surgeries of late. We have had a public clinic that we can send those patients to. The waiting list on average is around three months, if I recall correctly, but prior to that it could be quite lengthy.

The Hon. WALT SECORD: How about tonsillectomies for little kids who cannot swallow?

Dr PERRON: If they are more urgent, they get increased up the categories; it can be quicker. But they do average out about 12 months.

The Hon. WALT SECORD: What about young mums, bubs and that kind of stuff? Aboriginal babies have a lower birthrate and more challenges. What is the experience in western New South Wales?

Dr PERRON: We do have a great team at the AMS with a midwife and a child and family health nurse who helps us with a lot of our antenatal care, and we do have partnerships with the antenatal clinic at the Dubbo Base Hospital and the Aboriginal Maternal and Infant Health Service [AMIHS] girls who see the mums and bubs in the community.

The Hon. WALT SECORD: What about kidney dialysis and respiratory? I will give you an example. This is our fourth day of hearings. We have had one in Sydney, one in Cobar and Deniliquin. We were down in Deniliquin and the renal chairs in the dialysis centre were being used three out of seven days a week. What about kidney dialysis in the community here and Aboriginal access?

Dr PERRON: I cannot speak for the dialysis unit themselves, but as far as my patients, I have had a pretty good experience with the dialysis unit actually. A lot of my clients will have access to dialysis at the hospital, and I also have one lady who has her own dialysis machine at home, with great support from that unit for myself and for her when anything goes wrong.

The Hon. WALT SECORD: What is the sweep of the Dubbo Aboriginal Medical Service? How far do you go out?

Ms KEED: We cover a lot of the smaller surrounding areas, such as Narromine and Peak Hill. We have patients come from Nyngan, Gilgandra—

Dr PERRON: I have got a few from Warren.

Ms KEED: From Warren.

The Hon. WALT SECORD: They come from Nyngan and Gilgandra?

Ms KEED: Yes.

The Hon. WALT SECORD: They drive in?

Ms KEED: Yes.

The Hon. WALT SECORD: What would be the longest trip?

Ms KEED: Nyngan would be about a two-hour drive.

Dr PERRON: I have got a patient who will travel three hours to and from Dubbo to come and see me.

The Hon. WALT SECORD: Would they pass MPSs and other health facilities? Why would they come to your facility?

Dr PERRON: I think because of the culturally appropriate care that we offer. Quite often once you build a rapport with a patient, they will make that effort to travel further to come and see you in an area where they feel comfortable and supported.

Ms KEED: We also have Aboriginal health workers and a team of nurses who will triage and do their post-appointment with them. That makes it a lot better for the patients.

The Hon. WALT SECORD: What about Indigenous workforce issues? I know that you are a doctor of Indigenous descent, Dr Perron. Are there many Indigenous doctors out here?

Dr PERRON: My cousin works in the emergency department.

The Hon. WALT SECORD: It is the family business.

Dr PERRON: That is about it at the moment. We do have about 250 indigenous GPs in Australia but we are spread across a broad range of areas.

The Hon. WALT SECORD: Okay, but workforce issues such as nurses, community liaison officers and things like that. Do you have enough? Do you need more? What is the state of play?

Ms KEED: No, I think we have quite enough with the nurses. It is always easier to recruit nursing staff and Aboriginal health workers.

The Hon. WALT SECORD: Has COVID had an unusual impact on Indigenous health in western New South Wales?

Dr PERRON: Absolutely. I think early in the pandemic we found there was a lot of fear around COVID, so we did miss a lot of opportunities to perform those health checks on patients because they were socially isolating even without directives. To get them in for their regular health checks, we did have a bit of trouble early on in 2020. Since then, that has picked up. We are picking up those patients and doing their screening checks again. That probably picked up around August last year. There was also a bit of difficulties in sort of the teething process of doing telehealth early on as well because the Indigenous population—like I suppose the rest of the population—do appreciate the face-to-face consults. With the constantly changing recommendations and the constantly fluctuating threat levels, it became too difficult to do a lot of face-to-face consults early on. But I think we handled it pretty well. I think after a while everyone sort of got used to the idea, and we do sort of a mix of telehealth and face-to-face now and it seems to be working.

The Hon. WALT SECORD: What about the challenges of COVID vaccinations for Indigenous people? You are smiling, laughing and raising your eyebrows. Hansard unfortunately does not record that, so if you could articulate your reaction.

Dr PERRON: Initially it did go really well. I do run a COVID vaccine clinic two days a week. Just juggling the workload to be allowed to do those vaccine clinics was difficult initially because we do not have enough medical staff. But the first couple of clinics I did run, everyone was really keen to get them done. They were very excited. We usually have fantastic vaccination rates within our community. But unfortunately more recently with a lot of the media attack on AstraZeneca and the clot risk and constantly hearing about it on social media, certainly the vaccination clinics have not been as busy as what I would like them to be. That is sort of a place where I tend to get a lot more of those acute appointments because everyone is a bit fearful.

The Hon. WALT SECORD: What about mental health services?

Dr PERRON: That is severely lacking in our community. I would like to see more culturally appropriate psychology services and, by that, also affordable services. We do have a great service through Marathon Health, but unfortunately I find that most of my patients are either far too severe or far too acute to be accepted into that service.

The Hon. WALT SECORD: What happens to them?

Dr PERRON: My referrals get rejected.

The Hon. WALT SECORD: Say that again.

Dr PERRON: My referrals get rejected.

The Hon. WALT SECORD: What happens to the patients? It is not a reflection on you.

Dr PERRON: I tend to have to do the counselling myself or seek alternative arrangements. We do have on average about an eight-week wait for a private psychologist. Unfortunately a lot of my patients live below the

poverty line and cannot afford the out-of-pocket cost to see a private psychologist, especially given you do need to see them on a regular basis. For a lot of my patients, they just do not have the ability to pay privately.

The Hon. WALT SECORD: What do they do? Do they do the first Medicare-approved ones and then fall away?

Dr PERRON: That is only a rebate. It is not a free service. You might get a rebate from it, but you would be paying around $80 out of pocket on average. For a lot of my patients, that is just inhibitory. Like I said, the service that is covered by—

The Hon. WALT SECORD: You step in yourself.

Dr PERRON: Hence the waiting list.

The Hon. WALT SECORD: What about people who are battling with ice addiction and treatment in that area?

Dr PERRON: The patients with dual diagnoses are another difficult issue. Quite often if you refer to, say, drug and alcohol for example, they will be sent back saying we need the mental health sorted. If you send to mental health, it is, "Sorry, they need their drug and alcohol sorted." It is very difficult to find someone who can manage both of those issues simultaneously. Quite often if you cannot get them into one of those allied health services to help support their mental health, a lot of that does fall back on the GP—certainly with my patients. A lot of them have got complex PTSD, which is post-traumatic stress disorder, childhood trauma, intergenerational trauma from a Stolen Generation. Fortunately we have had a counsellor for our Stolen Generation clients, so we do have that service now. But when it comes to sort of the schizophrenic patients, the more complex patients, the suicidal patients, there is a huge hole that we cannot fill.

The Hon. WALT SECORD: Ms Keed, there must be gaps that you see as an administrator. What are the gaps that you have that need to be addressed in Indigenous health services.

Ms KEED: Like Dr Perron was just saying, we do have the gaps of not being able to access psychologists. We were granted the funding to do so, but we just cannot get anyone to fill that position. That makes it hard on our patients, again, like Dr Perron was saying.

The Hon. WALT SECORD: What do you do then, Dr Perron?

Dr PERRON: It means more frequent visits with the GP. We can do GP counselling. I offer support for my clients. I will link them in with one of our health workers to offer that sort of pastoral support and just to check in and make sure they are going okay. Quite often, again, it does just mean more frequent reviews with myself just to see how they are going, offer a better basic cognitive behaviour therapy.

The Hon. WALT SECORD: But we are only talking about a short—

The Hon. WES FANG: Sorry, cognitive—

Dr PERRON: Cognitive behavioural therapy.

The Hon. WALT SECORD: Are we talking about a typical GP session that would be six to 15 minutes, depending on—

Dr PERRON: Fortunately, I have been lucky enough to have 20-minute sessions with my clients.

The Hon. WALT SECORD: You do 20-minute sessions?

Dr PERRON: I sometimes do not find that adequate. I would like longer with these mental health patients, but, again, when you have already blown out to six-week waiting lists and we have such a big community, it is just not an option. I do want to see my kids sometimes.

The Hon. WALT SECORD: So what is a typical work week for you?

Dr PERRON: It is Monday to Friday and we start around 8.30, quarter to nine, if I get in from the farm early enough, and then I will work through, officially seeing patients until five, but I may be back until 6.30.

The ACTING CHAIR: I have just got a few questions for Ms Chandler. Dr Perron mentioned that a lack of culturally appropriate health services existed around the psychology space. You also identified this as an issue within your submission. Can you tell us a bit more about some of the issues that you have noticed coming up and any areas that you think need urgent intervention and assistance?

Ms CHANDLER: I brought a box with me today and it is basically filled with people that are registered with us over probably the first four months that we opened. One of the main things that we did when someone

registered with us was we did a health check on them, and that health check covered everything from emotional, physical, sexual and mental health, and then we came up with a plan to help that person bring those barriers down in whatever way they were being affected. The most important thing that we found is that they felt unlistened to. So it did not matter where they were going or who they were seeing, or that they had had a bad experience with somebody due to their health and had not gone back, 90 per cent of people felt that going to the doctor just meant that they were going to be prescribed a pill or a tablet and sent out the door, or that they were having multiple appointments and not understanding the reasons why, so they would not go back. So their health care had been extremely badly affected over a long period of time.

What we do at Indidg Connect is a holistic health service. We concentrate on physical health first: Is this person not doing anything? Are they not physically active? What can we do to support them to become more physically active? Has this person fallen through the cracks? I can think of three people, straight off the top of my head, who have absolutely traumatic health issues, and ice addiction is definitely that outcome from it, but the main issue that they have is childhood sexual assault and it has been completely untreated. One person in particular—I am just going to call him J—his childhood sexual assault led to him offending the first time at 14, doing an armed robbery so that he could go to juvenile detention to get away from the person that was assaulting him. His medical records—because part of them engaging with our business is we get their medical records—right back to when he was 12 years old detailed that he had been sexually assaulted over and over again, yet there was no health care put in place.

Monday this week he came back to my office and he is now ready to tackle that assault, because through working with us, through Indidg Connect over the last seven months, doing what is appropriate—taking him to the doctor, getting his medication right, taking him to rehab, working with the justice system, doing all of that made no difference to his life and his offending. He had a five-week break from our service and in that time was re-engaged with the justice system. He came back in and he said, "Ann-Maree, I'm ready to do this but I am only going to work with you." Why is this person, who has been engaged with the justice system and the health system since they were 12 years old, which detailed this over and over again, only going to come in and work with me?

Another one that I dealt with, she had been engaged over and over again with the justice system and the health system, and had extensive medical records. The culturally appropriate service that I provided her with, after being expelled from every service here in Dubbo, including emergency housing—therefore rendering this woman completely homeless—I just said she needs to go home, back to her community, back to her family, because she was from another State. Having her here in our life, in our world, was damaging her spirit. So her cultural needs were not being met and she was not being respected as an Aboriginal woman. Now giving you details: she had an occupational therapist's [OT] report that said she could not cook. That woman could cook—I saw her cook. But when I asked her why she did not tell the OT she could cook, her response—and I am going to swear—is she did not want to tell that "white cunt". So we need to be realistic and the service that we are providing needs to be suitable for Aboriginal people.

Another woman I have worked with—unfortunately she has gone—had traumatic ice use. I said to her in my office when she came back in for help, "You're scaring me. The way that you're behaving right now is scaring me." She looked at me and said, "I'm not trying to scare you. I want help." I said, "Well, I'm trying to help you, but you're not listening to me. So sit down, stop doing what you're doing and tell me what's wrong." She sat down and said, "Nobody cares", and I said, "Well, let's go up to the hospital and put you in for the six weeks" to help her dry out and then get her the help. Her medical records again detailed that right back from when she was four years old she had been sexually assaulted, yet the service is not there in an holistic way to help her. Cultural needs are not being met or respected.

They go to services and are treated like they are just a junkie—I absolutely hate that word. Their psychiatric needs are met but they are given a pill and told that that is going to help them. Where is the psychology? It is not there; it is not available. Working with health, physical health, mental health—that means loving people to good health, not locking them up in jail, not giving them a pill and sending them home where they have got nowhere to go because they are homeless—working on physical or mental health and making them safe is what can make a difference. Because I have seen that work with many of our clients, but it is difficult because the services are not there, and financially they cannot afford it.

The ACTING CHAIR: It sounds to me like, from your experience and with the people that you are working with, that because there is not that culturally appropriate health care, that people are then sort of falling into the justice system as a result of that. Is that what your experience has been?

Ms CHANDLER: One hundred per cent. Intergenerational trauma, trauma experienced from colonisation is not acknowledged as being a health issue, and yet 100 per cent in Aboriginal community it needs to be acknowledged. There is no doubt that if you grow up in an Aboriginal community and you have experienced

that life and been a part of that, then that definitely is something that affects your physical and mental health. And unfortunately nowhere in the healthcare system is that acknowledged.

So part of what we did to start with—and I am just going to show you something because I actually think it is really important. My business model that I started starts with taking an Aboriginal person, working on their health—which is all the things I talked about—and their financial assessment; so establishing where they are sitting financially. Do they understand money? Have they got extreme amounts of debts? So many people have a debt that they owe for a phone or a power bill. But part of it is connecting back to culture—showing people how they can be a strong Aboriginal person because there is nothing wrong with them in our community and showing them how they can work with services to overcome their health issues.

So going to a doctor: "I need help. This is happening to me". "Here, take this pill." I have sat there and said to the doctor, "This person doesn't want to be prescribed a pill. They want to see a psychologist." The doctor actually turned around and said to me, "I am the professional here. I'm the one with the training", and I said, "I'm the advocate, this is the patient. You don't realise it but you actually work for that person. So do the mental health plan so we can access psychology."

The ACTING CHAIR: Dr Perron, you mentioned that you have got a six-week waiting list and I think your statement was, "I'd like to see my kids sometimes." This is something we have heard a lot about during this inquiry—the pressure, when there is only one person doing a particular role and the pressure that that puts on that particular person. What is that like for you to be sort of trying to find that work/life balance?

Dr PERRON: I have three beautiful boys at home and I am also a farmer as well as a GP, so I do have responsibilities outside my service. I would like to consider myself a dedicated GP. I work long hours at the office and I work long hours at home. I would like to be able to do more, but I am only one person. You do take these traumatic stories home. I have a lot of these traumatic stories and I think, being an Indigenous GP, I am privy to a lot of stories that perhaps some of my colleagues may not be; they feel comfortable to open up. I think having extra services in the community that we could refer to, knowing that our patients are getting the care that they would get if we lived in the middle of Sydney, would take a lot of that pressure off. But as a GP in a rural community with nowhere to send our patients, we do take that home.

We take on a lot of extra responsibility that we would not otherwise have to do, so it can be hard and we do all work within our limits of our training. You can get compassion fatigue. When you are hearing about these stories of sexual assaults, domestic violence, childhood deaths and suicides every day, you can get compassion fatigue and it can be difficult to have time to perform self-care when you are working such long hours. But it is something that I have trained to do; I have been doing this for 21 years, from med school to now. I trained to come home and help mob, so it is something that I am very passionate about. I would like to see more culturally available services, but I think we all need to work together because we all have the exact same goal. Working against each other is not going to solve the issues.

Ms CATE FAEHRMANN: Thank you all for appearing today and for the very important work you do for your communities. I will start with Dr Perron and Ms Keed in terms of the Aboriginal Medical Service. I just wanted to get a sense of the interaction between yourselves and the local health district [LHD] in terms of workforce planning and demand for Aboriginal people within the area. What does that look like?

Dr PERRON: We do have quite a close relationship with the primary health network [PHN] and the LHD. I did a bit of reading last night and read their submissions as well, and I think it is across the board that we are all having the same issues with trying to attract staff and retain those staff. We do quite often have discussions with them about attracting more speech pathology, more psychologists and more specialists, but they are working incredibly hard and still not getting anywhere either.

Ms CATE FAEHRMANN: Can I just get a sense of—there is need and then there are actual positions. There are two different things, I think; there is the need and then there is the potential of actual vacancies and filling those vacancies. The question, I suppose, was around actually working with the LHD and talking with them about what is needed. Do you do that yourselves or is there somebody within the Aboriginal Medical Service that does that, in terms of workforce planning? In terms of the need for Aboriginal communities here, is there a dialogue that consistently happens?

Ms KEED: If there are gaps—for instance, at the moment, we are struggling for our patients to see an ear, nose and throat [ENT] doctor. For one patient it could be over $15,000—our patients do not have that money—because the ENTs are now working privately. Myself and our CEO have had multiple meetings with the PHN to try to source funding so that we can utilise an ENT to come to our clinic. Wherever we see the gaps, we will take that to the PHN and the LHD to see what they can do to help us.

Ms CATE FAEHRMANN: So at the moment, for example, where you say you do not have an ENT, I would understand there would be a pretty significant need for an ENT in an area like this with a high Aboriginal population. You are suggesting there is a need. You are going to, did you say, the LHD as well as the PHN?

Ms KEED: Yes.

Ms CATE FAEHRMANN: That conversation is ongoing?

Dr PERRON: Yes.

Ms CATE FAEHRMANN: But at the moment there is no funding for that?

Ms KEED: Recently we have been given a small amount of funding. We can utilise that funding for the gap fee, which is $150. That would mean that our patients would have to pay the $150 per visit, but we will pay that for them with that funding.

Ms CATE FAEHRMANN: Yes, okay. Ms Chandler, thank you for your contribution. Would you like to comment on that as well?

Ms CHANDLER: Can I speak on that last question you asked?

Ms CATE FAEHRMANN: Yes.

Ms CHANDLER: You said, "What is the need there? What is actually available and who fills that gap?" One thing that I have identified in what we do very strongly is that there is a need for somebody to sit with an Aboriginal person when they visit the doctor. I know that sounds way over the top, but I can guarantee you that in my experience—I am going to use one example of somebody who was diagnosed with hepatitis C. They went to the doctor regarding the treatment plan and the doctor said to them, "Well, this can kill you." That was then the trigger for that person to not want to go back or not to seek treatment for something that is perfectly treatable, and to leave. That was definitely a language and cultural barrier.

There are other examples where people go for psychology and the person was asked, "How long have you used drugs?" He responded, "My whole life," and the psychologist said, "Well, that wouldn't be right because your mother wouldn't be putting it in your bottle." On both occasions I have then contacted that service and said, "Culturally that would have been for that person's whole life. That is how we talk. When we do something, we have done it our whole life." So, it is just those small things that seem so tiny. But when I have sat with a person and I have seen their reaction and then been able to smooth it over for them, they will actually continue on with their treatment rather than being impacted, leaving and not going back. From what I can see, in my experience, having someone support an Aboriginal person to an appointment would be an absolute need that is not being met. It would reduce impacts of other health issues from not seeking their treatment.

Ms CATE FAEHRMANN: Yes. We do have, for example, a submission to this inquiry from the Aboriginal Health and Medical Research Council that highlights the fact that the number of Aboriginal patients who discharge against medical advice because they do not feel safe or there is no culturally appropriate support within those hospitals—would you like to expand on that?

Ms CHANDLER: Yes. Absolutely, I can guarantee that that happens. I have spent hours in my own time on the phone to someone who was—sorry, it is really hard for me not to get upset. Anyway, I am just going to keep talking. It's alright.

Ms CATE FAEHRMANN: It's okay.

Ms CHANDLER: The doctor next door kept coming in about this person's health. I worked extensively for him to stay in hospital and get treated before he actually passed away—if he did not stay, he would have died—and that included getting family members to come and stay with him. Also, the other thing we have to be realistic about is allowing him to leave hospital so that he could go and use drugs and come back and finish the treatment. Other times where people a long way away have been to the doctor and, for want of a better word, gone off their head because they had said something and they were responded to in a poor way—and then that person saying, "Ring Ann-Maree." They rang, I sorted it out and they resumed their treatment. But, yes, not being understood or respected—when you feel that way, you are already in a traumatic situation when you are going to seek help. So, yes, we need more.

Ms CATE FAEHRMANN: We do hear from the LHD, as well as the hospitals that we have visited during this inquiry, about the fantastic Aboriginal support workers or Aboriginal health workers who are within those hospitals. We visited—yesterday it was Wellington, for example, and there was one there who was working at the time we visited. That is something, isn't it?

Ms CHANDLER: That program—yes, that's brilliant. I love that. I have actually worked with people to get into those positions as well, in another hat that I wear. They are brilliant. They are fantastic. More of them are definitely needed.

Ms CATE FAEHRMANN: More of them, in terms of the need to have more funding to put more in, if they are available?

Ms CHANDLER: Yes, to employ more of those people.

Ms CATE FAEHRMANN: Dr Perron?

Dr PERRON: I would like to respond to that one as well, please. I have been working quite closely with the Aboriginal health workers and the discharge team at the hospital; recently I have had quite a few of my patients in hospital, rather unwell. I think it is a great service. I do think that they have a fantastic role to play in the hospital, but I would like to see more of them; that is, the Aboriginal health workers. For a lot of my patients, when they do go to hospital—like Ann-Maree said, they are frightened. They are sick. Quite often my patients—if they are getting sick, some of them will come in early, but others will leave it until they are on death's door before they come in, because they know full well that cranky old Amy is going to say, "Go to the hospital."

By the time we go up there, quite often I will send an escort from the AMS—one of our health workers—to sit with them in the emergency department, knowing full well that if they are up there and they are treated poorly, which unfortunately some of my clients are, at least they have that person to talk them down and get them to stay. Once they are admitted, however, obviously our guys have to come home. And there are those support workers in the wards. Unfortunately, however, when there are a lot of Indigenous patients admitted at any one time, they may not get to see the health worker in a timely manner.

Over the past couple of weeks I have had a patient of mine in hospital who is rather unwell and who does quite often discharge early because she does feel unsupported and she is not necessarily given the help that she needs. I have actually sent a couple of my AMS health workers up to just do a check-up just to see if they are okay, change their clothes, just give them a bit of that social support while they are up there so they can see a familiar face. For some of my clients who I am more close with or have been treating for years and years, I will actually give them a call myself after talking to the team just to interpret what has been said. I would like to see more of that in the hospitals so that perhaps we would not have to send our staff into the community. And they can feed back as well if there are any issues. I am more than happy to ring them up and just have a chat, but there needs to be that person to actually give me a call and say, "Heads up, such and such is not doing well today."

The ACTING CHAIR: Ms Keed, did you have something further to say?

Ms KEED: A lot of our patients will not go to the hospital. They will constantly call us and say, "Can I please see the doctor there. I don't want to go." We could have patients who are having a heart attack and they will not go to the hospital.

Dr PERRON: We had one last week.

Ms KEED: I think that this is a barrier that needs to be closed now because our patients are dying waiting to get their health service at the hospital. They will not go to the hospital because of the way they are treated because of the colour of their skin. They will not go to the hospital because they are left in their beds for days without even having their sheets changed. No-one has visited them, as in Aboriginal health workers. I feel like there needs to be something done about this now.

Dr PERRON: I actually had a client of mine a couple of days ago say to me that she would not go back to the hospital because she is sure if she turned up unconscious they would think she had overdosed. She has not used in eight years, and she has actually had a missed heart attack because she was put in the waiting room as a malingerer.

Ms CHANDLER: That is pivotal too. If somebody has overdosed, it does not mean that they deserve any less treatment than anybody else.

The ACTING CHAIR: Of course, yes, absolutely.

The Hon. NATASHA MACLAREN-JONES: First of all, thank you all for coming today and, particularly, Ms Chandler, for the advocacy work that you do. Could you explain to the Committee the important role of bush medicine in mental and physical healing?

Ms CHANDLER: I am not across bush medicine, so I will not speak on that today, but I can guarantee that for Aboriginal people, holistic health service is what we need. I talk to people in this way, and I am sure everybody has something different. But to the people I talk with I say this, "If you are afflicted by white man's

ways, you use white man's ways for treatment." What I mean by that is if your issue is alcoholism or, say, childhood sexual assault leading to drug addiction, then you need psychology to help you with that so that you can work through the CBT and all of that stuff and unpack that and deal with the emotion that comes from that. Along with that, you also need to reconnect to who you are as an Aboriginal person with black feet on this soil in this country. That means going out bush, spending time with mother on soil in peace. We live in such a fast-paced world that is not natural, and it disconnects us from who we are. So taking ourselves out, sitting near water, having that self-care as well, then going to the doctor and working through those health issues also. It works hand in hand, not as two separate entities.

The Hon. NATASHA MACLAREN-JONES: Dr Perron, would you like to comment on that and the ways it could be integrated more by doctors in healthcare delivery?

Dr PERRON: I suppose I am in a bit of a privileged position because quite a few of my clients actually do practise bush medicine. I have a few shrubs at my place that we do utilise from time to time. I have a bit of an understanding of how some of these things work. Quite often I will ask them what they are using, what they are using it for, and that can give me a bit of a sneaky history as well as to what is going on for the patient. "What are you using this paste for? Why are you on Gumbi Gumbi?" It can lead me to diagnoses that we may not necessarily have come across. Certainly, we use a lot of the bush medicines as an adjunct to western medicines as well. I have no issue with them using their home remedies and the bush medicines in addition to things like their thyroxine for their thyroid disease.

The Hon. WES FANG: Complementary.

Dr PERRON: We have also had a couple of visits to town by the Ngangkari from Central Australia who have helped us a bit with smoking ceremonies, getting in contact with culture. It has been pretty widely accepted, hasn't it, Ms Keed? Everyone was really excited when these guys came. That was organised by our social and emotional wellbeing unit as part of the AMS. They also do quite a lot of cultural activities with the guys as well. I know Phil was organising some carving and yarning sessions with the blokes just to get them back and centred.

The Hon. WES FANG: Thank you all for appearing today. Dr Perron, if we could clone you I think we would have half our problems solved because we would have a ready supply of people who understand this area. Seeing as we cannot do that, how do we get more people who are growing up in western New South Wales to go and study medicine but to have that desire to come back and provide the services to the people they grew up with and with whom they have that connection and affinity?

Dr PERRON: I would love to get back out to the schools to chat with some of our young people again. When I was doing that regularly, I did find that we did have a lot of young ones who were actually quite passionate about going into the medical field—whether it be nursing, medicine, paramedics. Growing up, I was not expected to do anything either. My year 10 teacher told me I was going to be barefoot and pregnant at 16, so she was not going to mark my assignments. Good on you!

The Hon. WES FANG: My chemistry teacher told me I was so lazy I would marry a pregnant woman, so I think we have an affinity.

Dr PERRON: That is it, so I think just giving the power back to the kids. I am very passionate about ear health which is why I kept mentioning the ENTs. A lot of our kids drop back in education because they are deaf. I have had three sets of grommets because I was deaf through school with glue ear as well. I think when you are deaf and you are bored and you cannot pick up things in class, you tend to play up, and you get labelled "that naughty kid" and no-one wants to teach you. By the time our kids get to high school there are quite a lot of illiteracy issues, behavioural issues, and wagging because it is not cool to be the kid that cannot read. You would rather be the rough one or the bully so that nobody torments you. So I think focusing on education of our young people, first and foremost, and on getting those services for speech pathology and ENTs so that our kids are not starting behind from kindergarten. Like I said, getting out there and telling our kids that they can do it: They are smart, we are deadly, we can do anything that anybody else can do.

But also, once you get to that point when you have gone through secondary school, I would like to see an undergrad program for medicine in Dubbo. Postgrad medicine is great, but you are not going to get a whole lot of Indigenous guys into that course. We need the undergrad stuff. I am more than happy to mentor these guys; I am more than happy to offer support. But we need that undergrad program. We need to harness that passion while it is still there. I was young, bright-eyed and bushy-tailed at 17 when I went to uni because it was what I wanted to do and I had great mentors. I would like to see those services here in Dubbo, so that we can capture those clever kids, get them out doing what they need to do. These guys are not going to leave home. This is country for me. I am exhausted, my batteries are flat when I am anywhere else. I need to be home to help mob.

The Hon. WES FANG: It is a great story, and it is what we need to do more of. Obviously you would be aware that we are looking at putting in these rural medical schools so that people can do their undergrad studies in rural and regional locations. How do you see what it is that we are doing now and how do you see what outcomes that might have in the future, knowing that, obviously, it is not going to have immediate effect? Looking into the future, will it help us to address some of those concerns?

Dr PERRON: We need to have more intern and residency places in the community. We did not have that option when I was at school. I had to do my internship in the city, which was completely outside my comfort zone, being in the middle of Gosford and Newcastle. I would have dearly loved to have done some of my medical school time out here, done my internship out here. Fortunately we are getting more positions now, but I think in order to address needing more junior doctors in the community, we need more seniors to supervise them, so we do have to address that issue first. I think if you do your internship and your residency in a rural hospital, you tend to get that bug. You love it out here, you realise that we actually are awesome people out here in the bush, and a lot of these guys will buy houses and have families out here because it is a much nicer place to raise a family than it is in the smoky old city.

The Hon. WES FANG: You bet. You are talking my language evidently. Just on the issue of cultural appropriateness, I have heard some divergent views—even today—around how we address that. I think it is one of those issues that we need to focus on because it is breaking down that barrier. We have heard from Ms Chandler about how she views it. What is the AMS perspective? But also, just hearing some of what you were saying about the interactions that your patients may have had, what it is that you think we could do better?

Dr PERRON: It starts with culturally appropriate training for medical personnel—the hospital staff, for example. It needs to be local. I know when we did the cultural training for GP training we learned a lot of, "Don't make eye contact, don't name the dead," blah, blah, blah. That is okay for the Northern Territory but that is not Wiradjuri. That is not how we do things here. If you are behaving in that way towards an Indigenous person they are going to think you are a goose. You need that local culturally appropriate training. But I think for me it just comes down to treating the person like they are human. I do not care if you are the Queen of England or you live under a bridge: You are a person and you need help.

Quite often I think people with drug abuse issues, with alcohol issues or with homelessness need us more than anybody because they do not have the ability to get help for themselves. Just treating people like they are equal—like they are human—is a really good first step. That is something that I think is really lacking in medical services is just that unconscious bias—you just want to get that person out of your room as quickly as possible. I cannot speak for my other GP colleagues but I tend to run my clinics very casual. I like to get to know the person, yarn a bit, find out about their background so that when they come in I can ask them, "How's Aunty Joan going?" or "How'd you go at the footy on the weekend?" as a great icebreaker. I think that goes a long way—

The Hon. WES FANG: And break down the barriers.

Dr PERRON: Yes.

The Hon. WES FANG: Ms Keed, do you have some views on that as well?

Ms KEED: I agree with Dr Perron: We do need that cultural awareness training. It needs to be compulsory. We have students that come out to us and they do not know anything about the Aboriginal culture. That is appalling.

The Hon. WES FANG: Do you find it needs to be localised as well?

Ms KEED: Yes.

The Hon. WES FANG: I am from Wagga, I live in Wagga and it has always been Wiradjuri country as well. My wife is a doctor—a paediatrician, actually—so she did a lot of work with the local—

Dr PERRON: Tell her to come here!

The Hon. WES FANG: No, I think she is very comfortable in Wagga. But it is that local knowledge of cultural appropriateness and it does differ, does it not?

Dr PERRON: Yes, it does.

Ms KEED: It definitely does.

The Hon. WES FANG: Ms Chandler, do you agree that it needs to be a really localised focus on the traditions and the culture of the people in the local area as opposed to a broader training?

Ms CHANDLER: I think it is really difficult for people to understand. If they have never lived in an Aboriginal community, okay, they do not understand it. I grew up in community so I do not really—I have been in community and in different parts of society as well and I make myself fit in wherever. I'm me, and if you don't like me I do not care. Can I just give you an example? When I moved to Dubbo I moved over into Yaruga Street and I worked at Centrelink at the time. It was great—I loved it. I lived in that street. But pizza did not even get delivered there. You have two different perspectives on what being an Aboriginal person is.

Where is the balance with medical people? If they are seeing that this is what is broadcast in the news, rah, rah, rah—ABC did this thing years ago; I think it was called something like, "When the Natives Go Wild". I was there when that happened. To me, that was nothing like what they portrayed on TV. People who are working in our medical system have these views on people they are supposed to be providing care to improve their medical health. Cultural awareness training is absolutely imperative to the health care of our people, but it has to be appropriate like Ms Keed said, not Northern Territory stuff coming down here. It has got to be from this community—people going out and actually experiencing.

The Hon. WES FANG: And that is the real value we get around having these regional hearings and going to different communities, because we are certainly hearing that and I think that is something that we need to look at—and not just for the Indigenous culture but all the cultures. You can probably see by my surname I am from Chinese heritage. It is understanding all those different heritages when somebody attends a medical service that I think is really important. You talked briefly about work-life balance. Having seen the medical side from one perspective I understand how difficult it is. Can you talk about how you find the pressures of living in a small community where you might see your patients and then you are shopping and you see your patients again? It can be quite encompassing, can it not?

Dr PERRON: It can. Certainly I grew up in Dubbo, as well, so quite often I know a lot of these people and have had for 30-odd years. I think you just build those sorts of barriers when you first start up. You put your boundaries in place: "When I am shopping with my kids I don't want to know about the rash on your bottom." My kids have been trained from a young age as well. They usually do that, "Oh Mum, can we go?" so that we can actually get out and do our groceries. But most of my patients are really respectful. They will give me a wave or come and say hello but they will usually leave well enough alone if I am with my family. I was lucky enough to actually marry a non-medical person, so I did have a life before med school! He is very good at quarantining time as well. I have my debrief time when I get home and then it is, "No, you put your mum hat on now. We are just having family time." We do make sure we have that quarantine time at the end of every day just with Mum.

The Hon. WES FANG: It sounds like you could provide some guidance for a few other people as well. You have certainly got that balance, which is good.

Dr PERRON: It is very important for me. I would like to raise well-adjusted Aboriginal boys as well. They need their mother, they need that guidance and they need the snuggles at the end of the day. I am no good as a mother if I am stressed, I am tired and I am not sleeping so we have to make sure we are very strict with leaving work at work.

The Hon. WES FANG: The last question I have got is around a clash of services. From the Aboriginal Medical Service perspective, you would provide a service to your patients and the people who come in to interact with you. Do you find that there are sometimes issues with other people trying to provide similar services from a different perspective? Does it create a friction with your patients—instead of having a single source of truth they have potentially got others?

Dr PERRON: I have not so much found that in Dubbo. I do not think we have enough services to overlap!

The Hon. WES FANG: I am thinking advocacy services and the like. Does that create an issue for you at all?

Dr PERRON: Sometimes. There have been a couple of times that we have had different services come in and they have got their own agenda before they come into the room, but I am usually pretty good at juggling that and just saying, "Look, this is what we need to do. I am happy to work with you but we need to be on the same page." If we are pulling in two different directions it is not to the benefit of the patient.

The Hon. WES FANG: You will generally take the lead and lay down the law, shall we say?

Dr PERRON: I have got three boys. I am well trained at that!

Ms CHANDLER: Can I speak on that? I think what you said then was a very dangerous thing to say because it is up to the patient what treatment they want to seek. There is so much out there that people can take advantage of or use for their health care and there are lots of different ways to prescribe that. There are lots of

different thought processes on it. What works for one patient might not work for the other patient. The most important thing that I explain to people when they engage with Indidg Connect is that seeking health care is no different to going to the mechanic.

You might go to one mechanic and he might fix everything that is broken with your car, and you never have another problem and you just go back when you need service. You might go to another mechanic and drive out and your car is worse than what it was when it went in. You have the choice to seek the health care that you want. That is really important because some people will go to one place—say, a psychologist—and not get help and then not go back again because they have the assumption that everything is like that. We need to work together; all services need to work together. But we definitely need to let the patient or person seeking treatment know that they have choice and control over their own life.

Dr PERRON: Which is absolutely fine, but what I was trying to get at was, if you have a different service provider coming in with a client for a medical opinion and their opinion differs with yours, in the end you are in the room for a medical opinion and if that does not fit with the agenda then you do go and seek further opinions.

Ms CHANDLER: Definitely.

Ms KEED: I think that a lot of our patients are like an open book. They will tell you if they have been somewhere else and they will give us their consent to speak to whoever—for instance, the diabetes clinic at the hospital. We have a diabetes educator in town and we have built a partnership so they are aware that this patient has come down to see us and then we will let them know what is going on, with the patient's consent.

The ACTING CHAIR: Thank you for attending this hearing and thank you again for the work that you are doing. Ms Chandler, I will get the Committee staff to contact you about the flowchart to see if we can get a copy of that with your permission for the benefit of the Committee. They will speak to you after this. Thank you all again.

(The witnesses withdrew.)

VICKI KEARINES, Private citizen, sworn and examined

NEIL McCARTHY, Private citizen, sworn and examined

The ACTING CHAIR: We now have time for an opening statement. Do you each have an opening statement that you would like to give?

Mrs KEARINES: I have lived in Narromine most of my life. In the eighties when I had my children in our beautiful Narromine hospital that we were able to give birth at by caesarean, natural, we had minor surgeries done there. My husband even had a fractured cheekbone repaired there. They were the types of things that were done in our local hospital. We had two GPs who were visiting medical officers and attended the hospital after hours and during weekends to care for the patients of Narromine and district. We now have four to six doctors, some part-time at the beautiful Narromine medical health centre, none of which are visiting medical officers at the hospital. We have a virtual doctor system operating out of our hospital, which, when you consider that approximately 95 per cent of the patients that would be in Narromine hospital are elderly, palliative care patients—technology is beyond them and this is the best that we can do for them.

My biggest concern with that is that the information does not transfer. We have My Health Record and none of the information, unless the patients—if you attend Narromine hospital after hours, none of that information comes back to your local GP unless you bring the paperwork back, which a lot of patients do not bother doing. The duty of care is not there to continue their health records and anything could happen on that weekend and not be known by their local GP. It is not good enough. Yes, we have a beautiful hospital being built here in Dubbo with improvements beyond anyone's expectations for this area. But our local little hospitals in rural New South Wales need to be able to cater especially for our elderly. They deserve better. I also have a letter to table, if that is okay, on the mental health system. I did my submission very quickly and I did not include that in there; I am sorry.

The ACTING CHAIR: That is fine. Dr McCarthy, did you have an opening statement you wish to make?

Dr McCARTHY: I am a rural GP of 30 years' experience. I have worked at Narromine now for the last six years. I also have an appointment to the Lourdes Hospital in Dubbo, which is a highly regarded and much-loved service in Dubbo, and I also have a clinical advisory role with the Western NSW Primary Health Care Network, who you will be hearing from later today. I do not represent any of those organisations today. I am appearing as a private citizen and I appear on behalf of the people who I have served in the communities of Warren and Narromine over an extended period because I have noted, particularly in the last two years, a dramatic deterioration in the level of care being received by them in this area.

Because I feel it is important for the Committee to gain a deep understanding of the problems, I would like to table a document 'Reimagining Primary Health Care Workforce in Rural and Underserved Settings'. I believe you have been given that document. I do not expect that you will have read it. I would encourage you to read it from cover to cover, but what you should know is that this document has been written by a gentleman called Roger Strasser, who is an authority on the development of rural health services in under-served populations. He is an Australian. He is not a friend or an associate but his work has been significant in this area. I urge you to consider it, and I urge the Committee to use it in the work going forward so that you can really understand what all the stakeholders might be trying to say to you and how best to reach a compromise between all the stakeholders that are going to be competing for your ears. I will leave it at that for the time being.

The Hon. WALT SECORD: Thank you for your evidence and thank you for your time. Mrs Kearines, what was your late father's first name?

Mrs KEARINES: Ronald.

The Hon. WALT SECORD: I understand that he passed away on 4 January earlier this year?

Mrs KEARINES: Yes.

The Hon. WALT SECORD: If you do not mind, could you take us through the details?

Mrs KEARINES: Not at all. My father was a very strong, independent man. He lived at home by himself, cared for by himself. He was 92 and three months when he passed away.

The Hon. WALT SECORD: Did he live by himself?

Mrs KEARINES: He lived by himself in his own home. He did his own housework. He did woodwork, making kids furniture, tables and chairs and things like that. He also repaired lawnmowers as an ex-mechanic. He

mowed his own lawn up until September or October when he had a fall and I stopped him doing that, much to his disgust. He was very independent and strong. We went for an annual check-up in September. I took him to Dr McCarthy because Dr Sam, his previous doctor, was not working anymore, or not full time anyway. He had not been to the doctors for 12 months because last time he went in 2019 he lost his licence, which was devastating for him.

The Hon. WALT SECORD: Because he was 91 then?

Mrs KEARINES: He was unsteady on his feet and they were worried about him blacking out. That was fair enough, but it was a big dent to his pride. All through COVID he moved in with us for the lockdown period. We cared for him and had a wonderful six to eight weeks with him but he wanted to return home, so he went home. We went to see Dr McCarthy in September to do his annual blood test just to check that everything was okay and, unfortunately, it showed up that he had some type of blood cancer. According to the blood results, he should have been a very unwell man but he was not; he was still living at home taking care of himself.

The Hon. WALT SECORD: So he did not know he had cancer until he had the blood test?

Mrs KEARINES: No, not at all—and even then he did not believe it. We saw an oncologist here in Dubbo who kept regular checks on him. My father decided that he did not want any treatment. He felt at his age he just wanted the best quality of life he could have till the end.

The Hon. WALT SECORD: But this was all documented?

Mrs KEARINES: Yes. His blood tests were getting worse, but we had a big trip planned for Christmas up to my sister's at Lennox Head. He was to leave the Friday before Christmas—

The Hon. WALT SECORD: He was going to go with you?

Mrs KEARINES: Yes, the whole family was going to Lennox Head for Christmas. We were flying him up on the Friday before Christmas. On the Wednesday prior to that we had a phone call with his oncologist.

The Hon. WALT SECORD: In Dubbo?

Mrs KEARINES: Yes, and we got very bad news that his health was failing and he did not consider him well enough to travel. We had to do a quick cancel of Christmas accommodation and everything and we had Christmas at my house.

The Hon. WALT SECORD: In Narromine?

Mrs KEARINES: In Narromine, yes. The family who were at Lennox were flying down. Even then we were a little shocked that he was so unwell because he was still living by himself and still looked fine. We provided meals for him but he still did everything else for himself. My sister flew down from Lennox and spent some time and in those few days we did notice a deterioration. He made it through Christmas lunch but at Christmas dinner he was really unwell. The next day he asked to go to hospital.

The Hon. WALT SECORD: So he asked on Boxing Day?

Mrs KEARINES: He asked Boxing Day. He called me over in front of all the family and said, "I am really feeling crap. I think I need to go to hospital." So we called an ambulance and he was taken to Narromine hospital. To the nursing staff who were on duty at the hospital who did not know him, he appeared as a very old, frail man.

The Hon. WALT SECORD: Were there any doctors on duty at that time?

Mrs KEARINES: No.

The Hon. WALT SECORD: So there were just nurses?

Mrs KEARINES: Just nurses. They admitted him and for some reason they could not get his records from oncology. I had no paperwork but I had kept a record of all his levels.

The Hon. WALT SECORD: Did you inform them? Were you with him in the hospital?

Mrs KEARINES: I was with him. They would not take any notice because I did not have formal paperwork of his white cell count, his platelet count—any of that.

The Hon. WALT SECORD: But you did tell them that he had blood cancer.

Mrs KEARINES: Yes, I did tell them. He was admitted—reluctantly, but they did admit him to hospital. Can I say, the nursing staff and housekeeping staff at Narromine hospital are absolutely brilliant. I do not have an

issue with any of those. Our family's treatment with them—with COVID regulations, even though we could not all be there together, it was still wonderful treatment.

The Hon. WALT SECORD: So it is Boxing Day and you cannot get any of the records from oncology in Dubbo.

Mrs KEARINES: No.

The Hon. WALT SECORD: What happened next?

Mrs KEARINES: The next day—I have a brother and two sisters and a sister-in-law who was also very close. Between us, except for the nights, there were two of us with him—

The Hon. WALT SECORD: So you had good family support.

Mrs KEARINES: We had good family support, even though we felt with the first visit with the virtual doctor—

The Hon. WALT SECORD: So there was not a doctor at Narromine? You had a camera—

Mrs KEARINES: We had a laptop that was wheeled into the room. You can imagine older people who are hard of hearing—

The Hon. WALT SECORD: How did your father contend with e-health, the cameras—

Mrs KEARINES: Not very well at all. He could not hear. He could not understand. The virtual doctor had no concept of a rural hospital at Christmas time.

The Hon. WALT SECORD: Did you know where the virtual doctor was based?

Mrs KEARINES: No.

The Hon. WALT SECORD: Was he in Sydney or Melbourne—

Mrs KEARINES: I have no idea, sorry.

The Hon. WALT SECORD: But he was not in the region?

Mrs KEARINES: He was not in this region, no. Because it seemed to affect my father's legs—he was not able to walk—he wanted physiotherapy for him. In a rural situation over Christmas, there were no physiotherapists in Narromine on duty who could do anything with him. So then he suggested a virtual physiotherapist.

The Hon. WALT SECORD: For a 92-year-old man?

Mrs KEARINES: Yes. Because my father could not hear properly, when he spoke to my father we would have to relay anything that was being said. He asked my father, "Have you got anything to say?" And he said, "I don't want to be here." So the virtual doctor said, "What, in hospital?"—thinking that we had had enough of him over Christmas time and dumped him in hospital just to get a bit of family time away from looking after this frail man.

The Hon. WALT SECORD: So the virtual doctor had not been briefed properly?

Mrs KEARINES: Obviously not or had no concept. My father said, "No, I don't want to be alive." Because he knew he was dying he had had enough. He was in pain, he had terrible migraines—that seemed to be where the cancer affected. So then he wanted to order a psychiatrist to check him out. He then ordered that because he was a little bit constipated that he would be taken to Dubbo hospital on the Tuesday after Boxing Day to have a colonoscopy done to find out why he was constipated. This is a 92-year-old man who is dying of blood cancer.

The Hon. WALT SECORD: I understand that your father passed away in early January—4 January, I think. Is that correct?

Mrs KEARINES: Yes, that is correct.

The Hon. WALT SECORD: Did he pass away in Narromine hospital?

Mrs KEARINES: Yes, he did.

The Hon. WALT SECORD: What was your experience with the video health? What happened after that? Was there a complete miscommunication?

Mrs KEARINES: There was a complete miscommunication. I feel that half the time the records—it seemed sometimes that he did not even know really the background of my father as being different from another

patient with cancer in the hospital who was also dying at the time. We had a palliative care hook-up with the wonderful Lourdes Hospital—can I say how brilliant it is and how lucky we are to have it—where they ordered a syringe driver.

The Hon. WALT SECORD: So he was in a lot of pain, so he had morphine?

Mrs KEARINES: This was on the Tuesday. Any time before that they would have to try to get in contact with the virtual doctor to be able to order more morphine for my father.

The Hon. WALT SECORD: Was it the same virtual doctor or different ones?

Mrs KEARINES: I have no idea, I am sorry. I cannot tell you. A Lourdes palliative care nurse ordered that he have a syringe driver where he had the morphine being delivered on a regular basis so that he was not in pain. I had to battle quite strongly with the virtual doctor to get that done.

The Hon. WALT SECORD: You were arguing with the virtual doctor?

Mrs KEARINES: Yes, because he decided that my father could press the buzzer and request more pain medication.

The Hon. WALT SECORD: Was your father able to do that?

Mrs KEARINES: No. He had lost coordination of his hands. He was asleep most of the time, except when he cried out in pain.

The Hon. WALT SECORD: If a physical doctor was in front of him, a physical doctor would be able to—

Mrs KEARINES: Would have been able to see that, yes. He even suggested, the virtual doctor, on New Year's Eve that my dad did not have to be in hospital all the time and I could take him home on New Year's Day to have lunch with us all. He could not sit, he could not walk, he had no coordination of his hands to eat and we would have to feed him. When I said all of this he said, "Well, we can give you a wheelchair to get him around at home." He was asleep all the time, except when he cried out in pain, and he could not see that that was what was happening.

The Hon. WALT SECORD: Your father passed away on 4 January?

Mrs KEARINES: Early hours. It was about 1.30 a.m.

The Hon. WALT SECORD: During the time from being admitted on Boxing Day until when he passed away, did he physically see a doctor in the flesh?

Mrs KEARINES: I think there was one day that he did. A young doctor, I am not sure of his name, he did see, I think, on the weekend sometime.

The Hon. WALT SECORD: How do you feel about the use of visual doctors—virtual doctors—in country areas?

Mrs KEARINES: I think they are appalling, I really do. I do not know whether it is the red tape stopping our local doctors being able to visit the hospital, I am not sure of what that situation is, but we have a wonderful hospital. We have wonderful doctors in Narromine who care for their patients, they really do.

The Hon. WALT SECORD: What was the official cause of death of your father when he passed away?

Mrs KEARINES: It was cancer.

The Hon. WALT SECORD: Have you lived in Narromine all your life?

Mrs KEARINES: Yes, for all but two years of my life.

The Hon. WALT SECORD: And your father for virtually most of his life too?

Mrs KEARINES: Yes.

The Hon. WALT SECORD: Have you seen a deterioration in the quality of health care at that hospital?

Mrs KEARINES: Yes, even from 2016 when my mother passed away. She had doctors seeing her on a regular basis in 2016. There has been a big, big decline.

The Hon. WALT SECORD: Do you feel that if you had a physical doctor there, you could have provided more comfort to him in his final days?

Mrs KEARINES: Yes. It was terrible seeing him in pain. My sister is an ex-vet nurse. She made the comment that if that was her dog, she would be having police charges laid against her for letting it be in as much pain as what our father was in at times.

The Hon. WALT SECORD: Thank you, Mrs Kearines. Thank you for your time.

The ACTING CHAIR: Thank you so much for sharing all this and for having the strength to share your story with us. I assume you have spoken to family and friends and people in the community about what has happened to you and your family?

Mrs KEARINES: Yes.

The ACTING CHAIR: What has their response been? Has that developed a real nervousness around health care for their own families and friends?

Mrs KEARINES: Yes, it definitely has. A lot of people have applauded me for putting in a submission and coming forward because a lot of them are feeling that way. A lot of them are nervous about end of life for their elderly parents. Where do we go? Where is the best place to have them? You want them close by where family members and friends can visit and say their final farewells, but that is not a humane way to look after them in those last few days.

The ACTING CHAIR: Absolutely. Thank you. Dr McCarthy, you have also been quite critical of the telehealth system. In your submission you made the observation:

> When the clinical needs of the patient are undifferentiated (e.g., fatigue) there is a heightened risk of adverse outcomes for the patient.

We have heard an example of that here today. For the benefit of the Committee, have you heard of other examples or can you expand on that and some of the issues that you feel are concerning with telehealth?

Dr McCARTHY: Yes. I have heard many examples like that. First, let me say Ron was a lovely man. We were very sad to see him go. It really is very difficult for me to measure how painful it is for the communities that I serve. I cannot report enough how serious this problem is. I think the overwhelming feeling that the deployment of this service is leaving people with is that they now feel that the health service deems them not worthy of physical face-to-face health care. I cannot say that strongly enough. That is the impression I get. People are already seriously affected by drought and other hardships over a long period and now they are served up this service.

The ACTING CHAIR: You used the term "not worthy" of proper health care and then you talked about the other pressures. Do you feel this is affecting the mental health of the community as well?

Dr McCARTHY: Yes, undoubtedly. It is a very sad state of affairs.

The ACTING CHAIR: Going back to parts of your submission, you talk about that there is a lot of pressure on doctors and there are other aspects that are deterring doctors from moving into smaller towns. How are you finding smaller town doctors are coping with the pressure of all of this, of these compiling health problems and the fact that there is little support for doctors?

Dr McCARTHY: I am surprised, Ms Kearines, that you were not aware that I have resigned from the hospital.

Mrs KEARINES: No, I did not know.

Dr McCARTHY: The circumstances that forced that resignation were largely personal. My mother was dying of cancer in Sydney and I have an autistic daughter aged 18. In early 2019 she left secondary school and there was difficulty transitioning her into adult life. This was putting enormous pressures on my family. Coupled with that, one of my colleagues also decided to resign in late 2018. So coming into 2019, I was going to be the sole doctor on call at the Narromine hospital with supervision responsibilities for, I think, two trainees at that time. I had been left in a similar situation when I was in Warren when I departed there in 2014, where I had been a longstanding provider of healthcare services.

I found it very difficult because while there were supports provided to me, the long-incumbent doctor at Warren, in the form of locums and other visiting doctors, I was the go-to person in the community. It was very flattering that people thought so highly of me. However, a person has their limits. That was one of the issues that forced me to move from Warren to Narromine, which at the time when I arrived in 2016 had a large, very supportive group practice, and that slowly declined over several years. So that is my story.

The ACTING CHAIR: It sounds like there is a huge amount of pressure and there is no possibility for a work-life balance, and that is what is pushing doctors out. Is that your experience?

Dr McCARTHY: That is my experience. I read the submission from the doctors in Deniliquin. A doctor conceded she had no social life and who in the middle of the night could not name the drug that she needed but knew where to find it. This is very sad stuff; this is dangerous stuff. I was not going to work and potentially harm people in a service like that.

Ms CATE FAEHRMANN: I will continue with that line of questioning, Dr McCarthy. We do continue to hear reasons for the difficulties within hospitals and rural and remote health, for example, attracting the right people or the fact that young people are very different these days and have different expectations to be a rural generalist GP. However, you said in your opening statement that just over the past two years things have deteriorated significantly, so it is not just the difficulty with filling vacancies because it is just two years. In your opinion, why have things deteriorated significantly over the past two years?

Dr McCARTHY: I think because there has not been a physical presence of a doctor in Narromine for a lot of that time. There has been virtual services. There has been irregular locum services. There is now what they call the Virtual Rural Generalist Service. These services are well-intentioned, but they are not as effective as what Mrs Kearines and I would both like to see return to the hospital. And not just Mrs Kearines and me. There are many other people in the community who feel the same way.

Ms CATE FAEHRMANN: We have heard some positive things about virtual services and telehealth, and I am sure the witnesses this afternoon will continue to tell us that. In your view, has the Government put virtual services and telehealth in place at the expense of in-person services or GPs being physically in the room? Is that part of what is going on here?

Dr McCARTHY: I think you would have to discuss that with the health service. I do not know how you would expect me to understand their rationale behind them deploying that service. They make the decisions about how they staff the hospital and how they run the hospital. I am not sure that I understand the question.

Ms CATE FAEHRMANN: Do you think that enough is being done to attract and retain GPs within areas like Narromine for example?

Dr McCARTHY: I could not say. I do not know whether they are trying to recruit. I do not know what they are doing. I do not know, sorry. I do not know whether they are actively trying to recruit a full-time doctor to the hospital. I do not know whether they have decided that that is too hard. I just do not know. I am not privy to that information.

Ms CATE FAEHRMANN: I am asking because in your submission you talk about the role for virtual care. You state:

> There is a role for virtual care to enhance medical service delivery in north western NSW but it is not at this point in time sufficiently mature or evaluated to substitute for face to face medical service provision.

Dr McCARTHY: Sorry, I understand your question now. For many years, I worked alongside virtual care in Warren and in Narromine. The virtual care I am referring to there is where there is a doctor physically in the hospital and the remote specialist has access to video of the patient being treated. That is the vCare service, not the Virtual Rural Generalist Service which replaces the physical doctor. I think we should make that distinction. I see a role for that support for rural and remote doctors, but I do not see a role for the replacement.

Ms CATE FAEHRMANN: Yes, because your submission specifically states—and Mrs Kearines, you probably have something to say here as well—that regrettably it is frequently the default medical service delivery methodology and therefore used in isolation. Is the fear that this is going to become the default because it is getting too hard to attract doctors to regional areas?

Mrs KEARINES: I feel, yes, that this is what is going to happen more and more. Because we are very fortunate in Narromine, we do have not as great a number of full-time doctors as it was when Dr McCarthy came to town but we are getting more that are working a couple of days a week. We are very fortunate. I realise that, because there are a lot of towns in the area that cannot get even one doctor to the practices. Yes, I think that that is the worry, that it is going to be how we are going to do our health system in rural areas. We all know that some things are hard to see face to face. In my letter that I tabled about mental health, I have a husband who suffers dreadfully with depression, anxiety and PTSD. When he first got unwell, he could hide it to a virtual doctor. Seeing him face to face, you would not know that anything was wrong with him. There are diseases that you cannot diagnose through a camera. You need to be that hands on. You need to know the patients.

Ms CATE FAEHRMANN: Dr McCarthy, your submission specifically talks about the rural generalist medical practitioner as a solution for rural health woes. What is your recommendation to the Government to attract more people into those positions, if you could make those recommendations today?

Dr McCARTHY: Also in my submission I have talked about how doctors are trained and doctors for rural practice are trained. I mention that in current medical training, very few Australian medical schools that I am aware of actually provide longitudinal clinical placements—basically long placements in rural general practice. The research evidence would suggest that that creates doctors who are more likely to practice in rural areas if they get that experience in their undergraduate training, even more so if those students are actually drawn from rural areas and then exposed early to rural general practice. I think I mentioned my understanding is that the James Cook University has that as part of their undergraduate program—long clinical placements. That is not a solution that is going to work today; that is going to work in five or 10 years when those students graduate. What do you do today? It is very hard.

The Hon. NATASHA MACLAREN-JONES: I will follow on from that line of questioning. Thank you very much for the additional information and the discussion paper that you provided. Obviously I have not had a chance to read it in the last 20 minutes, but one thing I did notice is the author lived in Australia and then moved to—

Dr McCARTHY: Ontario.

The Hon. NATASHA MACLAREN-JONES: Yes, in Canada—

Dr McCARTHY: Northern Ontario.

The Hon. NATASHA MACLAREN-JONES: —which has similar health to us. I am interested in the work he has done relating to the retaining and recruiting of the medical health force, particularly into those rural areas. What differences did he find compared to what we do here in New South Wales that we could learn from?

Dr McCARTHY: I am not over all the detail. I think that it would certainly be worthwhile reading the details of his paper. I present the paper because I think it is going to be helpful to the Committee to look at the situation we are confronted with and compare the information in that paper to where we are at. This Roger Strasser, in developing the Northern Ontario School of Medicine, has effectively reversed the problems that we now are confronting, particularly what I see in western New South Wales. As I say, I do not know him, but I believe he is now working in a rural health faculty somewhere in New Zealand. So he has left Canada after doing his good work, but I understand that the medical school is still running, it is still functioning on the principles that he established. I am sorry I cannot give you answers to that, but it is definitely there.

The other reason I think we should look at this paper and not think this is just a whole new idea, I am certainly not suggesting that a new medical school be established. What I am suggesting is that his work be looked at very closely line by line. That paper is very heavily researched and cross-referenced. There is evidence there it works and we cannot ignore it.

The Hon. NATASHA MACLAREN-JONES: No, that is fine. We have got the Department of Health coming this afternoon, so we will make sure they have a copy as well because they might be able to do a comparison with some of the things that we are doing and where we could look for improvement. The other one is in relation to the fit for purpose and the integrated health system. Do you have any comments on how what we do now could be improved to look at lessons learned from his research?

Dr McCARTHY: I think what I see is a lot of very good people in different areas, sometimes working together, often working together, but I think we need to work together more and we need to have clear goals, and I sometimes see that the goals are not clear where we are headed, what we are trying to achieve. So I think there needs to be more of that collaboration and setting long-term goals in particular—I know these are general terms, but I think a lot of the elements are there in front of us. We need to work with what we have and I think, following Dr Strasser's blueprint, we may get to where we want to be.

The Hon. NATASHA MACLAREN-JONES: Thank you. I will hand over to my colleagues.

The Hon. WES FANG: Thank you for coming today. Mrs Kearines, I just wanted to say I am really sorry for your loss. I lost my father to cancer in the days leading up to Christmas, so I have kind of got a shared experience. It has been hard to listen to your story but I have that absolute sympathy for what you have gone through and thank you for sharing your story.

Mrs KEARINES: Thank you.

The Hon. WES FANG: Dr McCarthy, I had a read of your submission and I am hoping you can expand a little bit more on what it is you think it is that we can do around that training that we are going to be providing into the future with the rural medical schools. I am sure you are aware that we are looking to build, with the Federal Government, rural medical schools in regional locations to train doctors there. Training them and getting them used to a regional area is one thing, but obviously there is the other component about what it is that they

learn. Do you have some insight into that, having been a rural generalist, and what do you think it is that makes a good rural generalist able to work out in the regions where they are not perhaps as supported as they might be in a metropolitan centre?

Dr McCARTHY: Yes, I can share some insight. If you believe what Professor Strasser says, you will train your rural generalist in the field, in community practice. When you read the paper it is quite interesting because that sound preposterous, it sounds ludicrous, and that is what he was confronted with when he proposed his medical school. But it can be done. There needs to be more people training in general practice in the regions.

The Hon. WES FANG: So I assume by looking at that model and those ideas that he is putting forward, there really is a requirement, an incumbency on the staff that are already in those rural areas to provide that support to those trainees.

Dr McCARTHY: Well, this is the difficult thing, that there may not be staff there. It will not happen without considerable effort and considerable support and considerable changes in the way that business is done now—"business" being the medical education—and it probably will not happen, but I think we should perhaps hope that it will.

The Hon. WES FANG: I noted the responses that you gave to some of my colleagues' questions around the vCare or the virtual rural generalist and you made the distinction, which I think was really important, that there are distinct models. I note that, I want to say they were wanting to lead you down to being critical of it, but sometimes you were not critical of it. You said that there was application for where it had good outcomes for patients. Do you think you might be able to talk to us about that and perhaps elucidate is it something that we could be possibly using to provide some of that support to, say, a new doctor in a rural or regional setting that may not feel that they are getting the support from colleagues because they do not have that many colleagues?

Dr McCARTHY: I could give you examples—there are many examples—that it does work and it would work in the scenario you are proposing. It is supportive—it was supportive for me when I worked particularly in Warren Hospital when it was first utilised. I can vividly remember the first time that it was used in Warren. I was confronted by a young boy who had had a knife thrown at him and it had embedded itself in his upper lip. The normal procedure with that sort of injury is to leave the foreign object in place and then transport them to a surgical facility where that can be managed. The overhead camera in the emergency department at Warren Hospital was switched on and the surgeon who was on duty in Orange viewed the situation and gave instructions on how we were to manage that patient and transferring them to Dubbo hospital, I think. Instantly that surgeon had a very good idea of what was going on. He could see that the patient's airway was not compromised; he could see that there was no haemorrhage. I could have described all that to him over the phone—

The Hon. WES FANG: He was picking it up on the visual.

Dr McCARTHY: The old story: A picture is worth—

The Hon. WES FANG: A thousand words, yes. If I cannot put words in your mouth but can I put a suggestion to you that the vCare system is a very good system but that what we need to do is make sure that when we have situations like you experienced, Mrs Kearines, where it is about pastoral care as much as it is about medical care, we need to be very cognisant of that if the system is being deployed? But for a situation like you have just pointed out, the deployment of that system can have a very positive patient outcome; we just need to be making sure that we look after and care for patients with that bedside manner and care that they deserve and expect.

Dr McCARTHY: I have no doubt that it has a very important future and I think the system will evolve, but I think it should evolve alongside face-to-face care.

The Hon. WES FANG: To complement it.

Dr McCARTHY: It is a complement. It cannot be standalone. If it is used standalone it is cruel.

The Hon. WES FANG: I think that insight that you have both been able to provide to us today is really important because we have heard really positive stories around, particularly telestroke as well, which is one of those ones where we have got really fantastic patient outcomes. I am cognisant that I do not want to throw the baby out with the bathwater, but we need to make sure that we provide the care that people deserve. Your father, he was such a wonderful man, by all accounts, and he deserved that. So, again, like I said, I am passing on my sympathies to you and thank you, again, for coming today to share your story.

The Hon. LOU AMATO: Mrs Kearines, first of all, sorry for the loss of your father.

Mrs KEARINES: Thank you.

The Hon. LOU AMATO: I was distressed to hear how he used to wake up in pain a lot. Can you tell us a little bit more about the pain management or how it was administered, who was administering the pain management, especially to someone who is very close to you?

Mrs KEARINES: Yes. Obviously the virtual doctor would prescribe what medication he was to have over the 24-hour period. Unfortunately the disease took us all, including him, by surprise at how quickly it progressed. Even his oncologist felt that he would still be with us at Easter, so he was shocked that he was in hospital and deteriorating. I think it was just such an evolving progression that the medication was prescribed at nine o'clock today by six o'clock tonight was not adequate to manage the pain that was progressing so quickly. Our hospital has lots of empty wards and very few nursing staff. I think we have maybe 12 beds allocated to the hospital. We had minimal nursing staff; they were worked off their feet because the majority of patients were palliative care. We could press the buzzer to say that he needed medication, but they were already dealing with three or four patients that needed them at that moment, so it could be two hours before he got his medication delivered.

The Hon. LOU AMATO: I understand the anxiety and the stress that you went through.

Mrs KEARINES: It was not the nurses' fault. Please do not think that I am blaming them. There were minimal staff there working with the type of patients they had. That is why the syringe driver was so important to get for him; they loaded it up and it automatically medicated him so that he was not in pain for two hours before he got the medication to try and ease that pain down, which would not happen immediately.

The Hon. LOU AMATO: Thank you very much. It reminds me of what I experienced many years ago with my mother's death through cancer, and how she would be screaming out from pain as well. This was 25 years ago, but it brought back memories. I am deeply sorry for what you have been through.

Mrs KEARINES: Thank you.

The CHAIR: Thank you for attending this hearing and for sharing your stories. We will now have a lunch break.

(The witnesses withdrew.)

(Luncheon adjournment)

JESSICA BROWN, General Manager, Strategy and Growth Business Development, Marathon Health, sworn and examined

JULIE CULLENWARD, Practice Lead – Allied Health, Marathon Health, sworn and examined

TANYA FORSTER, Psychologist and Director, Macquarie Health Collective, affirmed and examined

BILL MAIDEN, Chief Executive Officer, My Emergency Doctor, affirmed and examined

JUSTIN BOWRA, Founder and Medical Director, My Emergency Doctor, affirmed and examined

The ACTING CHAIR: I now welcome our next witnesses. Ms Brown, do you wish to make an opening statement?

Ms BROWN: Committee and Acting Chair, thank you for inviting us to expand on our submission to your inquiry. Marathon Health is a regionally based not-for-profit organisation working in western New South Wales, the Murrumbidgee and the south-east. We are passionate advocates for equal access to quality health services for people, wherever they choose to live. We responded to this inquiry to draw attention to the missing middle in health care in our communities, which has been created by the lack of allied health services. We also wanted to highlight some of the work that we have been doing to try and fill this gap so that people living out here can access services that keep them out of hospital and continuing to live independently. The critical shortage of community-based allied health professionals is well documented, with demand only increasing due to the NDIS and aged-care reforms.

They play a vital role in identifying issues early and linking people with other aspects of our health system. Without this link, we are seeing some worrying case studies emerge. Two in the last week from our staff are: 40 preschool-age students in one rural community who have been identified with speech issues but have no access to services, so their families, carers, teachers and communities have just accepted that they will never speak properly; and the residents in an aged-care facility in a remote town, who are at serious risk of choking, which one of our speechies only noticed because they were there for something else. These gaps exist across all sectors: public, not for profit and private. Bulk-billed allied health services were once an option for all, particularly lower income people, but they have all but disappeared from rural towns due to the demand for higher value work.

On a positive note, we know that when we have a skilled and experienced allied health workforce regularly visiting regional communities and linked in with other parts of the health system, we can create great health outcomes. The Chronic Disease Management and Prevention Program provides monthly access to dieticians and diabetes educators out of medical practices across western New South Wales. People needing the service wait less than a month. Plans are developed for people that link in with their GP and they are much less likely to be hospitalised. To fill the gaps, we have invested in growing our own workforce. Over the past three years we have supported 48 speech, occupational therapy and social work students to complete clinical placements with us. It was an enormous effort from our staff, but it has resulted in 21 students choosing to work in regional New South Wales and 12 of those students gaining employment with Marathon Health.

We don't just do this for our own benefit; we are committed to growing the regional allied workforce to improve the health outcomes of people who live outside our cities. We know it works. Building relationships with universities, hosting students on clinical placements, demonstrating the benefits of working regionally and maintaining the connection with students through their studies results in them working and living out here—but it does come at a cost to our business. Our strategies in selling life as an allied health clinician in regional, rural and remote New South Wales are a genuine success story, but it is not something that we can sustain by ourselves. With the right investment and carefully thought-out public-private partnerships, we can work together to grow an allied health workforce that adequately supports the missing middle, provides integrated care, supports the work of our GPs, creates better health outcomes and reduces the strain on hospitals. Thank you.

The ACTING CHAIR: Thank you very much. Ms Cullenward, did you have an opening statement you wanted to make?

Ms CULLENWARD: No. That was our joint opening statement.

The ACTING CHAIR: Ms Forster?

Mrs FORSTER: Hi, my name is Tanya. I am a psychologist and the director of Macquarie Health Collective and Macquarie Valley Family Practice. I am a Central West local and a farmer's wife raising a family on the land. I hope this allows me to provide a unique insight today, representing the local community, the private sector and both general practitioners and allied health providers servicing our community. In preparing for today, I anticipated that you have probably now heard from a number of people who have discussed the variety of

challenges we face in regional New South Wales. While I think this is important to cover, I also hope today to discuss some of what we are attempting to do to move forward and provide practical solutions for our community. I established my practice with the goal of providing innovative and collaborative services for regional New South Wales. I face the same challenges that I am sure you have now heard about across these hearings.

Recruitment is challenging. Retaining staff is challenging. Servicing our broad distances is challenging. I do believe that there are things that can be done to help, however. We propose that innovative models of health care and collaborative partnerships across organisations may assist in providing a solution to some of the current barriers to health care in regional New South Wales. In preparing for today, I spoke to a number of providers. I find that so often at these events, unfortunately the people doing the work do not get the opportunity to speak, as they are busy doing the work. I hope to do my best today to represent these individuals. We know that doctors do not want to relocate from metropolitan areas to remote communities where they have to practice as a solo GP with minimal support, no cover for leave, no employment for their partner and minimal services available in their community.

I think it is time we rethink the way we approach this, rather than repeatedly trying the same thing and getting the same outcome. Flying in VMOs is costly and does not lead to a sustainable service for our regional communities. I think a potential solution comes back to collaboration and partnerships across organisations. We have been in discussions with the LHD about how we can co-recruit and allow opportunities across our organisations. We have an established medical and allied practice, allowing doctors to join a team of colleagues with strong supports in a well-resourced community that can adequately provide for them and their family. We think this can be leveraged to help provide outreach services to regional communities.

As a psychologist myself, obviously a key target of our organisation relates to mental health. Currently I lead a team of four psychologists and clinical psychologists and continue to expand on this service. I hope we can continue to think creatively about how we support not only Dubbo but also regional New South Wales. Another key focus for our business is palliative care. We have partnered with Dubbo Area Nursing Service and the Death Literacy Institute in an attempt to provide collaborative, community-based services. In the coming months we hope to conduct a community forum to allow people the opportunity to contribute to the development of these services.

While we have been providing telehealth services for some time, across the course of COVID-19 one thing we have learnt to do is provide strong, high-quality telehealth services across all of our disciplines. The benefit this has brought to regional New South Wales is profound, and this service needs to remain. Prior to the provision of telehealth services we had families driving four hours each way to access our providers. Can you imagine driving four hours to attend a 50-minute psychology appointment only to turn around and drive home again? Yes, we would love to have providers in all locations across New South Wales, but that is not a realistic reality.

Telehealth allows us to complement face-to-face services to ensure a service is available that otherwise would not be. You would not believe the number of people I have spoken to on their header, tractor or park on top of the hill in a Land Cruiser ute. These are people who would not have accessed that treatment had telehealth not been available. We know the statistics around farmers and health care, particularly mental health care. How amazing that they are actually engaging with this service. How amazing that after the years of drought they have endured we are allowing them access to services without the pressure of leaving the farm and the stock the need to feed.

As a representative of the private sector, I believe we provide a unique position to be able to assist with health care in regional New South Wales, but we are not often involved in these conversations. The private sector allows agile, innovative and cost-effective services and, when used in conjunction with other government and non-government services, I believe there is potential to bridge the gap we have faced for so many years. The final point I want to raise today is that I think we need to change the perception of rural health care. I hope this inquiry can strive to do this, rather than reinforce some of the negative stereotypes.

We need to change the culture in medicine that working rurally would be a career setback. We need to change that culture from medical school onwards. Working regionally needs to be seen as a career progression just as much as working in a major city hospital. We also need to change the stereotype of living regionally. We are more than mice and a dust bowl. Dubbo is beautiful. Join me on my deck for lunch and take in the views. I can assure you it is a spectacular sight. I thank you for the opportunity to speak with you today. I think it is incomprehensible that it is 2021 and still we have not got health care right for regional communities. I hope we can start a conversation about how we can do better. Our communities deserve it.

The ACTING CHAIR: Mr Maiden, do you have an opening statement?

Mr MAIDEN: Dr Bowra will speak on my behalf.

The ACTING CHAIR: Dr Bowra?

Dr BOWRA: My name is Justin Bowra and I am a fellow of the Australasian College for Emergency Medicine. I am the founder and medical director of My Emergency Doctor. With me is Mr Bill Maiden, our CEO. I would like to begin by acknowledging the traditional custodians of the land on which we meet today and pay my respects to their Elders, past, present and emerging. I founded My Emergency Doctor with a mission to end the healthcare postcode lottery, so that rural and regional Australians could have access to the same specialist emergency medical care that those of us, like me, who live in cities take for granted. As a specialist emergency physician myself, I know the life-saving difference that my colleagues and I can make every day working aside the younger doctors in our own emergency departments.

I understand that the Committee has discussed the various experiences to date of telemedicine for GP consultations and referred specialist consultations. I think it is fair to say that telemedicine in the emergency department can actually be the most complex and has been delivered in many different ways. Today I would like to share with you how my colleagues and I practise it and the benefits to patients and their onsite clinicians. Emergency specialist doctors are fellows of the Australasian College for Emergency Medicine. We are experts in rapidly assessing, diagnosing and treating the sickest of the sick, either in person or via telehealth. In my telemedicine service we are only emergency specialist doctors, 24/7, 365 days a year. We have been providing that support since 2016. We have conducted over 72,000 consultations since that time.

We work in two ways: We help ambulance services such as NSW Ambulance provide secondary triage, managing patients at home when local community GPs are closed, and in so doing we free up ambulances to look after the sickest patients. Across Victoria and New South Wales we also support the onsite clinicians and carers who look after sick patients in rural hospitals and nursing homes. Every day we work side by side with emergency doctors, nurses and carers via a secure video link. It is as though we were standing next to them looking after the patient with them. As a result of our work, we have helped save lives, improved patient care and reduced the strain on ambulance services and emergency departments.

When I set up this service, even my own medical colleagues expressed their doubt that we could provide emergency care at all by phone and video. But after managing more than 70,000 cases I no longer hear this. When rural emergency clinicians call, we answer. We have looked after children and adults in extremis with septic shock, life-threatening asthma and even cardiac arrest. The reality is that emergency specialists do this to support junior colleagues via telehealth every day. Even when I am on duty in my own hospital in Sydney, I am telephoned every day by GP and remote colleagues asking for urgent help and advice. While of course it is much better to have the actual physical doctor there, the trouble is that the specialist emergency physician cannot be everywhere. There are simply not enough of us to be on duty all day every day in every hospital and multipurpose service in Australia. That is why we set up our service. When the onsite staff need our help most urgently, they call us and we are there to help them give the best possible care they can give. The onsite staff have told us repeatedly that they really value our support and the education we provide.

I should add that most of our work helping clinicians and patients in country hospitals is after hours between 6.00 p.m. and 6.00 a.m. That helps take the burden of the local GPs so that they can get a good night's sleep. I would also like to acknowledge the proactive stance taken by NSW Health over the years in this regard as well as by the rural clinicians themselves. One day I would hope that every patient in Australia will be able to receive care by an onsite specialist emergency physician, but until that time my colleagues and I will continue to support our rural colleagues by telemedicine. The reason Mr Maiden and I are here today is to let you know that telemedicine, the way we do it, where the onsite staff have the opportunity to ask for help when they need it, that works every day. Honourable members, once again Mr Maiden and I would like to thank you for your time. I hope that the information that I have provided can support the inquiry accordingly.

The ACTING CHAIR: Thank you so much. We will now move to questions. We will hear questions from the Government, the crossbench and the Opposition. We will start with the Opposition, the Hon. Walt Secord, who has nine minutes.

The Hon. WALT SECORD: I will get quickly to my point. Are Marathon Health and Macquarie Health Collective both for-profit organisations?

Ms BROWN: We are not for profit.

The Hon. WALT SECORD: Ms Tanya Forster, is Macquarie Health Collective for profit?

Mrs FORSTER: We are for profit.

The Hon. WALT SECORD: Ms Forster, what are you actually seeking? I have read through your submission. Are you seeking an expansion of public-private partnerships?

Mrs FORSTER: Yes, I think that there is definitely value in that. We have already been in discussions with other private, non-government and government agencies. I think there would be a lot of benefit to increased collaboration. Realistically, the problem is too big and no service can do it independently. That being said, of course assistance in terms of funding for those partnerships would be important because otherwise it is me working hard and funding it out of my own pocket.

The Hon. WALT SECORD: You said that you are involved in a practice of four psychologists?

Mrs FORSTER: Amongst other things. Yes, correct.

The Hon. WALT SECORD: Does your practice have a Medicare rebate?

Mrs FORSTER: Yes, that is right. To access a psychologist specifically, most people come via their GP and get a Medicare rebate on consultations. In addition to the psychologists we have a team of GPs, medical specialists and other allied health providers.

The Hon. WALT SECORD: Is your practice based in Dubbo?

Mrs FORSTER: That is correct.

The Hon. WALT SECORD: Without going beyond the number, how many clients would you have on your books?

Mrs FORSTER: Approximately 4½ thousand to 5,000.

The Hon. WALT SECORD: It is quite a large practice.

Mrs FORSTER: Yes. We have approximately 20 providers.

The Hon. WALT SECORD: Do you provide virtual consultations?

Mrs FORSTER: Correct—a combination of telehealth and face-to-face services. At the moment that is at the discretion of the client. Obviously there are some things we need to see in person so we will then encourage them to attend a clinic if need be. Otherwise, they can select whether they would like to access us face to face or telehealth which, as I mentioned, really helps people who live at a distance from our practice.

The Hon. WALT SECORD: Of the—I think you said the figure was 20,000—clients, how many of those would be Aboriginal?

Mrs FORSTER: I do not know the exact percentage. We have a very high Indigenous population that accesses our psychology services in particular. We work in partnership with the Aboriginal Children's Therapy Team to provide a free psychology service for Indigenous families who reside in the 2830 postcode aged zero to eight years, which is an amazing service. We work in conjunction with their allied health team to provide services for these families that otherwise would not access service. They are complex, high-needs families and the outcomes that we get are life-changing.

The Hon. WALT SECORD: This morning we heard evidence that there was difficulty amongst the Aboriginal community navigating the Medicare system and getting the rebate, and that it actually dissuaded them from seeking services. Have you found that?

Mrs FORSTER: That program removes that barrier because they are able to just access free psychology through a different funding system. I would say that there is, however, less service available for adults. Indigenous adults in our community unfortunately do not have the same access that the children do. The paediatric program is brilliant, but from my knowledge it pretty well stops with paediatric.

The Hon. WALT SECORD: In your submission you make a reference to palliative care services. Are you proposing that palliative care be provided by for-profits?

Mrs FORSTER: I think we play a role. I think in conjunction with other services—

The Hon. WALT SECORD: Sorry, you will have to repeat that. I could not hear that.

Mrs FORSTER: Sorry. I think that in conjunction with other services we certainly play a role. The agencies that I mentioned today when I was speaking are also profit services but we have been trying to form a partnership together because I can see significant gaps in the service availability at the moment. We have a visiting specialist relief that comes once a month. We have two nurses who are servicing a huge area. They are overstretched. Outside of hours, access to services is really poor.

The Hon. WALT SECORD: How do you envisage the palliative care services taking place? Will they be face to face or will they be teleconference?

Mrs FORSTER: I think the majority of would be face to face and the Dubbo Area Nursing Service that I mentioned would provide the nursing services under this partnership. They would take a key role in some of that face-to-face caring provision and then we would assist by providing things like general practice and psychology services for these families.

The Hon. WALT SECORD: Dr Bowra, were you here earlier for the evidence from the daughter of the man who died at Narromine Hospital?

Dr BOWRA: No, I was not.

The Hon. WALT SECORD: Are you familiar that there could be challenges diagnosing or dealing with patients who are, for example, 92-year-old men—diagnosing or engaging with him via virtual medicine?

Dr BOWRA: There are issues diagnosing anyone. We have come across—in my practice, in hospital and in telehealth—difficulty diagnosing. It is often more related to the seniority and expertise of the doctor concerned. I am not familiar with the case you are talking about. Was the gentleman unable to communicate, for example?

The Hon. WALT SECORD: No, he was able to communicate but he was 92 years old. He had a blood cancer disease. However, there was miscommunication on the link and from the doctor in Sydney. I will jump forward, then, if you did not see it. Your practice is called My Emergency Doctor.

Dr BOWRA: That is right.

The Hon. WALT SECORD: You say "your practice". Is that a for-profit practice run by you?

Dr BOWRA: Yes, it is.

The Hon. WALT SECORD: How does it navigate or intersect with the New South Wales health system?

Dr BOWRA: What we do is the New South Wales health system commissions calls from us. For example, if a patient calls NSW Ambulance triple zero they will be sometimes assessed if they are calling from a nursing home, for example, and the carer will get put through to us. Or if in rural—for instance, in the Murrumbidgee Critical Care Advisory service the onsite nurses and doctors will call us for assistance with a patient.

The Hon. WALT SECORD: So I can get my mind around this, do doctors in points around the State in remote areas call a special number and they are patched through to one of your doctors?

Dr BOWRA: That is right.

The Hon. WALT SECORD: That is how it works?

Dr BOWRA: Yes.

The Hon. WALT SECORD: Okay. What training do your doctors receive?

Dr BOWRA: As well as every one of our doctors being a specialist emergency physician we give them extra telehealth training of our own, because obviously it is not enough just to be a specialist; you have to be good at telehealth as well, as well as the limitations and constraints. One has to be very careful to do the right thing and have an appropriate extra level of caution, if you take my meaning.

The Hon. WALT SECORD: I take your meaning, because this is our fourth hearing and we have had written submissions and we have had personal evidence from individuals—from surviving family members—that it is a matter of just simply putting a patient in front of a camera.

Dr BOWRA: I think this speaks to the different ways that people use telehealth. I cannot speak for the way that other providers do, but this is why we are very careful to say, "Look, there actually has to be, in the rural hospital or emergency department or what have you, an onsite clinician standing there with the patient"—

The Hon. WALT SECORD: Will your service receive a call from a nurse?

Dr BOWRA: Yes, a nurse or a doctor.

The Hon. WALT SECORD: What if a nurse is there by herself or himself? You will still take that call?

Dr BOWRA: If they are asking for our help, of course.

The Hon. WALT SECORD: Do you get many calls a day? How many calls would come into your service a day?

Dr BOWRA: We would get about 120 or so.

The Hon. WALT SECORD: How long would each last in duration?

Dr BOWRA: It depends. Probably the shortest call might be about 15 minutes, but the longest call in recent memory was four hours.

The Hon. WALT SECORD: Four hours?

Dr BOWRA: Four hours, yes. It was a very sick asthmatic child so our specialist emergency physician stayed on the line with the onsite staff until the retrieval doctors could come.

The Hon. WALT SECORD: Some 120 calls a day?

Dr BOWRA: Yes.

The Hon. WALT SECORD: And that is from all points of the State, the most remote areas such as Narromine, Warren, Gilgandra?

Dr BOWRA: It is not only from all points of the State; it is also from rural Victoria as well. Yes, we keep pretty busy and some of these calls are extremely long because some of the patients are very sick.

The Hon. WALT SECORD: One last question: What if something goes wrong—

The Hon. WES FANG: No, no.

The ACTING CHAIR: Thank you. No—

The Hon. WALT SECORD: What if something goes—

The Hon. WES FANG: Walt, Walt!

The Hon. WALT SECORD: What if something goes wrong on a call?

The Hon. WES FANG: Walt.

The Hon. WALT SECORD: No, what if something life-threatening—

The Hon. WES FANG: You are burning everyone else's time.

The Hon. WALT SECORD: No, I want an answer to this.

The ACTING CHAIR: Very quickly.

The Hon. WALT SECORD: What if something life-threatening happens on the call? What do you do?

Dr BOWRA: I can probably answer that by saying we get called because there is something life-threatening and they need a specialist emergency physician—

The Hon. WALT SECORD: But what—

The Hon. WES FANG: Let him answer!

The ACTING CHAIR: Order! Mr Secord—

The Hon. WALT SECORD: But what if something spirals—

The Hon. WES FANG: Point of order: Walt, don't—

The Hon. WALT SECORD: No, what happens if something spirals—

The ACTING CHAIR: Order!

The Hon. WES FANG: This is the stunt that you keep doing!

The ACTING CHAIR: Order!

The Hon. WALT SECORD: I want to know what happens when something—

The Hon. WES FANG: He was answering it!

The ACTING CHAIR: Order! Mr Secord, I have asked you to stop speaking, please.

The Hon. WALT SECORD: It is a very important. I want to know what happens when something spirals out of control.

The Hon. WES FANG: Point of order: Walt—

The ACTING CHAIR: There has been a point of order taken.

The Hon. WES FANG: Everyone has been very civil today. You have always got to do one stunt a day and this is the one that you are pulling. I would ask that you not do it.

The ACTING CHAIR: Can the honourable member please direct the point of order to the Chair, not to the member—

The Hon. WALT SECORD: It was a very serious question.

The Hon. WES FANG: It is a serious—let him answer it!

The Hon. WALT SECORD: To the point of order: It was a very serious question and I think the community wants to know what happens when a situation spirals out of control when a poor nurse—

The Hon. WES FANG: He was—

The Hon. WALT SECORD: —is in a remote hospital by herself.

The Hon. WES FANG: He was answering it.

The Hon. WALT SECORD: That is my question. I will end it there.

The ACTING CHAIR: Would you like to put that question on notice?

The Hon. WALT SECORD: No, I would like to have it answered today but I will bow to the Chair's decision.

The ACTING CHAIR: Thank you.

Dr BOWRA: I am happy to answer it.

The ACTING CHAIR: Yes, if you could give us a very short answer that would be very appreciated. Thank you.

Dr BOWRA: Of course. Typically we are called when it spirals out of control so that we can help the onsite staff. Of course, many of them are not as experienced as we are in supporting those patients. We have actually had people calling us because they are doing chest compressions and so on with people in cardiac arrest. We support those onsite staff to give the best possible care that they possibly can because, when you think about it, if we were not there it would still be out of control as much as it would be if we were there. But when we are there we can help and we can improve the care that those patients get—give them the best possible care that those clinicians can give and actually support the clinicians, the patients and their families through what is probably the worst day of their lives.

The ACTING CHAIR: I have a couple of questions for Ms Brown and Ms Cullenwood. You note in your submission that many nurses and allied health students feel underprepared working in rural locations. What do you think needs to be done to address this issue?

Ms CULLENWARD: There are a number of things that can be done: having relationships with universities to put in place pathways and education for rural students or people wanting to take a placement in a rural area; there are existing online modules that people can do; universities have developed some training. I can give you an example. One of our colleagues has just delivered a paper for students at the University of Newcastle. One of the questions she got was from students in the room about what it would look like if they went to a rural area, what were the supports that they required and wanting to know at that level what it would look like and they were very interested in the types of supports that were available. I think a structured process for that.

A lot of universities do have rural placements. They have a requirement for their courses that there is a rural placement. But in reality it is quite difficult to get rural placements and so some students miss out on having a rural, rural placement and they might go to somewhere closer to their large city or their large regional centre, because students have to leave their job and leave their home. It is expensive; some students have two or three jobs. There are a number of things that are required to go rurally: preparation for knowledge, financial remuneration, education around what the placement will look like for them, and accommodation.

The ACTING CHAIR: Did you have something to add to that, Ms Brown?

Ms BROWN: Yes, also culture safety training, so making sure that those students feel confident delivering the services in a culturally safe way to Aboriginal and Torres Strait Islander people. That is something that we are doing and that receives some funding to do just to make sure that they are confident and delivering safe services.

The ACTING CHAIR: You also argue in your submission that there needs to be greater investment in preventing chronic diseases in the community. What is happening currently in this space and what needs to happen?

Ms BROWN: An example is our Indigenous Chronic Disease Clinic in Bathurst that we run and have run for quite a number of years now. What we are seeing is a multi-generational impact of diabetes on families, so grandma, mum and now children coming into a service. It is just about having the skilled and experienced allied health clinicians in communities who can pick those issues up early and work with doctors and work with other health professionals, community nurses and others in the healthcare systems to spot those things early and put interventions in place to stop that multi-generational impact. We are running a research project in Wellington to identify some of the success factors around stopping multi-generational diabetes' impacts, and we should have some more findings about what the successful interventions are out of that.

Ms CATE FAEHRMANN: I had a few questions for Dr Bowra in relation to My Emergency Doctor. Are there other organisations like yours providing this service?

Dr BOWRA: Yes, there are. For instance, in Western Australia they have an emergency telehealth service and there are also critical care advisory services throughout New South Wales that Fellows of the Australasian College for Emergency Medicine [FACEM] like myself assist with.

Ms CATE FAEHRMANN: I am just trying to work out how it works in practice. For public hospitals, how do they know who to connect through to? Who makes the choice in terms of whether it is a doctor at the end of, say, My Emergency Doctor or another organisation that is providing the service?

Dr BOWRA: I think that is probably a question for the hospitals themselves. But basically as far as the clinician is concerned, they press the button or make the telephone call and they are put through to a specialist emergency physician. It is clinician to clinician; it is regardless of who the organisation is. I am not sure if I am answering what you were asking.

Ms CATE FAEHRMANN: The question is then coming to funding and basically how it is set up. I can definitely ask the government representatives who are coming after you. From your perspective, what is the funding model for My Emergency Doctor clinicians?

Dr BOWRA: It is obviously free to the patient and family of course, but the hospitals themselves or NSW Ambulance for instance have the contractual arrangement with us.

Ms CATE FAEHRMANN: Right, so My Emergency Doctor would receive some kind of payment from the clinicians, therefore I am assuming that the service you have set up is a for-profit service.

The Hon. WES FANG: He already said that.

Ms CATE FAEHRMANN: Yes.

Dr BOWRA: Yes, I have to pay my doctors.

Ms CATE FAEHRMANN: Your submission also makes a point about the COVID-19 pandemic that it is an accepted part of life to receive health care in a face-to-face setting. Was My Emergency Doctor specifically set up as a result of COVID-19?

Dr BOWRA: No, we were not. I first had the idea several years ago and started it in 2016.

Ms CATE FAEHRMANN: What is the growth that you have experienced since you started?

Dr BOWRA: It has certainly been quite profound. I think the exigencies of COVID have meant that a lot of people have understood what we can do with telehealth and telemedicine to support regional and rural communities. There has been quite a lot of growth since then.

Ms CATE FAEHRMANN: Mrs Forster, you state in your submission that you have had discussions with the Hon. Mark Coulton, MP, the Minister for Regional Health—

The Hon. WES FANG: Great Minister.

Ms CATE FAEHRMANN: —in relation to the potential public-private partnerships that you are advocating for today. You state:

> If Government funding was available to support these models, we feel our potential to support the community would be greatly increased.

What does government support look like to you?

Mrs FORSTER: I think that what we are trying to do from a private practice in Dubbo is provide clinical support to a huge area of our State and to a big percentage of people in New South Wales. I think that there are costs that are associated with that and we do our best to be able to minimise that for families. But because we are a private practice, the cost does then come to the family. I think that if we are going to really look at collaboration across agencies, there needs to be some consideration taken of the costs that are involved in that. I think historically a lot of funding opportunities probably do not really go into the private sector. They generally do fall with other agencies, which is completely fine, but I think the other agencies also were not able to fully meet the need. If we were able to look at partnerships across agencies, then I feel like we have a stronger workforce to be able to bridge the gap and meet the need across the State, not just in Dubbo.

The Hon. WES FANG: Thank you all for coming and appearing before us today. Thank you for taking the time and sharing all of your experiences. Mrs Forster, your opening statement was profound and fantastic. There were two things that I thought were notable in your opening statement. The first one was the distinction you made around telehealth. It is a word we have heard bandied around in these inquiries, but you made quite an important distinction that there are differences in telehealth. There is the telehealth that a patient will receive from a clinician in a room and they might be, like you said, on a ute on top of a hill, and it is providing that access to health care and, say, psychology services or specialist services that they would not have got as opposed to the vCare system or the rural generalist care system that is in hospitals. So thank you for broaching that.

One other thing you broached was the negative stereotypes. I am from Wagga, so I love rural and regional communities and I could tell when you spoke about Dubbo that you do as well. How do you find it when people come here that they have perhaps a negative stereotype in their head, that it is actually corrected when they come here? The other thing we have heard recently is that this inquiry itself has generated quite a lot of negativity around health services in rural and regional settings, and that is creating an issue of attracting people to those settings. Can you provide some thoughts on that?

Mrs FORSTER: It is a big question but I will do my best. Yes, I do think that people have a negative stereotype in their head occasionally and I think when people are able to come here and experience what it is like to actually live in Dubbo or surrounds, that their mind can significantly change. We have people who have relocated, joined our practice and are now here 20 years down the track. Rural life is great, it is not what it is often portrayed to be, and I think once they experience the community then they finally get to see that. Like I said, we are not just mice in a dust bowl.

The Hon. WES FANG: Exactly, yes.

Mrs FORSTER: The second part of your question, sorry, was?

The Hon. WES FANG: Just around the negativity. We have seen a lot of negativity around rural and regional health care and that, one, it makes it hard to attract people but, two, we had reports of some of the frontline staff being attacked because of, say, some of the political attacks that are coming out of this inquiry. Can you elucidate on that?

Ms CATE FAEHRMANN: What? That was just evidence.

The Hon. WES FANG: You heard it today, Walt, so just sit there and listen.

The Hon. WALT SECORD: It is evidence before the inquiry, Madam Chair.

The Hon. WES FANG: Ms Forster, ignore them.

Mrs FORSTER: So yes, unfortunately there is a negative message that comes out and that is why I raised the point earlier, because I really hope that is not the summary of what comes out of these hearings. We do not want to make people who live in the city, especially doctors who are living in metropolitan areas, believe that rural health care is in a major crisis and is a major problem, because why would you want to move to that? Why would you want to take on that challenge? I think that we need to be able to show some of the good news stories, we need to be able to show some of the things that are going well, and that is why I did not want to focus my talk today on the problems in health care. Yes, they are there, we all know it, and you do not need me to harp on about it, you have heard it for four days. There are a lot of great things going on—we see it at this table today—and I think we need to show people that.

The Hon. WES FANG: Thank you so much for that. Dr Bowra, thank you very much for appearing today. I have been an advocate for telehealth or vCare, or whatever name we put around it, but from my lived

experience, having been in retrieval medicine, I have seen it firsthand, but also I guess you have seen way more than I would have. You have seen the political attacks that have come out and the way that people have been trying to politicise it. Can you possibly provide some insight into what good things can come out of having that support from vCare or telehealth medicine?

Dr BOWRA: Thanks very much. I think that cuts to the heart of it. It says, look, telemedicine practised correctly should never displace and it should never replace; it should augment and support. So realistically, the best way of telemedicine is to say there are onsite clinicians, doctors, nurses and what have you—allied health—and the specialist comes in and helps them and supports them, and it is the same specialist as you alluded to that is four hours away. It would be lovely, as I said, to have the specialist there, but this is the next best thing. It is basically allowing that patient to get the best possible care they can get at that time; it is allowing the family to get that support; and it is allowing the onsite staff. To speak to getting people out here to the communities and getting health professionals out here to the communities, you know—because I know you would have heard this—there is a lot of healthcare professionals that come out and might feel isolated, but this helps end that because you have got your mate there and you have got your support there and they are able to help you. So it is not just allowing the best possible patient care; it is also talking about retention and supporting the onsite people who are giving the care every day.

The Hon. WES FANG: You would have heard throughout the inquiry that there have been limitations, instances where telehealth or vCare has not been the best way of providing support or treatment to a number of people, and that has certainly been ventilated and we acknowledge those stories. But do you know of any good stories where without the intervention of the virtual care we would have had very negative outcomes?

Dr BOWRA: Every day. I will give you an illustrative example. It is about a month or two ago, one of my colleagues was called as part of our service and the onsite clinician said the patient could go home, he had reflux and a bit of heartburn and my colleague said, "Can I see the ECG?" The onsite clinician said, "Look, it's fine." We looked at the ECG and the guy was having a heart attack. The onsite clinician was a great clinician but junior and perhaps just a little less experienced, and that is the point about getting the specialist right there immediately available to support them. And we saved that guy's life with the onsite clinicians. That is the sort of story that we are seeing every day.

The Hon. WES FANG: That story is unique?

Dr BOWRA: It is not unique.

The Hon. WES FANG: I guess in that instance it is not publicised, is it? We are not talking about those positive stories about the intervention of an emergency specialist providing that support; it is not getting out there and so we are only getting sort of a slanted view of the telehealth system.

Dr BOWRA: I think that is true. I think there is a belief, and it is very understandable, that the tele-emergency, when people are talking about it in rural and regional communities, is talking to a doctor through an app instead of an onsite doctor. It is not about that. The onsite doctor is there and the patient is there and their family is there and they are all there and the specialist is beamed in and they are by their side and they are making it better. They are improving patient care.

The Hon. WES FANG: And it is not just emergency medicine, is it? We are talking about specialties across the board that you would not necessarily have in a rural and regional setting. Obviously you provide emergency medicine, but you could be talking about neurosurgery or—

Dr BOWRA: That is very true.

The Hon. WES FANG: —cardiology support, that you would not necessary have those people in a base hospital or in a secondary-type hospital?

Dr BOWRA: I think that is the point, is it not? Every specialty is now doing telemedical support in rural and regional Australia. Every one of my colleagues is doing it—cardiologists, vascular surgeons, renal physicians—and it has been a game changer. It is a game changer for rural and regional Australians.

The Hon. WES FANG: These are services that were never provided to even large regional cities.

Dr BOWRA: That is right. And if they were, they had to travel four hours to get there and four hours back.

The Hon. NATASHA MACLAREN-JONES: In your submission you referred to a report that has been prepared, I think, by a department in Victoria in relation to their emergency care and you said it is going to be released at some stage this year. Do you know when that will be released, or if you could give a copy of that to the Committee to be looked at as well?

Dr BOWRA: I will be very happy to.

The ACTING CHAIR: Thank you all for coming today and for attending this hearing.

(The witnesses withdrew.)

SCOTT McLACHLAN, Chief Executive, Western NSW Local Health District, on former oath

SHANNON NOTT, Rural Health Director of Medical Services, Western NSW Local Health District, on former oath

ADRIAN FAHY, Executive Director, Quality, Clinical Safety and Nursing, Western NSW Local Health District, sworn and examined

ROBERT STRICKLAND, Acting Chief Executive Officer, Western NSW Primary Health Network, sworn and examined

ROBIN WILLIAMS, Board Chair, Western NSW Primary Health Network, sworn and examined

SONYA BERRYMAN, General Manager, Primary Healthcare and Integration, Western NSW Primary Health Network, affirmed and examined

The ACTING CHAIR: I now welcome our next witnesses. You now have an opportunity to give a short opening statement. Mr Fahy, do you wish to make a statement?

Mr FAHY: I will defer to Mr McLachlan, if that is okay.

The ACTING CHAIR: Certainly. Mr McLachlan?

Mr McLACHLAN: Thank you, Madam Chair. I would like to acknowledge that we are meeting today on Tubba-Gah country of the Wiradjuri nation and offer my respects to Elders past, present and those emerging in the future. I would also like to offer my respect to the 30,000 Aboriginal people right across western New South Wales and the nine Aboriginal nations. At the recent hearing of this inquiry in Cobar, the Chair emphasised the grave concerns that were being expressed in this forum and the good faith of those people who are appearing as witnesses. I can assure the Committee and all of our communities that we absolutely want to hear experiences. We respect the courage that it takes to come to this type of proceeding and tell personal and distressing stories.

To those who have experienced care that was not what they needed or wished, I want to say again how sorry I am. We have a strong culture of accountability in our district. While the majority of people who come to our services leave with an outcome and experience they do value, when that does not occur we are committed to learning from it. Part of that learning is growing our understanding of Aboriginal culture. In our footprint, over 13 per cent of the population are Aboriginal and have a strong cultural connection, bringing a beautiful strength and diversity, but this comes with a deeply distressing history and a need to engage and provide health services differently. We know that there is a long way to go, but we have a genuine commitment to creating respectful, culturally inviting and safe services for Aboriginal people to access care.

This is a path we are walking alongside partners including our Aboriginal Medical Services, the Murdi Paaki and Three Rivers regional assemblies, our Aboriginal health workers, patients and communities. We are absolutely open to engaging and hearing how we need to change. I do want to make a couple of comments in relation to testimony provided yesterday that may be of concern to people in our communities. To be clear, there are no restrictions placed on the medication or consumables stocks that are kept in a hospital. Obviously not every hospital is able to keep stock of every available medication; however, if a patient is unable to be treated because the precise medication they require cannot be sourced, it would constitute an event that should be reported. We have not been able to locate any such reports in our small rural hospitals over the last 12 months. All of our hospitals do keep a stock of routinely used antibiotics.

If a different medication is required it can be ordered through our pharmacy services and delivered by our courier services. Standard insulin types are kept in our hospitals; however, patients often require highly specific insulin medications. In those cases, it may be the case that a patient is asked to bring their medication with them if they come to hospital, until their specific prescription can be ordered by the hospital. We also do not place any restriction on the stock of consumables such as incontinence pads, wound dressings and suture kits. Our hospitals routinely keep sufficient amounts of stock to cater for the usual volume of work. If stock does run low or is exhausted, then it should be reported and addressed by the local manager. Madam Chair, the realities of our medical workforce challenges deserve our determination and focus. At the heart of these problems is the ongoing supply of local GPs who are available to work in our hospitals.

Rural generalist doctors, known as GPs, are a crucial part of our primary care services, as you will hear from Dr Williams today. Their care helps us stay well and it can help us avoid illness and help us avoid needing care in a hospital. As well as working in their private practice, doctors sometimes also work in their local hospital as visiting medical officers or VMOs. They will work in the emergency department and admit patients to hospital beds. This is work that requires a particular skill set. Even when there are GPs available locally, not all doctors

want to, or can, work at the hospital. For the ones who do, it is challenging to find a balance between working on call, running a business and their personal life. When we cannot find a local GP who wants to be a VMO, finding fly-in doctors willing to commit to ongoing support for a community can be really difficult to source—

Ms CATE FAEHRMANN: Point of order: Can I just check how much of this is a repeat of what the Committee heard two weeks ago? Fair enough in terms of addressing the issues we had yesterday, but we have limited time and I feel like I have heard this statement in some ways before. Could you please not include the paragraphs we have already heard last time, which were of a generic nature? Could I suggest that he shorten his statement because I feel like we are running out of time?

The Hon. NATASHA MACLAREN-JONES: To the point of order: I am happy for the sum of that to come out of Government question time, if it needs to be on the record.

Ms CATE FAEHRMANN: Sure, okay.

The Hon. WALT SECORD: That's a fair compromise.

The ACTING CHAIR: In that case, I will leave it up to the witness and whether he wants to continue or shorten.

Mr McLACHLAN: Thank you, Madam Chair. I am mindful of the comments made by the Chair of this Committee at the Cobar hearing that no-one should pretend that everything in rural health is wonderful; we certainly do not. The challenges we face are not new and they are not ignored for a second. The reality for our communities is not lost on us, Madam Chair. Their health needs are critical in our everyday consideration of what we want and what we can provide. I give our commitment to listen, understand and continue to improve.

The ACTING CHAIR: Thank you. Dr Nott, did you have anything to add to that?

Dr NOTT: That's fine. I am happy for my colleagues to talk.

The ACTING CHAIR: Thank you. Mr Strickland, did you have a comment?

Mr STRICKLAND: Dr Williams will talk.

The ACTING CHAIR: Thank you. Dr Williams?

Dr WILLIAMS: Thank you. I would like to acknowledge the traditional custodians of the land we are meeting on and remind people that we live and work on Aboriginal land. I also acknowledge the Aboriginal Elders of this community, those who have passed and all Aboriginal people attending this meeting today. My name is Robin Williams and I am Chair of the Western NSW Primary Health Network. More importantly to me, I am a coalface GP and VMO, having practised as a rural GP in Wales for 10 years before emigrating to New South Wales. I have been a GP in Gulgong for 10 years previously and in Molong and Yeoval for the past 14 years. This will be my fortieth year as a doctor. Our small towns in this region are in crisis. The PHN has identified that there are 43 small communities which are at risk of losing GP services in the next five to 10 years as older GPs retire, or burn out and leave, or die and are not replaced by the new generation of doctors. Remedial action is required now.

There is a fantastic resource of committed people in our health services who care deeply about our communities, who are here to help with reforming health delivery—reforms that need to be radical. In my 24 years in the Central West, I have been honoured to serve on a number of organisations: as Chair of the Dubbo-Plains Division of General Practice, as Chair of the NSW Rural Doctors Network and as Chair of the Western NSW Local Health District, as well as numerous appointments to advisory committees, always advocating for rural communities. Many of those appointments have been ministerial appointments and have come from Ministers on both sides of the political spectrum. I have been happy to give advice from the coalface to anyone who sought it in order to try to move the reform agenda forward. I am happy to have constructive dialogue with anyone, but I fear that health becomes a political football that is kicked around to create sound bites for the media, especially at election times. I will put it in a historical context here: We cannot afford to "fiddle while Rome burns".

Health is too important to get caught up in the quagmire of State versus Federal politics. The only people who can lead us to find real solutions are you, our elected representatives. Rural health needs a unified approach involving Federal, State and local government coming together to get away from the perennial blame game. I have met many fine politicians on both sides of the political divide in both the Federal and State spheres, but while I am here to answer your questions, I first would like to pose a question to all of you. This is where my second and final historical quote is apt. Sixty years ago John Fitzgerald Kennedy was inaugurated as US president. His inaugural address contained this statement, which I will ask of you and of all politicians who have the means to facilitate the provision of equity of access and world-class health services to this, a First World, country if only you have the resolve: Ask not what your country can do for you; ask what you can do for your country.

The ACTING CHAIR: Thank you very much. We will now go to questions from the Government, crossbench and Opposition. We will start with 15 minutes of questions from the Hon. Walt Secord.

The Hon. WALT SECORD: Mr McLachlan, you heard my questions earlier to Dr Justin Bowra. What steps do you take when there is an adverse outcome or a death that occurs during a virtual doctor incident?

Mr McLACHLAN: Mr Secord, we take every adverse outcome or death very seriously. We have a lot of processes and systems in place to review what happens and come up with solutions and recommendations for the future. Mr Fahy is the head of a team of specialist clinicians who come in to investigate those incidents. I will hand over to him to talk about that.

The Hon. WALT SECORD: Mr Fahy, are there many "adverse outcomes"—I am using a medical phrase—deaths?

Mr FAHY: Thanks, Mr Secord. In the last year, for 2020, there were 11 of those types of adverse events that you would reference there today.

The Hon. WALT SECORD: So, 11 that occurred with virtual doctors in your local health district?

Mr FAHY: No, sir, 11 totally across the local health district. If you look at the presence or absence of a medical officer for those events, there were four of those events when there was not a medical officer present.

The Hon. WALT SECORD: So, four events. Are those called "SAC 1s"?

Mr FAHY: Harm score 1s, Mr Secord.

The Hon. WALT SECORD: So that is the top escalation?

Mr FAHY: Correct.

The Hon. WALT SECORD: There were 11 in the local health district. Four involved no doctor present.

Mr FAHY: That is correct, in the last year.

The Hon. WALT SECORD: Thank you. Continue please, sir.

Mr FAHY: There is a mandated process that is legislated, that those events undergo a root cause analysis investigation. That is a high-level investigation with internal and external people who come in and view each of those harm score 1 events and provide advice on what happened, what are the system recommendations and whether there are any personal or professional issues.

The Hon. WALT SECORD: When an incident occurs when a nurse is by herself in a hospital, is there a doctor watching the sequence occurring? Is there a doctor somewhere or is it just the doctor in Sydney and the nurse in the hospital by herself or himself?

Mr FAHY: Can you please clarify that further, Mr Secord?

The Hon. WALT SECORD: I am talking about virtual medicine, virtual doctors.

Mr FAHY: Yes.

The Hon. WALT SECORD: For example, we have been to Cobar. A nurse is by herself and calls Sydney for help. Are they the only two people on the sequence?

Mr FAHY: There is the nurse on the sequence with a headset on talking to the doctor and there are the other medical staff who may be present in the facility—nursing staff, it could be paramedic staff supporting the resuscitation.

The Hon. WALT SECORD: But that is a case when there is no doctor there. That is what I am referring to.

Mr FAHY: Yes.

The Hon. WALT SECORD: We have had four incidents in the local health district where four people have died because of that. What happens when a situation spirals out of control? When you have a situation where a patient is clearly dying or something is happening and they cannot be diagnosed, what happens?

Mr FAHY: We have a number of our nurses who are trained in advanced life support in a course called First Line Emergency Care. There are approximately 230 of those nurses trained in western New South Wales, and about 70 per cent of those actually live and work out in our rural settings. They are the types of nurses who are able to provide airway, get an intravenous line to treat with advanced supportive drugs.

The Hon. WALT SECORD: Of those four deaths that occurred where it was a virtual doctor in Sydney and a nurse here, how many have been referred to the Coroner?

Mr FAHY: All of those deaths, Mr Secord.

The Hon. WALT SECORD: All four have been reported to the Coroner?

Mr FAHY: Every sudden, unexpected death that we have where we are not able to immediately provide a cause of death or a death certificate for is initially referred to the Coroner—sudden, unexpected deaths.

The Hon. WALT SECORD: So, in your health district in the last year four deaths have occurred with virtual doctors that have warranted being referred to the Coroner.

Mr FAHY: Yes.

The Hon. WALT SECORD: Thank you, sir. I will move on to other questions. Can you tell me the names of those four hospitals?

Mr FAHY: I would need to take that on notice. I do not have that information with me.

The Hon. WALT SECORD: You will take that on notice and provide it to us. Mr McLachlan, how much does the local health district spend on virtual doctors? In the 2020-21 budget, how much do you spend on that?

Mr McLACHLAN: Mr Secord, we spend over $150 million on doctors in total.

The Hon. WALT SECORD: I am asking you a specific question, and I only have 15 minutes, sir.

Mr McLACHLAN: Sure. In our virtual services, about $4 million for a team of the Virtual Rural Generalist Service that supports all of our 33 small rural health services. On top of that, there are additional emergency specialists, intensive care specialists and a range of other specialists who contribute to that.

The Hon. WALT SECORD: But $4 million a year, thank you. Can I take you to the evidence? Will you guarantee today that the four hospitals in the Warrumbungle shire have antibiotics, incontinence pads and dressings? Will you guarantee that all four hospitals have everything they are supposed to have?

Mr McLACHLAN: They all do have supplies. If they need additional supplies, we can get those to them quickly.

The Hon. WALT SECORD: Will you guarantee that there is insulin at Canowindra?

Mr McLACHLAN: Sorry?

The Hon. WALT SECORD: Canowindra. It is my accent.

The Hon. WES FANG: It is his lack of locality.

The Hon. WALT SECORD: I will spell it if you want. I think you know which hospital. Excuse my accent. I have lived here for 33 years, but I still have it. I think you know the medical service I am referring to. Does it have insulin?

Mr McLACHLAN: I understand it does.

The Hon. WALT SECORD: Is it the fact that the operating theatre at Parkes Hospital is shut three days a week?

Mr McLACHLAN: We have increased surgery just recently. We are putting extra surgery into Parkes Hospital, so it is more than two days a week. It is sporadic on different days of the week to help us perform operations on more people.

The Hon. WALT SECORD: Do you have dietitians on duty on the weekend at Dubbo Hospital who are able to conduct sip tests? Are you familiar with sip tests?

Mr McLACHLAN: I am.

The Hon. WALT SECORD: Do you know what a sip test is?

Mr McLACHLAN: I do.

The Hon. WALT SECORD: Can you tell me what a sip test is?

Mr McLACHLAN: A sip test is the ability of a patient to swallow solid foods. It is performed in situations where patients have either been intubated or for other reasons.

The Hon. WALT SECORD: Is it a complex test to undertake?

Mr McLACHLAN: I am not a trained clinician in that area.

The Hon. WALT SECORD: Dr Shannon Nott, is a sip test controversial or complex to undertake?

Dr NOTT: No, it is not. It is actually not the remit of dieticians to do sip tests. That would usually be the remit of a speech pathologist or an appropriately trained nurse.

The Hon. WALT SECORD: Can a nurse or a doctor—can most people in a hospital conduct a sip test?

Dr NOTT: If they are appropriately trained, yes.

The Hon. WALT SECORD: But you said it was not a complex procedure to undertake.

Dr NOTT: No, it is not.

The Hon. WALT SECORD: Does your hospital at Dubbo now have a person who can do sip tests on the weekend?

Dr NOTT: Yes, I believe so.

The Hon. WALT SECORD: Do you know why I am asking questions about this? This relates to the tragic death of Mr Allan Wells.

Dr NOTT: Yes, I do.

The Hon. WALT SECORD: Are you now confident that there are people on duty who can conduct sip tests at your hospital?

Dr NOTT: Yes, I am.

The Hon. WALT SECORD: Are you also comfortable with the allegation that when he tried to remove tubes from his arm when he was in absolute distress, he was tied to the bed?

Dr NOTT: I am not familiar with the case that you are mentioning. My role—

The Hon. WALT SECORD: But it was our national television. It was on—

The Hon. WES FANG: Point of order—

The Hon. WALT SECORD: I will continue to be respectful, but this is an important line of questioning.

The ACTING CHAIR: Mr Secord, a point of order has been taken.

The Hon. WES FANG: I do not want to interrupt but I think it is important that all the witnesses be provided the ability to finish their answers before the Hon. Walt Secord jumps in again.

The Hon. WALT SECORD: Okay. Wes, I am sorry. I hear Wes.

The ACTING CHAIR: Thank you, Mr Secord.

The Hon. WALT SECORD: I am referring to the explosive *60 Minutes* report that we all saw, and I am referring to the treatment of Mr Allan Wells. Was any follow-up done or were any investigations taken after that?

Dr NOTT: Yes, there was. I will refer that to the director of clinical governance.

Mr FAHY: Mr Secord, there was an investigation into the death of Mr Allan Wells that occurred. It was a detailed investigation. It was submitted to the Ministry. There were some findings, recommendations and outcomes that have subsequently been implemented as a result of that investigation.

The Hon. WALT SECORD: What were the steps that were taken? What were the results of his death?

Mr FAHY: The steps that were taken—there were some obvious steps around better communication with the family. That was an obvious one. There needs to be better communication certainly between the orthopaedic surgeons and the family, particularly when there was a clinical deterioration of a patient. There were a number of recommendations—I do not have the report in front of me, but four or five of those recommendations, I understand, have been fully implemented at Dubbo Health Service as a result of that investigation.

The Hon. WALT SECORD: Mr McLachlan, how many nurses were on duty at Cobar hospital this weekend?

Mr McLACHLAN: This weekend?

The Hon. WALT SECORD: Yes.

Mr McLACHLAN: We would have three nurses.

The Hon. WALT SECORD: Earlier this morning we heard about a phenomenon called exit block. In Sydney we have something called trolley block, or we have ambulance block. We have ambulances queued up outside hospitals, but we have a different situation in country hospitals where we have what is called exit block.

The ACTING CHAIR: Mr—

The Hon. WALT SECORD: I can ask questions based on information provided. I will continue. Are you familiar with exit block?

Mr McLACHLAN: Yes.

The Hon. WALT SECORD: It is where there are not enough beds—Mr McLachlan indicated that he is familiar with the concept. Mr McLachlan, does exit block occur here?

Mr McLACHLAN: Mr Secord, we have over 800 acute beds across the local health district. On a daily basis all of our services prioritise the patients who are coming through our emergency departments who need admitting to hospitals and those who can go home or are referred to other services. On a daily basis they are decisions made by clinicians and our service managers in making sure that patients get to the right place of care. In some instances, we do not have the ability to discharge as quickly as we would like. What we have done is resourced a lot of support services out of hospital. They are being significantly enhanced at the moment, particularly I have seen an increased number of patients come through in wintertime typically. We recognise there is an issue and we continue to resource additional services to support that.

The ACTING CHAIR: I will ask the Hon. Walt Secord to move on to a different line of questioning, given the sensitivity of the topic of conversation.

The Hon. WALT SECORD: Okay, fair enough.

The ACTING CHAIR: Thank you.

The Hon. WALT SECORD: You said this morning that there were three nurses on duty at Cobar hospital on the weekend. I count right now that there are one, two, three, four, five NSW Health bureaucrats here. There are more bureaucrats in this room at this moment than they were at Cobar hospital on the weekend. I think that is a very good point to make.

The Hon. WES FANG: Point of order: Yet again, the Hon. Walt Secord has 15 minutes to ask questions to get answers out of this. It is not a chance to make a political statement.

The Hon. WALT SECORD: This was showing context.

Ms CATE FAEHRMANN: You have been doing it all the time.

The Hon. WALT SECORD: He is eating into my time, Madam Chair.

The Hon. WES FANG: You know, Walt, that you are supposed to be asking questions of these witnesses.

The ACTING CHAIR: Excuse me, could you please direct any part of a point of order to the Chair?

The Hon. WES FANG: Apologies, Chair.

The Hon. WES FANG: The Hon. Walt Secord well knows that the format for this is agreed: To ask a question and illicit a response from the witnesses. I would ask him to do so.

The Hon. WALT SECORD: To the point of order: My question goes to priorities. There are one, two, three, four, five senior bureaucrats brought to this inquiry to monitor our proceedings all day—

The ACTING CHAIR: I think that the question—

The Hon. WALT SECORD: —and then on the weekend only three nurses in a hospital.

The Hon. WES FANG: What is the question?

The Hon. NATASHA MACLAREN-JONES: Point of order—

The Hon. WALT SECORD: I think this Government has the wrong priorities

The Hon. WES FANG: Is that the best you can do as a stunt, Walt? Seriously?

The ACTING CHAIR: A further point of order has been taken.

The Hon. NATASHA MACLAREN-JONES: This is the Opposition's time. They might want to stick to asking questions rather than referring to members of the audience. He knows that he should never reflect on members of the audience who are here.

The ACTING CHAIR: We have just over a minute left for the Hon. Walt Secord. He has been very respectful and I appreciate that.

The Hon. WALT SECORD: I will leave my questions at that.

The ACTING CHAIR: Dr Williams, I note in the submission from your group that there was concern around patients in the area having difficulty accessing GPs in their practice so they go to the emergency department. Obviously that must put a huge amount of pressure on the emergency department. How did that affect the staff and their ability to attend to everyone that presents at the emergency department?

Dr WILLIAMS: That is a very important issue. Certainly, where I work in Molong, if we get too full in our rooms, the default position is the MPS and then the on-call VMO will be called, which is me. So I go from my rooms up to the hospital to see patients there if there is nowhere else to physically see them. We try to encourage people to be seen in the rooms whenever we can. Again, it comes back to the workforce. The workforce issue is the problem. The huge problem that we have is not—I think the real problem is we have to reboot all of rural health, certainly in the small towns, to encourage younger doctors to come out, which means the funding model has to change, we have to move away from purely fee-for-service to a blended model, and we need to have Commonwealth and State governments designing that with local input. That is the answer for the future so then we can move forward.

I have a very good relationship with my local MPS. The management there are very supportive. Telehealth has supported me to stay in that town. As the sole VMO for the last three years, apart from when my colleague Dr Zambo covers me for holidays, I am it. So for four days a week, I do 24-hour cover for my inpatients and I cover the ED during the daytime. On the other three days of the week I go in and do a ward round, sort out whatever is in the ED department and then I am off. That keeps me from being burnt out. If I did not have vCare, I would have had to leave long ago. If I had left, then my two registrars would have left with me, there would be no training opportunities for any young doctors, and Molong and Yeoval and the surrounding towns would not have had any GP services whatsoever.

We need to very quickly try to develop a new model of funding and—again, I cannot reiterate this too strongly—for Federal and State to work together to try to develop a new model of care. It is vitally important. I must say, I have had a very receptive hearing from Mr Mark Coulton from the Federal level. I must say, of all the States' Ministers who I have worked with across the political divide, there are two stand-outs for me. One was Craig Knowles and the one that stands out more than any of them—and there have been a lot of them since 1997 when I emigrated—is Jillian Skinner. She was really committed to rural health. So this is not a party political issue. That is why I am a little bit frustrated that it is going to degenerate into a shouting match between people across the political divide.

This is about rural health and our communities. We need politicians of all colours and from across the spectrum to work constructively to work out what is best for our communities because, as I said, if we keep on talking and having more reports and a new investigation, all we are doing is spiralling into a worse and worse situation where people of my generation—I am now 63. I am not going to go on forever. There will not be people to replace me in the future if we do not change the model to make it more attractive for younger doctors. We have got to do that.

Then, on from that, we have to make sure that it is more attractive for allied health and nurses because they are vitally important. I could not do my practice work without my nurse support. So we have got to rethink what we are doing. That is what I am here for—to ask you as our leaders, our elected representatives, to work with your colleagues as a matter of urgency to do something to support small towns in the Central West and beyond because the further out you go beyond, the worse the morbidity is, the worse the mortality is. This is meant to be a First World nation.

The ACTING CHAIR: Beyond the model that you talk about, I note that in your submission you also talk about the fact that, in rural areas, 23 per cent of households have reported no access to the internet. How is that also then affecting people who are seeking health care and do not have access to the internet?

Dr WILLIAMS: I think that is an issue. Certainly, as COVID came round, we found that certainly Zoom was not really effective to talk to our patients. Because we knew our patients, because they knew us, a phone call works very, very well. For telehealth, if you know your patients and they know you, a phone call works

very, very well. So internet is not a huge issue for that. It is the contact and knowing your patients and them knowing you. It is the personal touch. That is what people really want. While I agree we do have to have video health and support, especially in acute setting—having doctors on the ground whenever you can is what patients actually like. That is why I have got patients who still come and see me from Gulgong. I have left there 10 years. I have still got patients from Dunedoo. I have actually got patients in Lightning Ridge that come down to Molong to see me. It is the personal side of things which I think is very, very important, especially with an older population. The younger people do not really worry so much about that personal touch, I do not think. I don't know. It may be just that my patient cohort is getting older as I get older.

Ms CATE FAEHRMANN: One of the things we have been hearing—and we cannot really disagree with this evidence—is that there has been a systematic removing of resources from some hospitals in rural and remote New South Wales. For example, Gulgong and Coonabarabran. We have heard a number of witnesses talk about the fact that these are very different to what they were 20 or 30 years ago. Just to the situation of incontinence pads and dressings not being available sometimes in some of these hospitals, that is an issue of budget, is it not? We did hear, Mr McLachlan, that these hospitals have to buy within the parameters, of course, of a supply budget. Is that correct?

Mr McLACHLAN: Ms Faehrmann, we have got a budget of over a billion dollars.

Ms CATE FAEHRMANN: For each of these small hospitals. It's—

Mr McLACHLAN: Across the whole region. Our budget has grown over $250 million in the last seven years. Coming down to some of those facilities you talk about, Gulgong has in the last seven years seen a 49 per cent increase in their budget; Dunedoo, a 63 per cent increase in the budget. We continue to increase the budgets and the resources for towns that are relevant for the services they need to provide. The commitment we bring is to continually look for opportunities to increase services for rural towns. There are a lot of examples of when we do that. Certainly, the budget growth has been a significant part of that. But the big challenge for us is workforce, in finding the right workforce for all of our health services. As you have heard over a lot of these hearings, that is our most significant challenge.

Ms CATE FAEHRMANN: You are suggesting that there have been increases. Is this in the supply budget specifically or the budget for the hospitals?

Mr McLACHLAN: Total budget.

Ms CATE FAEHRMANN: Yet, of course, we have also heard of many hospitals being directed to not provide particular services anymore. For example, where they used to be able to operate or offer maternity services. So there has been a significant change over, say, the past 15 or 10 years in relation to many of these hospitals. Are you saying that the budget has increased at the same time while the services have been cut?

Mr McLACHLAN: Ms Faehrmann, there have been changes to services over the years. There is no question about that. The vast majority of the cause of that has been workforce availability. If I go to the example of Parkes maternity—it was raised earlier this morning. We have struggled for a lot of years to recruit the GP obstetricians, the GP anaesthetists, the midwives to staff those services. What we have done in response to that is grow a service connected across Parkes, Forbes and that region. That will be a service that is more sustainable.

Ms CATE FAEHRMANN: You would have heard yesterday, because you were watching that hearing as well, the evidence in relation to Coonabarabran hospital where examples of what the LHD has deliberately stripped away from the hospital include surgical instruments, obstetric labour beds, a CTG machine to monitor foetal movements and uterine contractions for pregnant women and their babies, cardiac stress test treadmill, neonatal crib and paediatric beds. What is that submission referring to?

Mr McLACHLAN: Ms Faehrmann, there is no question that as services change we will need different equipment and staffing for those services. There are things that we do not need in a service like Coonabarabran, where they do not deliver maternity services. A lot of those examples you gave are 10 and 15 years ago, when there was substantial change to some of those services.

Ms CATE FAEHRMANN: I think you would have heard Councillor Iannuzzi's evidence in relation to—I think it was the equipment used to undertake stitching or sutures for patients. He said that was one example, that the quality of the equipment seems to have been downgraded as well. What is your response to that?

Dr NOTT: I might jump in there. I heard the testimony of Dr Iannuzzi yesterday and his reference to surgical equipment. In all of our small sites, and across the State even in larger sites, reusable equipment is not uncommon, including suturing equipment. The equipment that was referenced was that there was a removal of autoclavable—which essentially means cleanable and reusable—equipment. However, doctors and nurses are provided the equipment that they require to be able to suture and undertake those procedures. Certainly, that is

the case at Coonabarabran. Mr McLachlan referenced that as services change so too does the equipment. So to recognise that or acknowledge that, if you look at Coonabarabran in recent years—there has been investment in a new anaesthetic machine to be able to provide anaesthetic services for colonoscopy patients that undertake colonoscopy in Coonabarabran. There has been special equipment to help in the event of an emergency in regards to video laryngoscopes. That is essentially a device that allows doctors in crisis situations to be able to intubate a patient while awaiting retrieval. There has also been investment in BiPAP machines for respiratory failure, high-flow nasal problems, which reflects the increase in numbers—

Ms CATE FAEHRMANN: I have got one minute left. Bathurst council also presented with their concerns in relation to what they have provided evidence about and what seems to be the case of quite substantially less resources provided to them compared to the other centres, Orange and Dubbo. What is the reason for that?

Mr McLACHLAN: Ms Faehrmann, quite the opposite. Bathurst has seen a greater percentage budget increase than both Orange and Dubbo. There has been substantial investment in Bathurst health services to grow orthopaedic services, to grow intensive care services and to increase the neonatal health support services.

Ms CATE FAEHRMANN: When you say percentage increase, could you just explain? Do you mean in terms of per capita or percentage in terms of the overall rise?

Mr McLACHLAN: Percentage on the basis of their total budget.

Ms CATE FAEHRMANN: Their evidence is still correct, though, is it not? The budget for Bathurst is $88 million, for example, compared to $138 million for Dubbo and $151 million for Orange but their population is slightly more than Orange and Dubbo. Is that correct?

Mr McLACHLAN: Bathurst's budget, that $88 million, has grown by 44 per cent in the past seven years. It is a significant increase; it is a larger increase on a percentage basis than Orange and Dubbo. We have invested in additional services for Bathurst, recognising that not just Bathurst but the communities around it—which do total around 60,000 in population coming into Bathurst—do need those additional services.

Ms CATE FAEHRMANN: But the overall population of Bathurst—for the numbers of people in Bathurst, the LHD is funding Bathurst less compared to Orange and Dubbo.

Mr McLACHLAN: No, but there is a greater population that comes into Dubbo. A population of 120,000 comes into Dubbo, about 90,000 into Orange and about 60,000 into Bathurst. There is a proportional difference between the populations that they serve and the scale of the services.

The Hon. WES FANG: Thank you all for coming and appearing today. Thank you to Mr McLachlan and Dr Nott for appearing again, having seen you already in Cobar. Dr Williams, thank you very much for your opening statement. I thought it was profound because what you identified was what we have been hearing throughout this whole inquiry. We know that GPs are effectively a Federal responsibility, hospitals are a State responsibility and we have heard from councils all across the State that they are feeling like they have to become involved in health care because there is a need to have a value add to health services to bring doctors there. As you said, people do not care which level does it or who does it. They just want the services and we need to find a way to work together, both State and Federal. I think that was really well enunciated in your opening statement. Being a PHN, obviously you look more at the GP component. Being State based, we would look at the component that we do. How do you see us being able to integrate what the State does and what the Feds do in order to start to tackle the issues?

Dr WILLIAMS: Thank you for your comments. It is a story I have told before, but I will repeat it for those of you who have not heard this. If a patient presents to Molong MPS with a condition and I go to see them and am paid for that by the State and then a week later I follow them up in my rooms then you have the same patient, the same condition, the same doctor and two funding streams—which is a nonsense. The first thing we need to do is to have a blended system between Commonwealth and State so that we can actually see where the money could be best spent. With that, I think that we could set up a system by which—it will be a blended system.

I do not want to de-incentivise health care; I think it is important for people to realise that if they work hard they get paid more. But I think we have to get away from this idea of just the business model of the MBS, which is universal across Australia. We need to enhance that in the country because we have higher morbidity, we have higher mortality, we have higher costs and a lot of younger graduates do not want to come and live in the country. It might be out of fear, it might be because their partners already have jobs in the city—all sorts of factors. We have to try to change that. The problem is not our workforce per se; it is that the market is wrong. There is a statement that says you cannot buck the market. Well, I think we have to change the market. We have to have intervention from all levels of government to change that so that rural health becomes something that can be supported and that younger graduates want to support. That is very, very important.

The Hon. WES FANG: And there really is a role for each level of government—both local government, State Government and Federal Government—working together on this, is there not?

Dr WILLIAMS: Absolutely, and that is something that the PHN has been working on. What we would like to see would be an entity set up with input from State, Commonwealth and local government and obviously local coalitions in which we can maybe set up a virtual practice to support different communities so we are not ending up with a bidding war between towns—which is what councils often talk about and which is something that is really destructive—something in which we can support other towns. For example, myself in Molong, I would be happy to remotely supervise other doctors but the trouble is I have to earn a living too. That is the business model, which I think is flawed. We have to start getting away from this idea of fee for service. Maybe we need to set up a totally different way of doing business, and that will need government support because no entrepreneur will go in and do something in really hard-to-deal-with areas. It has to be bankrolled by all levels of government and it has to have clinician input. That is the vision for the future that we need to have, because we need equity of access. Our country people deserve to have first-class services.

The Hon. WES FANG: Absolutely.

Dr WILLIAMS: That is so important, because if towns lose their GP services—I have a daughter. She is a teacher in Queensland. She will never go and work in a town that does not have a general practice. If you lose a general practice and the MPS, young people will not go and live and work in that town. You lose the town, the economy goes and we end up—people joke that NSW means Newcastle, Sydney and Wollongong. That will be the truth in the future except here it will be Dubbo, Orange and Bathurst.

The Hon. WES FANG: Not if I have any say in it.

Dr WILLIAMS: No, nor me either, because the lifeblood of this country is the rural communities. We have to support them; they deserve that.

The Hon. WES FANG: In your experience, as a State-based government, do you think that we have the ability to do this on our own and tackle these problems or will it be the case that we will need all three levels of government?

Dr WILLIAMS: I think you will need all three, but you can make a start from the point of view that obviously Government Ministers at Federal and State level have the power. That is what my opening address was about. You as politicians have the power to do anything in this country. You can close borders.

The Hon. WES FANG: Not us.

Dr WILLIAMS: No, but the point is it is still Government that can do that. If it can do that then there are all sorts of other things that governments working collectively can do. General practice is funded by the Commonwealth but the hospitals are funded by the State. Why can there not be a blended system where the money that the State puts in will come through to an entity and the MBS money plus some other money can develop a new model of care? That is the vision that we need. The problem is—I have been talking about this sort of thing for a long time to anybody who was willing to listen. But we are at the pointy end now because if my generation dies or retires or burns out, there will be nothing. If you think that telehealth is bad, that is all there will be.

The Hon. WES FANG: I really value that input and that insight because as we are travelling around, people are raising issues around GP services. As State members we say it is the responsibility of the Federal Government and the PHNs. People do not care. They want us to have that integrated system, so I really appreciate having those insights today. Thank you for that. I just want to turn to Dr Nott. I recall from Cobar I think you said that you worked in Canada for a time.

Dr NOTT: I have done research in Canada, yes.

The Hon. WES FANG: You have done some research in Canada. Over the lunchbreak I had a bit of a read of the—and I do not know if you were here when we had some evidence from Dr—

Dr NOTT: McCarthy.

The Hon. WES FANG: Neil McCarthy, yes. He was talking about this *Reimagining Primary Health Care Workforce in Rural and Underserved Settings* from Dr Roger Strasser. I note he was doing some research over in Canada as well. Can you provide some insights into that?

Dr NOTT: Yes. First of all I acknowledge the work that Dr McCarthy has done for our region and continues to do in Narromine. I agree completely with Dr Williams that general practitioners are the cornerstone of health care in all of our small rural and remote communities. That document that Roger Strasser has written does talk to the fact that rural generalists are required for small rural and remote communities. What we do not

need and what some of that document talks to is a fractured system where you create hospitalists competing with general practitioners in a small rural and remote community.

For us, I agree completely with Dr Williams' statements that we need to work together across State and Federal jurisdictions to be able to address some of the workforce challenges in the general practice space and to be able to address hospital workforce challenges. Roger Strasser set up the Northern Ontario School of Medicine, which I have been to and have met with and I know Professor Strasser personally. That is an opportunity for us to be able to look at: How do we grow our own? How do we create a pipeline of future rural generalists?

Our region is very lucky that we will, as of next year, have two medical schools that go end to end in terms of being able to deliver all of their training in a rural or regional environment. What we will need though is to ensure that those students get out to places like Molong, get out to places like Cobar, get out to places like Bourke and many of our other small communities, and get I suppose immersed in communities so that they are more likely to return. That is the first point. I could go on but I appreciate that there is a lot of questions.

The Hon. WES FANG: I just wanted to give you an opportunity to perhaps address some of what we have heard in the past couple of days. An inquiry like this can provide a very negative view of practising medicine in a rural remote community. Do you have some views on being able to attract a workforce after just the negatives are focused on without having any balance of the positive lifestyle benefits that can come from practising rural, regional and remote medicine? Have you heard of what we have heard about staff being attacked after some of the negative focus has been happening on these medical areas?

Dr NOTT: I think I will start with the last component of your question there. Our staff get up every day and do an incredible job and are committed to their rural and remote communities. They live in those areas and every person living in a small rural and remote community should be proud of the staff that live and work there. When our staff do hear stories, because of their dedication to delivering high quality care, it does affect them personally. I am aware of many of our staff in some towns who are physically and mentally affected by some of the stories that are heard. This does not mean that we should not be listening. We know that as a local health district, we do not get things right 100 per cent of the time, regardless of whether we have got face-to-face doctors, whether we have got virtual doctors, whether we have got nurses, allied health in any community. We need to listen to those stories, but we also need to move forward and part of our role is being able to understand how do we do better every day, and our staff are committed to that.

The Hon. WES FANG: Just finally I wanted to ask Mr McLachlan a question. I note the Hon. Walt Secord's last question about people who might be here to I guess look at and witness the hearings. Do you see that as a negative or do you perhaps see it as the local health district and the Department of Health taking rural and regional health seriously, and how important it is that we tackle some of the issues that are being ventilated and presented to this inquiry?

Mr McLACHLAN: I think to start off, we are all incredibly committed to rural health and we have all grown up in rural regions. We are here because this is our life, this is our family and our friends that we are caring for. I know right across the NSW Health system that the members of the Ministry that are here, they are here to listen as we are and here to find solutions to problems that we have been challenged by for a lot of years. The absolute commitment we bring is to listen and understand but also try hard. We will work harder for some of the solutions we need to find.

The Hon. WES FANG: I may be politically cynical but I suspect that he would have criticised had there been nobody here. Thank you very much for your answer.

The ACTING CHAIR: Thank you all for attending this hearing. I note that there were some questions taken on notice. The Committee has resolved that answers to questions taken on notice will be returned within 21 days. The secretariat will contact you in relation to the questions you have taken on notice.

(The witnesses withdrew.)

The Committee adjourned at 15:15.