REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

CORRECTED

At Smithurst Theatre, 144 Conadilly Street, Gunnedah NSW 2380 on Wednesday 16 June 2021

The Committee met at 9:15 am

PRESENT

The Hon. Greg Donnelly (Chair)

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

The CHAIR: Welcome to the sixth public hearing of the inquiry of Portfolio Committee No. 2 - Health into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. The inquiry is examining health outcomes and access to services, patient experience, and planning and capital expenditure in rural, regional and remote New South Wales. Before we commence, I acknowledge the people of the Kamilaroi nation, who are the traditional custodians of this land. I also pay respects to the Elders past, present and emerging of the nation and extend that respect to them and any who might be joining us on the internet today. Today we will be hearing from a number of stakeholders, including local community groups, local government, private citizens and medical professionals. I thank everyone for the time they are going to make available today to give evidence to this important inquiry.

Before we commence, I will make some brief comments about the procedures for today's hearing. Today's hearing is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available, which will be in a few days' time. In accordance with the broadcasting guidelines, media representatives—welcome to the media who are joining us this morning—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 they may make to the media or to others after they complete their evidence before the inquiry. 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 or 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 microphones. I confirm that there are two microphones before you. There are microphones for the room itself and there are microphones for Hansard. Everyone should have a microphone near them. If not, please move closer if need be. Finally, everyone should turn their mobile phones to silent for the duration of the hearing. I welcome our first panel of witnesses.

KATE McGRATH, Former Chair and Founding Member, Gunnedah Community Roundtable, sworn and examined

REBECCA DRIDAN, Chair, Gunnedah Early Childhood Network, affirmed and examined

REBECCA RYAN, Representative, Gunnedah Early Childhood Network, sworn and examined

JAMIE CHAFFEY, Mayor, Gunnedah Shire Council, sworn and examined

ERIC GROTH, General Manager, Gunnedah Shire Council, sworn and examined

The CHAIR: On behalf of the Committee, I welcome you all to the hearing this morning.

The Hon. TREVOR KHAN: Just before opening statements are made, I think I should make one declaration—or, actually, two. The first is that my wife and her brothers operate a business that operates in this town and my brother-in-law and sister-in-law live in the town. I only make that declaration in case.

The CHAIR: Thank you very much. The honourable member has done the right thing. We make a declaration of any matters that might be related to the hearing—even implicitly. Thank you to the Hon. Trevor Khan. That is noted. There are effectively three groups organised to give evidence for this first panel this morning. Your submissions have all been received, processed and duly uploaded onto the Parliament 's website. For the Gunnedah Community Roundtable, your submission is number 442 to this inquiry—as I am sure you know. For the Early Childhood Network, your submission is number 270 to this inquiry, and for the Gunnedah Shire Council, your submission is number 63. I say with respect to the shire council, thank you very much for some initial documents that have been provided. They have been circulated and all Committee members have a copy. I understand you will be referring to some or all of that over the course of the evidence.

I invite each group to make an opening statement and to keep it reasonably on point to enable the maximum time for questioning from members. There is no need to go through your submissions in detail—you can take them as read. Committee members will have read them. Bowl up a nice, tight opening statement to set the scene and then we will open up for questions. Just to confirm, we have a broad range of parties represented here today, which gives you good coverage of all the political parties in this State. That gives you plenty of opportunity to address any particular points you want across that broad range of representatives. We will start with the Gunnedah Community Roundtable. Would you like to commence with your opening statement?

Mrs McGRATH: Thank you, members, for meeting with us today and thank you to my fellow Gunnedah residents for sharing your experiences to inform our submission. I acknowledge the Kamilaroi people—the traditional custodians of this land. I pay my respects to Elders past and present and the emerging leaders to whom the future is entrusted. I recognise that due to the various structural, systemic and historical factors, the challenges to accessing health care are compounded for our Aboriginal community members. Today I am representing the Gunnedah Community Roundtable—a multidisciplinary inner agency for organisations and community members to share ideas, knowledge and resources to develop local solutions to local problems.

The round table has around 200 representatives from 85 organisations working in aged care, homelessness, health, education, disability, employment, mental health and child protection. Across all of these areas, there is a consistent barrier to supporting the most vulnerable and disadvantaged members of our community. That barrier is access to health care. The lack of GPs in Gunnedah is creating crises. A GP referral is required to access specialists and most allied health services. When a person is unable to access a GP, they are shut out of the entire system. This one limitation of service creates a ripple effect. How do we access NDIS services with no diagnosis? How do we access counselling without a mental health plan? How do we go to hospital if no doctors with admitting rights are available? How can chronic illness be managed without continuity of care? How can we get a check-up with no-one to check us? These are the unanswered questions that plague our community. Is it any wonder that we are sick for longer and die earlier?

It is the most vulnerable people who suffer the most. Consider an older person with a disability. His doctor left but he was not informed until he tried to book an appointment, when he was told that he was no longer a patient of that surgery and they had closed their books. Fortunately he contacted a community transport provider who advocated for him to become a patient in another town and transported him to get essential prescriptions that will prolong his life—driving 140 kilometres, a 2½-hour round trip, for a simple prescription. This is outrageous. And this happens every single day. Many of the roundtable services have developed stopgap measures including transport, partnerships with GPs in other towns, providing space for outreach and directly engaging and paying for allied health services. It is not the responsibility of community organisations to fix the healthcare crisis. None of this should rest on our shoulders and every one of these interim solutions is bleeding resources from a sector that is already severely underfunded.

The health system we all depend on is not working in the best interests of our community. We are tired of false promises from politicians and bureaucrats passing the buck. We were told in August 2020, when the rural health centre was absorbed by Hunter New England Health, that GP services would be re-established. This was untrue and 10 months later we are no better off. There are no GP services at that site. Where is the accountability? That site would be ideal for prescription clinics run by a nurse practitioner, for referral clinics to allied health or a psychologist and social workers who are empowered to do mental health plans. It could pilot from that site. But no, our State member, Minister for innovation, refuses to innovate. Our Federal member, Minister for regional health, refuses to provide health care for this regional town. Thank you, senators, for listening to us today and I implore you to make change.

The CHAIR: Thank you, Mrs McGrath. The next organisation is the Gunnedah Early Childhood Network. I invite one of the representatives to make an opening statement? Did you both want to make a contribution?

The Hon. TREVOR KHAN: Sentence about.

Ms REBECCA RYAN: We will not go the three minutes.

The CHAIR: I do not want to trouble you but if we keep it reasonably tight to maximise, but happy to share.

Ms REBECCA RYAN: I have been a resident of Gunnedah for 23 years. I came here as a journalist and worked in PR for 10 years and I have been director of the Gunnedah Conservatorium, where we came into contact with 200 community members and their families on a weekly basis for 10 years. I am married and I have three children. I am actively involved in their school and sporting communities and I see daily the impact of the lack of our primary allied health services on our community. Likewise, I have witnessed the impact on our family and ageing parents-in-law, as Ms McGrath has just pointed to. I am also a member of a group, PaediatRic and Maternity Support, which raises funds for our local health service and has directed, through grants and fundraising, close to three quarters of a million to our local hospital over the last 14 years, since the birth of my first child.

For this group I have just got a couple of little anecdotes much like Ms McGrath shared. One of our members, who recently had a baby, said she did not see much support for young families in the town and mums with new babies should not have to be driving 45 minutes to Tamworth to utilise services they should have in their own community. She had one appointment with the community health nurse after the birth of her first child. She realises now she was probably struggling with separation anxiety and a bit of postnatal depression. She had one visit that went for 10 minutes and that was the end of it. She was asked if she was happy and she said "yes" and she went home. The issues that people experience, particularly in postnatal, there is simply not the time to identify them. Every person will have a story like Ms McGrath has pointed out. A friend of ours says she will drive to Tamworth before setting foot in Gunnedah Hospital these days due to numerous ordinary experiences over the years.

It makes it a bit easier now that it is not so far for her as she lives halfway between the two towns. She cut her finger earlier this year and waited at the doors of emergency for over an hour before being acknowledged as arriving. She gave up and drove herself to Tamworth and she lost the top of her finger. You have our submission and it raises our concerns about the provision of health and allied services in the community. Rebecca Dridan will touch on that. We are invisible in regional New South Wales. You only hear about us if there is a fire, flood, a mouse plague or a drought. For the most part the issues that we experience on a day-to-day basis are ignored by the mainstream media and do not even make it to the Sydney papers. I welcome the inquiry today and I welcome the members of the Legislative Council being here and listening. I look forward to some positive impacts.

Mrs DRIDAN: I will be even briefer.

The CHAIR: Please take your time.

Mrs DRIDAN: My focus as the Chair of the Gunnedah Early Childhood Network is around early childhood, which is zero to eight years. During this period of life more than 90 per cent of a child's brain is developed and everyone knows the statistics of a dollar spent in early intervention and you get a $13 payback later on in life. This is evidence that is reported in paperwork from the New South Wales Government and accepted. The cost to our economy on a national scale is $15 billion in a recent report. I do not understand why we cannot invest more for our young children in rural areas, where we just do not have the same level of service that they do in metropolitan areas.

The CHAIR: Now to the council. Mr Mayor, thank you for coming along with the general manager. Would you like to make an opening statement?

Mr CHAFFEY: Thank you, Mr Chair. Firstly, I would like to thank all of the Committee members for coming to Gunnedah to hear passionately from the people, as you have just heard, also from other organisations. I would like to acknowledge the Kamilaroi people as the traditional custodians of the land upon which we gather and pay my respects to the Elders both past and present. What I would like to do is start with the recommendation the council would like to see come from this inquiry. Then I would like to move onto these four documents—three new documents that we have tabled this morning that I believe the members of the Committee will have a copy of—and highlight some of the information within those factual documents. Firstly, as I said, I would like to talk about what council would like to see as one of the major recommendations that comes from this Committee and that is that the State Government establish a Minister and a ministry team for regional health, in line with council's resolved position and the position that is now the position of the New South Wales Country Mayors Association.

The reason is to deliver on the endorsed recommendations of this inquiry, conduct a review of the local health districts and measure the level of delivery of service to the entire communities that are within their district and also for the value of money that is delivered, and to ensure that the State funding that may be required to effect changes as per the endorsed recommendations of this Committee is made available. The topic of this inquiry is one of great importance to the community of Gunnedah. From my conversations with local people right across our community—and that is talking also to all of the medical professionals, whether they be doctors, community or allied health services; anybody who is charged with offering that medical care for our community has been the highest priority with my conversations—the issue of health and lack of GP services is the number one priority for our community and an issue that we are facing.

The Gunnedah shire, as you may be aware, has a population just short of around 13,000 people and we are bucking the trend of population decline. Unfortunately, the ability for our community to access quality health services not only impacts on the quality of life of our current residents but it also continues to limit the growth of the community and therefore our economy. The first document that I would like to refer to for members of the Committee is our actual submission, submission 63. The inquiry I believe received more than 700 submissions. I will be quite brief as I refer to some of these documents. I would like to refer to paragraph six in our opening statement and that reads:

> Local GPs are effectively running a crisis medical service and preventative practice is non-existent. Those lucky enough to get an appointment with a local GP face long waits and appointments are significantly delayed or not sought until a health complaint has escalated to a critical level. The concept of an annual health check-up with a local GP is a luxury that is simply not attainable for many local people. The complete lack of preventative care has a compounding effect, creating further demand on local services and in turn further escalating an increasingly desperate situation. Undoubtedly, this will lead to a continuation of the ongoing decline in local health outcomes when compared against a metropolitan population [will be dire] and it may be many years before the full extent of this problem is apparent in [our community] health statistics.

Also in our submission council conducted a quick poll of our workforce with the limited time that was available when submissions were first called for. The details are within our submission, but shortly I will also expand on a further community-wide survey conducted conjointly with the NSW Rural Doctors Network and talk briefly about some of those statistics. That is all I will say in relation to our submission we put forward.

Secondly, I would like to refer to a document that members have before them, which is the Rural Doctors Network *State of Play of the GP Workforce in Gunnedah Shire*. In November 2020 council resolved to engage the NSW Rural Doctors Network to do three things: firstly, to collaborate with council, Hunter New England Health and other stakeholders to identify a short-, medium- and long-term approach to address the GP shortage within the shire; secondly, to consult with the representatives of medical practices in the community of Gunnedah; and, thirdly, to deliver a strategy that will list actions to address the GP attraction and retention for the Gunnedah shire to advocate to both State and Federal governments to achieve change.

One of the first steps was getting a baseline. So the state of play document that I have tabled before you is a really good document that talks factually about the medical situation within the Gunnedah shire and that is dated 15 February this year. I would like to refer Committee members to item 4.7.1. Again, it is a great document that I table and I encourage Committee members to continue to peruse through this at their leisure when the time allows. Item 4.7.1 talks about the doctor to population ratio. Initial analysis undertaken by the Rural Doctors Network shows that Gunnedah is currently serviced by 4.7 full-time equivalent GPs—a ratio of one doctor to 2,700 residents, which is well below the desirable ratio of one to 1,000. The Rural Doctors Network estimates that the bare minimum that should be required to serve a population is 13 full-time equivalent; a more desirable level would be more like 17 full-time equivalent.

I now move on to item 4.7.6, if we may, in relation to books closed—so talking about GPs. As a result, the last portions of our population are seeking their primary care needs outside of the shire and this is now escalating to a level that is placing pressure on neighbouring towns such as Boggabri, Quirindi and Tamworth. I am led to believe that in all of those locations now there are GP practices that have closed their books because

of the extra pressure that is coming from the Gunnedah shire. The next item—4.10.14—I would like to bring to your attention is in relation to inpatient services. The shortfall means that patients requiring admission are regularly and necessarily transferred to hospitals outside of Gunnedah—usually to Tamworth. Tamworth Base Hospital is an hour drive away and this is a two-hour round trip that places additional stress and pressure on families trying to support those who are ill. Not everyone is able or willing to travel to see a GP. People that cannot will either ignore their health complaints and not seek early intervention or attend the emergency department for care.

Residents keep getting told how important it is, and we all know how important it is to get regular check-ups to see your GP for tests. For certain ages it becomes more important than others. It would require taking time off work and travelling to a neighbouring town. Not everyone can afford to do that, and I fear that this inability to access preventative care locally will have serious impacts on people living in regional, rural and remote communities like Gunnedah in the years to come. I want to be clear that we are very fortunate and lucky to have great people working in our health system within the Gunnedah shire, which includes the doctors and all health service workers. These are dedicated people who do an incredible job with limited resources and under trying conditions a lot of the time. A new hospital is welcome and the news that that is coming—the $53 million commitment—is one that certainly has the Gunnedah Shire Council and the Gunnedah community entirely quite excited about what a difference that may make in helping us to attract doctors to come because they will have a fantastic facility to work in.

Currently, the lack of local GPs means that our hospital emergency department is now staffed mostly by locums. The issue that we have in Gunnedah shire is that locums do not have the responsibility or the ability to admit people who may need it into the Gunnedah Hospital. If you present and you need medical care outside of the emergency department, you are transferred to Tamworth if it is a locum because they are not able to admit you to the Gunnedah Hospital. That causes major concerns. Right through the document—and in a further document that I will talk about, the community survey, shortly—there are some quite concerning statistics that go into there, especially when it talks about birthing within our community.

The CHAIR: Mr Mayor, I say this reluctantly. We only have effectively 20 minutes left for the panel for the questioning till we have to move on to the next panel.

Mr CHAFFEY: I have two more documents—two more points, if I may?

The CHAIR: No, that is fine, thank you.

Mr CHAFFEY: I will be as quick as possible.

The CHAIR: I am sorry about the tightness of the time, but I just wanted to draw that to your attention.

Mr CHAFFEY: I do appreciate the tightness, Mr Chair, but I think it is important that we are able to articulate the concerns within this community.

The CHAIR: Of course.

Mr CHAFFEY: I will leave that document. As I said, it is well worthwhile reading that factual information that has been done by a very respected organisation in the NSW Rural Doctors Network. The next document that I would like to refer to is a mayoral minute from the Gunnedah Shire Council's April ordinary meeting, and that document itself has been tabled. I refer you to motion two within that document. That document reads:

> That the NSW Country Mayors Association calls on the NSW Government to establish a new Ministry called the Ministry of Regional Health with responsibility for driving urgent improvements to Health services in Regional, Rural and Remote NSW.

The reason that I table that is to bring to your attention that that motion was unanimously supported by Gunnedah Shire Council, then put forward to the NSW Country Mayors Association at their main meeting and was unanimously supported as well. So it now is a position of the NSW Country Mayors Association of advocacy to the State Government. The last document I refer to quickly is the NSW Rural Doctors Network results of a community survey.

The CHAIR: Yes, briefly.

Mr CHAFFEY: Very briefly. Since lodging our own submission, in which we did a straw poll basically of our own council employees because of the lack of time we had to put a submission forward, we, as part of that early work with the Rural Doctors Network—the second component of that was doing a community consultation. A survey, which listed 21 questions, went out to our community. We received 711 submissions, which is the largest single survey the council has done that has had a response from our community, which shows just the passion of our community about those concerns. Quickly I would like to refer you to three areas—4.2.2, if I may.

This question was, "In the past 12 months have you been encouraged by your GP practice to seek an appointment in another town?" The results were quite strong, with 69 per cent of respondents having been advised by their GP to seek services elsewhere because they could not be accommodated within their practice here within the Gunnedah shire. So a very significant number.

We go onto item number 4.2.3. This question relates to, "In the past 12 months have you made the choice to transfer to a practice in another town outside Gunnedah?" Sixty per cent of the respondents stated that they had decided to transfer to a GP practice outside of Gunnedah for their ongoing treatment in response to advice or of their own volition. That just shows the level of the issue and the acknowledgement of our community that you just cannot get in to see a doctor for any support. The last item which I would like to bring in follows item 4.2.12. I do know that I am out of time, but there is one sample statement there that really captures a lot of the issues that were put forward by respondents. I will not read that because I can see, Mr Chair, that I have used more than my allocated time. But I would encourage members of the Committee to read through that because it is a very true representation in terms of our community.

The CHAIR: I can assure you that we will read the material, yes.

The Hon. WALT SECORD: I am Walt Secord and I am representing the Labor Party. My first questions go to Ms Ryan and Mrs Dridan. In your submission you say that there are waits for paediatric services of up to two years and there are more than 700 children on the waiting list. What are the things that these children are waiting for? What are the services that they are needing?

Mrs DRIDAN: Predominantly the children that are on the waiting list are those that are not designated as a medical priority. So if, let's say, you present with a case that your child is having difficulty breathing, you will get in in a flash. If you present with a referral because your child is having behavioural issues, you will be on the waiting list for—well, I would speculate—longer than two years. That is in the public system with community health. There is another private rural specialist practice in Tamworth, which now has five paediatricians, which is fabulous—all fly in fly out [FIFO], but that is the nature of the beast these days. However, it is a private practice, so you will need to pay a lot of money to go and see a private paediatrician.

The Hon. WALT SECORD: But as a parent, developmental issues would be as important to you.

Mrs DRIDAN: In terms of early childhood, in terms of brain development, getting them ready for school—this is what we all keep talking about. We need to have our children ready for school. The Australian Early Development Census is still talking about one in five children not being ready for school. That is 20 per cent of our kids not ready to start school. How are they expected to do well and transition well into education and have a positive trajectory in life if they are not ready for school? We are talking about early intervention services that should be available across the board. Unfortunately, because we do not have universal services that cover children from birth through to school age, a lot of children just get missed. They fall through the cracks.

The Hon. WALT SECORD: We are a parliamentary Committee and we make recommendations to the Government. What do you want to see happen in regard to paediatric services in Gunnedah?

Mrs DRIDAN: I want a paediatrician in Gunnedah.

The Hon. WALT SECORD: You do not have a paediatrician?

Mrs DRIDAN: We do not have a paediatrician. There used to be a paediatrician who used to be delivered via outreach from Tamworth and that is through the community health system. Unfortunately, they have not been able to maintain their full-time equivalent allocation at Tamworth and so they have identified that they cannot reinstate an outreach service to Gunnedah because they cannot provide.

The Hon. WALT SECORD: What do you do if you cannot afford to drive to Tamworth or you cannot take time off work or you are a single parent? What do you do for paediatric services in Gunnedah?

Mrs DRIDAN: You pray that once your kids go to school, the school helps them.

The Hon. WALT SECORD: The school helps them?

Mrs DRIDAN: And it is too late. It is too late by then.

The Hon. WALT SECORD: Can you give me an example of a paediatric service that you know that a child—some examples that are desperate—protecting the confidentiality—

Mrs DRIDAN: Yes, of course. Allied health in particular: occupational therapy [OT], speech, even psychiatric and psychology services. Just speaking to the rural specialists centre over in Tamworth with the five paediatricians that FIFO, they can give a referral for an OT, but you cannot find an OT. They are completely overrun with clients. Part of that is actually a flow-on effect from the NDIS. Anyone who is familiar with the

NDIS in terms of what that has actually done for the cost of services too—if you have actually got an NDIS plan that is great. But, if you are living in a rural area too, quite often you have actually got to pay out of your NDIS plan travel money for that person to actually get to you. If you are a private patient or somebody in the community health system, they are already overworked.

We do not have the allocation for allied health. We recently had a meeting with our local representative from the primary health network [PHN] and our fabulous new health service manager, who is now permanent at Gunnedah, which we are really excited about, and a whole bunch of allied health specialists who are in town. But we need more of them. We are not allocated. Because we are so close to Tamworth, we are overlooked. We are expected to travel. Rural people—you may have come across this already—just get on with it. That is fine for people with resources. I have a very close experience with this. I have a child with disability but I have resources. I can drive. I can take my child to rural Far West. I can travel to Lord knows where for all of our specialist appointments. I have the resources to do that. But there are a lot of families that do not.

The Hon. WALT SECORD: For example, in your submission you say that there is at least a two-year wait. So a child could be waiting in fact—

Mrs DRIDAN: Forever.

The Hon. WALT SECORD: —for longer than they have been alive for a doctor's appointment.

Mrs DRIDAN: Quite often that is what they do, absolutely. The parents just have to wait until they get to school and hope school will sort it out. But schools are not the place for us to sort out developmental concerns for children. We need those services for them when they are young, when their brains are plastic and when we can actually have the most impact. The research is there. If you spend a dollar you are getting $13 back. How do you argue with those economics? You cannot out-argue that. But it is not a sexy topic, early childhood. We are not valued, early childhood. That is one of the purposes, the mission, of our Gunnedah early childhood network: See the value of our children and invest in our children and you will see the benefit in the long term.

The Hon. WALT SECORD: Ms McGrath, thank you for your submission. You touched on access to a GP in Gunnedah. What is the situation with GP services in Gunnedah at the moment? Are the books open? Are the books closed? How long is the wait for a GP in the city?

Mrs McGRATH: Currently I do not think any of the surgeries are taking on new patients.

The Hon. WALT SECORD: So what you do?

Mrs McGRATH: Well, the round table worked together. Currently GoCo, which is the community transport service, do a bus run to Tamworth three times a week. But again, that is a 2½-hour drive to pick up a script. Winanga-Li, which is the Aboriginal child and family centre, has partnered with TAMS—Tamworth Aboriginal Medical Service—to get outreach doctors once a week, but even then they are only able to see maybe seven people a day, if that. Realistically what actually happens is that people just do not go until—

The Hon. WALT SECORD: It is too late.

Mrs McGRATH: —they present at emergency.

Ms REBECCA RYAN: Can I just add that the books are closed, but also you might think you are a patient of the surgery and then you ring and then you find out that you are not anymore.

Mrs McGRATH: Yes.

The Hon. WALT SECORD: What do you mean by that?

Mrs McGRATH: An example of that might be—so Dr Parsons is one of our local doctors. He is wonderful, booked solid, overrun. When I was pregnant with my youngest child I was able to see him. I was prioritised. There were no issues there. He took excellent care of me. However, when I was no longer pregnant I was no longer able to see him. As a result, I am no longer a patient at that surgery.

Ms REBECCA RYAN: My father-in-law had a fall in his driveway. He had to go to hospital. He was admitted to hospital, treated—all okay—was told to get a follow-up with his surgery, rang the next Monday to book into the surgery that he has been a patient of for 40 years, and they said, "Sorry, your doctor has left here. You are not a patient of this surgery anymore." So my family are accessing services in Tamworth and they have ongoing medical concerns, so they now have a doctor in Tamworth. My son had a concussion. I could not get a follow-up appointment in Gunnedah. He was seen in Tamworth because his doctor is no longer in Gunnedah. His doctor whom he last saw in Gunnedah is now in Tamworth. I cannot make an appointment at that surgery in Tamworth either because their books are closed.

The CHAIR: Circle back.

The Hon. WALT SECORD: So what do you do if you cannot get into a GP?

Mrs McGRATH: You do not get into a GP.

Ms REBECCA RYAN: You just do not get into a GP.

Mrs McGRATH: That is what we are saying.

The Hon. WALT SECORD: But what do you do then?

Mrs McGRATH: You cannot get into a GP. You do not get into a GP.

Ms REBECCA RYAN: You go to emergency.

Mrs McGRATH: I do not understand what is hard to understand about that. We do not have doctors. If they are not there and if you cannot get into a doctor, that's it—end of the line. You do not get to see a doctor.

Mrs DRIDAN: The evidence is that we are seeing 1,000 more presentations to emergency in our region compared with metro areas because people are not getting in early.

Mrs McGRATH: What we would really like from you in that specifically in terms of—there has been lots of discussion about how to get more doctors. Nothing has come to fruition. We would really like to start exploring other options. Something we feel would be really beneficial is—in the local health space, currently you require a GP to do a mental health plan. You cannot move into receiving services, receiving counselling, any of that, until you have that mental health plan unless you are willing to pay and unless you are able to pay. We would really like for you to make a recommendation that psychologists and social workers be empowered to do mental health plans. They have the skills; they have the expertise. No-one is suggesting they should be able to write prescriptions—simply do the plans. That would make a massive difference in terms of relieving some of the burden of the GPs and also ensuring that people are able to get timely mental health services and avoid presentations at emergency. Prevent those crises happening.

The Hon. EMMA HURST: I want to pick that a little bit further out, Ms McGrath. You mentioned the mental health plans in your opening statement, but in your submission you also talked about expanding the scope of duties for registered nurses to be able to perform. Can you give us a bit of an idea about what you have in mind there and whether that is a position you have come to out of desperation because of the situation?

Mrs McGRATH: Absolutely. My understanding is that currently nurse practitioners who have done appropriate levels masters are able to take on some of those duties in terms of prescriptions and some of the assessment work. The issue that we have here is that if people want to further their career, they have to leave. That is just the reality. So what we would really like to see is support for nurses who are already here, who are already embedded in this community, to upskill and be able to perform some of those duties that might then relieve some of the pressure from the doctors.

The Hon. EMMA HURST: It sounds like the whole situation is very stressful. Are you finding that people are moving out of the area because of concern?

Mrs McGRATH: Absolutely. It is not uncommon, particularly when people make a decision to start a family, when people are ageing and develop more health issues—they are the two big points in time when people realise that Gunnedah is simply not a viable option in terms of them remaining in the community.

The Hon. EMMA HURST: Councillor Chaffey, you mentioned that there are long waiting periods. What do you mean by "long waiting periods"? What is a typical waiting period for somebody?

Mr CHAFFEY: I might refer you to that document, the survey from the Rural Doctors Network. There is a particular point there which talks about some of the respondents who have come. The second point, they are struggling to obtain an appointment in Gunnedah.

The CHAIR: What page is that?

Mr CHAFFEY: It is item 4.2 of the Rural Doctors Network survey results. Unfortunately, it does not have a page number.

The CHAIR: That is okay. Thank you. I have got the reference.

Mr CHAFFEY: If you go down to some of the comments on that second item, struggling to obtain an appointment in Gunnedah:

> Respondents spoke of the competition to obtain the few on-the-day emergency appointments—

that are available within the few medical practices that are here. So if you are actually able to see a doctor, if they will accept you, even if you are on their books, if you do not have an appointment you have to call. Several mention phoning up to 100 times before being able to get through and then missing out on the appointment in that case. Others mention the frustration of either not being able to obtain an appointment or having to either attend the Gunnedah Hospital emergency department or to find a new practice outside Gunnedah. Also the next item, 3, which is long waitlists for appointments in Gunnedah, "Respondents spoke of wait times of between two weeks to three months and more." That is if you are actually able to be seen at one of the practices within Gunnedah.

The Hon. EMMA HURST: That three months, is that including quite extreme cases of health issues?

Mr CHAFFEY: If you have an extreme case of issue with your health, you need to present to the emergency department of Gunnedah. And of course, as I have stated before, the problem is it is run by locums who are not able to admit you to the hospital. So if you are in need to be put into a hospital, you need to be put straight into an ambulance and sent to Tamworth, or if not it is an expectation that a family member or someone who might care for you would take you across to Tamworth if it is not an absolute emergency where you require an ambulance.

Ms CATE FAEHRMANN: I think you mentioned earlier, Councillor Chaffey, that GPs have closed their books here but you mentioned that GPs are looking in other areas at closing their books as a result of people from Gunnedah going to other places because they have closed their books here. Where does this end?

Mr CHAFFEY: The real concern that I and the community have is for those doctors who have been serving our community for a very long time. The 4.75 full-time equivalent doctors that are here in this community, they are under enormous stress and pressure. We are concerned about how long they can sustain that before they simply just give up because the pressure is too much themselves. So whilst the numbers are extremely low, we are at a critical point in our community of those who do provide medical care, whether they can sustain that for their own health themselves for any long period of time. So unless there is change, dramatic change, in a short period of time, the community of Gunnedah is at a crisis point; there is no doubt about it.

Ms CATE FAEHRMANN: It certainly seems like it is at a crisis point. You are talking about GPs having closed their books and, of course, then people go to the emergency department because they cannot get seen anywhere else. What happens at the emergency department? What are they receiving there? Are there enough doctors, nurses? Who would like to comment on that?

Mr CHAFFEY: There are also comments within that document but, again, time will not allow us to go through that.

Ms CATE FAEHRMANN: We do have the document in front of us. I will go to Mrs McGrath, if that is okay. I will have a look at that in a second. Mrs McGrath, you laughed?

Mrs McGRATH: Yes, that is hilarious. The concept of a hospital having doctors, what are you talking about? We have locums. Many of the locums are here—essentially we are in a position now where if you need to have a baby, make sure you have it on a weekday because you cannot have it on a weekend. Of the 4.75 doctors that we have, two of those are approaching retirement age. This is kind of well beyond crisis point. It is not just the fact that we do not have GPs, it is that the same GPs who are serving the community through the day are then expected to somehow service the hospital as well—that if the locums cannot admit, it becomes the responsibility of our local GPs to do that. It is ridiculous. It is absolutely obscene and it is dangerous.

Ms CATE FAEHRMANN: Ms Ryan?

Ms REBECCA RYAN: I just think it is important to note that lots of people will make the decision not to go to emergency at Gunnedah; they actually will drive straight to Tamworth. If you think your child has broken an arm, you will not go to Gunnedah, you will go to Tamworth. And actually, if they end up breaking that arm, you will end up spending the next six weeks over in Tamworth every week at the fracture clinic. Like my friend, who sliced a finger while cutting up a sourdough, she waited an hour and she did not even see anyone. She was waiting at the door and then made the decision to drive herself to Tamworth. When she got there it was quite significant. Normally when you go over to Tamworth Hospital and you end up waiting with children—and knock on wood, I have not had to do it many times—but I am told it is a Gunnedah reunion. Half the people who you meet in the waiting room or in the paediatric area are people from Gunnedah waiting.

Mrs McGRATH: And at night too—

Ms CATE FAEHRMANN: Sorry, I am sure this is not the first time that you have asked for help in terms of your health system here at Gunnedah. What have you done in the area of lobbying and advocacy? I might go to Mrs Dridan.

Mrs DRIDAN: In terms of the early childhood network, we initially went directly to Brad Hazzard as the health Minister. Where is a paediatrician? We are talking about early intervention, getting in early before things get more complex. We are starting at the bottom end, the basic necessities. It went back to Hunter New England Health, which said, "Look, I'm sorry, we don't have the resources to be able to provide a service to you." Then the health inquiry came along and, guess what, you guys have got the same thing basically. Why do we not have basic services for our children? The flow-on just continues in terms of the age span. The evidence is there in terms of what is happening in rural communities. They are ageing, you get more complex cases. You need preventative care, not bandaid approaches where you rock up to emergency and hope for the best.

Mr CHAFFEY: Can I just add to that question? I believe that was originally asked of me. If you look at survey item 4.2.12, it is on emergency department results. In that survey, item 4.2.12, it talks about the emergency department comments that have been made from our community. In my opening statement too I talked about a quote that captures many of the issues that responders spoke about, which is on the following page. If I could just quickly read it, that would answer in a nutshell what the community's position is.

The CHAIR: Could you give us the reference? I do need to defer to the Government members. Just give us the reference, if you do not mind.

Mr CHAFFEY: The reference is this is from one person who presented to the emergency department because they were unable to secure an appointment either locally or out of town to see a GP. This person arrived at 10.15 a.m., was attended to by a doctor at 6.15 p.m.—so some eight hours after—was very tolerant, spoke very well about the nursing staff and the locum who finally did see her but made comment about the fact the locum had not even had an opportunity to unpack his bag in his accommodation or even have a break because of the amount of hours that he had to do. She overheard the locum say to one of the nurses, "We really need two doctors here," with which this person agreed 100 per cent. It goes on but I will pull up there. It is a really typical response by members of our community.

The CHAIR: What is the paragraph reference you are reading from?

Ms CATE FAEHRMANN: Just the page number and the paragraph number.

Mr CHAFFEY: It is the survey.

The CHAIR: Is there a paragraph reference? That quote you just gave, was there a paragraph reference?

Mr CHAFFEY: What I just gave was throughout there, not just the paragraph. It is in the document in relation—it is the following page from 4.2.12. This document is a draft document. Unfortunately, there are no page numbers at this point.

The CHAIR: That is fine. I just wanted to get that for Hansard.

Mr GROTH: If the members may also refer to graph 20, it illustrates the 711 responses to a survey by the Rural Doctors Network—239 of those responses presented to hospital, 123 of those were admitted to Tamworth. So less than half were actually admitted to Gunnedah Hospital on presentation.

Mr CHAFFEY: Out of the obstetrics consultation, 64 in Gunnedah, there were only 31 births in Gunnedah. So where were the rest?

The Hon. TREVOR KHAN: Coming from Tamworth, the story of the shortage of GPs in Gunnedah, as long as the 30 years that I have been in Tamworth, has been the story that I have been aware of. Indeed, I did some of my practice here as a lawyer in Gunnedah, so I am very much alive that this has been an ongoing problem for a very long period of time. You do not need to convince me that there is a decided issue, but I am interested in—you do accept, do you not, that this is not a problem that has simply arisen in the last couple of years? It has been an ongoing problem. Indeed, in a way, it really reflects the time from when, would you agree, those old doctors who essentially started post-World War II began to retire, so back in the eighties? It has been an ongoing problem with a change in the structure of general practice. For instance, in Gunnedah, a lot of the GPs that you have got really have moved out of obstetrics almost entirely now. That is right, is it not?

Mrs McGRATH: One of our main doctors, that is predominantly what he does.

The Hon. TREVOR KHAN: Sure.

Mrs McGRATH: He is very dedicated in that area, and I know two other doctors support him heavily there. So I do not know that that is actually true.

Mrs DRIDAN: I think a couple have moved—two have also left town.

Mr CHAFFEY: Two of the 4.75 full-time equivalent doctors are still in obstetrics in Gunnedah.

The Hon. TREVOR KHAN: But the others are not?

Mr CHAFFEY: Certainly the problem has been there before. There have been previous moves by the community to try to improve the number of GPs, and that was successful.

The Hon. TREVOR KHAN: I think I remember Gae Swain talking about it when she was mayor.

Mr CHAFFEY: That is exactly right, honourable member. Unfortunately, the problem is far worse than it has ever been at the moment—down to 4.75. Those doctors, as it has been already mentioned, are copping a terribly hard time. They are not only under stress and pressure of the work, but they are copping abuse from people in the community about they should work longer hours, they should just see a few more patients and so forth. So it does not take too much brainpower to work out people are not going to hang around in those situations.

The Hon. TREVOR KHAN: Sure. I have only just come onto this inquiry, so I went looking for some material and I see that there has actually been some manpower analyses done across the medical profession and across Australia to look at this issue. I think it is Dr Anthony Scott from Melbourne University who looks at the change in the nature of the medical profession in terms of a percentage drop in the number coming out of university who, for instance, go into the GP field as opposed to into the specialties. There has been a long-term trend away from GPs. Are you aware of that?

Mrs McGRATH: Yes, absolutely. I think there are a lot of incentives for people to move into specialising in a particular area. There is not a huge amount of incentive to be a GP.

The Hon. TREVOR KHAN: Indeed, there is also the problem of getting the GPs out of Sydney, Wollongong and Newcastle as well. So there is a combined problem; you would agree with that. What we seem to have is a problem in rural areas, not just in Gunnedah but across rural areas, in attracting GPs to come and work in our communities.

Ms REBECCA RYAN: That is true.

The Hon. TREVOR KHAN: Is that fair?

Mr CHAFFEY: That would be a fair statement.

The Hon. TREVOR KHAN: If we have got that as the problem, that there is an essential structural problem across indeed Australia but certainly across rural Australia in, first, getting graduates to go into the GP area and, second, getting them into rural areas, then what are the drivers that would change that long-term trend, do you think?

Mrs DRIDAN: Trevor, I am hoping that you are talking to a lot of doctors about this because they are the ones that honestly will be able to give you the answer to that. We are not doctors in terms of attracting those people out.

The Hon. TREVOR KHAN: Let me tell you this. My father was a GP in Wollongong and he was talking 20 and 30 years ago about the change in the profession, the fact that when he had a very large—

Ms CATE FAEHRMANN: Point of order—

The Hon. TREVOR KHAN: No, no. I will explain it.

Ms CATE FAEHRMANN: It is a point of order because of the time and getting to a question.

The CHAIR: A point of order has been taken.

Ms CATE FAEHRMANN: I urge you to urge the member to ask questions of the witnesses as opposed to telling anecdotes and stories.

The CHAIR: I think he is coming to his point now.

The Hon. TREVOR KHAN: Let me and I will explain it. Twenty and 30 years ago this problem was starting to come to the fore and we have not solved it in that 20 or 30 years. That is a problem. Mr Chaffey, you have obviously spoken to your Federal member with regard to the level of Medicare rebates, have you?

Mr CHAFFEY: In the tabled document, you will see from the council meeting the first motion actually talks about—if I may just read it quickly.

The CHAIR: Sure.

Mr CHAFFEY: The first motion calls on NSW Country Mayors Association to call on the Federal Government to formally acknowledge that rural and remote New South Wales government areas are being seriously disadvantaged due to the lack of GP practices; increase the Medicare payments to general practitioners

who choose to practice in the regional and remote New South Wales; and reduce the Medicare payments to general practitioners in metropolitan areas to offset the increase of expenditure for regional and remote areas. Basically, yes, I have been speaking to the Federal Minister for regional health and that was a position that was unanimously supported by Gunnedah Shire Council to look at ways that potentially is going to help impact or make an impact of trying to encourage more doctors who are metropolitan based to come out into the bush.

That is the reason why Gunnedah Shire Council also resolved to bring in the Rural Doctors Network, because we are not specialists in this particular field but they are. The reason that we called them is to help the community, discuss with the community and medical professionals to put a strategy forward with short-, medium- and long-term objectives that will give us the tools we need to talk to State and Commonwealth governments about what changes potentially should be made and also the reason that I put forward from council, on behalf of our community, that recommendation or that wish that this Committee, as part of your final document, puts a recommendation forward that there is a new ministry established for regional health, with that Minister responsible for changing the outcomes for people in regional communities.

The Hon. TREVOR KHAN: I think you have probably got us all over the line on that one.

Ms REBECCA RYAN: You are right. This is not a new issue. When I was at the *Namoi Valley Independent* I covered a major event. John Anderson was the Federal member; Michael Wooldridge did a whistlestop tour of all the regional towns, looking at this doctors crisis about 20 years ago; Gae Swain was mayor. One of the outcomes was train more rural kids to become doctors and they will go back to rural areas. I think that does work, and we actually have two doctors that grew up in Gunnedah around that time. They are working in rural areas but just in Tamworth. So that does work.

The Hon. TREVOR KHAN: Yes, close but—

Ms REBECCA RYAN: Close, yes. So a mechanism. But I think the thing is—The Greens point about what have we been doing, we have been given lots of promises over the last 20 years. We thought the rural health centre was going to be the answer. We thought training rural young kids was going to be the answer. So over the last 20 years, every kind of five years there is a promise of something is going to be better or changed or it is coming; you just have to wait. Well, we are sick of waiting.

The Hon. TREVOR KHAN: The problem with the rural health centre was when it went out to tender, was it not? The people who actually responded to the tender were local GPs, essentially, just transferring?

Ms REBECCA RYAN: Yes, we understand that.

The Hon. TREVOR KHAN: It did not actually bring anyone else into the town.

Mrs McGRATH: That is untrue.

Mr CHAFFEY: I believe there was one.

Mrs McGRATH: Tamworth Aboriginal Medical Service did tender for that. They were unsuccessful. There was actually a proposition for several services to co-locate and reduce overheads and essentially enable them to make a bit more money and attract a few more people. So that is an untrue statement. There was a GP service that was willing to come out here that was unable to—because the decision was made to put services that we already have in that building.

The CHAIR: Thanks very much. I allowed this one to go over because this is obviously a group of organisations that had much to say and so you had well and truly more time than normally we would allocate. I know we could go on, but we have got to move on to the next panel. Thank you all very much for the passionate way in which you put forward your concerns about matters of health in Gunnedah and the region.

(The witnesses withdrew.)

LIZ JONES, Emergency Physician, Tamworth Base Hospital, affirmed and examined

DAVID SCOTT, Chair, Tamworth Medical Staff Council, and Member, Physician Group Tamworth Base Hospital, sworn and examined

The CHAIR: Thank you both for making yourselves available to come along and give evidence today. To both of you, just to confirm, we have got the submission for the Tamworth Medical Staff Council, submission No. 608, to this inquiry. It has been received, processed and stands as a submission on the inquiry's webpage. We have also got submission No. 348, which stands in the name of Dr Scott. It has been processed and sits on the inquiry's webpage. Can I invite an opening statement? But I have got to be tougher than I was with the previous witnesses. I have got to be ruthless, as I am reminded by everyone, except I do not take my own advice. I am not being frivolous because we have just got to work through this. Did you both wish to make an opening statement, because I will need to take time and provide a path?

Dr SCOTT: Slightly different, I think, but I will make it as brief as possible.

Dr JONES: Mine is quite short.

The CHAIR: I am sorry to do this, but it maximises the time for the questions. Please proceed.

Dr SCOTT: My opening statement will be fairly brief: to say who I am, the three reasons why you should listen to specialists in the country, and two areas where you can put your attention. I am a gastroenterologist, a specialist physician working in Tamworth, serving an area of almost 200,000 people, which goes from the Queensland border to the Upper Hunter and the Newell Highway to the Great Dividing Range, and I represent the specialists at Tamworth Hospital and a physician group in particular, of which I am one. Also, I am married to one of the few paediatricians in Tamworth, so I have got some kitchen-table experience of those issues as well.

There are three reasons why I think we need to think about specialists. I have read some of the transcripts and submissions and a lot of the focus is on general practice, and that is entirely appropriate. Affordable, reliable, local and sustainable general practice is the cornerstone of our health service. But there are three reasons why specialists in the country also need attention. Firstly, I think it oversimplifies rural health to say that everyone who does not live in Sydney lives in a small town staffed by one or two close-to-retiring GPS. At least half of the people who live outside the cities live in or near regional centres and they expect local specialist care. The second reason is that the ratio of patients to GPs is well known—it is worse in the country—but, in fact, the ratio of patients to non-GP specialists in the country is even worse. For example, if I worked in the city I would be expected to look after about 20,000 people in Sydney, while for almost 10 years I was the only person for almost 200,000 people. So it is a big difference, and that is a greater ratio than you would see with GPs in the country.

Thirdly, rural specialists support rural general practice. GPs in the country like to have a personal local service so that they can refer patients to the person they know, they can call me up on the phone, get advice—all this ad hoc sort of work that we do with the GPs. The old model of a rural generalist who wants to and can do everything, that is not really going to be the way of the future. These new GPs will want to have local specialist services to help them to work in places like Gunnedah, knowing that there are paediatricians, gastroenterologists and other specialists nearby that can help them to maintain their quality of health care locally. There are two areas where I think we need to put the attention on rural specialists: Firstly, it is with the workforce, but attracting doctors to this region is difficult for all the reasons that you are familiar with.

But think about the specialist training pathway; they cannot train in the country for the vast majority of specialties, they have to go back to the city; the training is longer usually than that for a GP. So come their mid-30s, they have got a partner with a job in the CBD, a couple of kids in school—why would they leave Sydney to come to the country at that stage in their life? It is a very awkward time to move. So the trouble in getting specialists here is it is harder. Local health services need more flexibility in being able to attract these specialists. Some of that is with financial incentives, obviously and sadly, but it will be flexibility to be able to say you can have a visiting medical officer contract as opposed to just a salaried doctor; flexibility to say we are going to create theatre space for a new surgeon, "We are going to make theatre space for you so that you can come and work here"; flexibility with guarantees of how much on-call they are going to be able to do.

Other specialists are attractive for their specialty. We need to have constructive, creative models that can attract specialists out of Sydney by saying "Here is a package which should look really attractive to you. Come and move to Tamworth", or places like that, "so we can employ you there." The second area I think that we need attention with rural specialists is with training. The training colleges for specialists are inevitably urban based and, like their members, are urban focused. They do not appreciate the opportunities, but also the limitations of country hospitals for training; so their workforce is heavily geared towards putting the trainees in urban centres. They are

not supported as well when they come here and we need to have trainees here so we can showcase what it is like to live and to work in these rural areas.

The CHAIR: Thank you very much. My one and only quick question: When you say "urban", are you talking Sydney only?

Dr SCOTT: Sydney, yes—and Newcastle and Wollongong.

The CHAIR: So there is training in those respective cities as well.

Dr SCOTT: Yes.

The CHAIR: Thank you very much. Dr Jones.

Dr JONES: Thank you for the opportunity to provide both a written submission to the inquiry and provide evidence today. My focus would be on the inequitable treatment of junior doctors who decide to live and work in regional and rural settings. This is an issue that affects all junior doctors during their hospital training years regardless of their final specialisation, be that as a hospital-based specialist such as myself or as a GP working in a small rural town. As I stated, I am an emergency physician. I provide specialist emergency care in regional emergency departments—I am in Tamworth at the moment and I have been there for the last decade. During this time I have been involved in the education and training of junior doctors as well as in their recruitment and career progression including their term allocations.

Junior doctors often rotate between hospitals to gain different clinical experience. Currently, under the junior medical officers [JMO] award and employment conditions, metropolitan-based junior doctors who are retained to work in regional and rural settings will be paid an increased salary and provided accommodation plus flights back to Sydney every seven weeks, simply because they are rotating. This means that two junior doctors who are at the same stage of training, working the same role in a regional or rural location, will be paid differently simply because one is rotating from a metropolitan hospital. This also impacts the rotation of the regional- and rural-based junior doctors to metropolitan locations as they will have to find their own accommodation and there is no change to their salary. This is a disincentive for junior doctors to work in regional settings.

As was covered in the previous session, there are a number of factors influencing medical practitioners' decisions to work in regional and rural locations. This includes being in a rural location and spending time in a rural location during training. The current award employment conditions do not encourage junior doctors to work and live in regional settings. With the Chair's leave, I submitted two documents to table. These are specifically the JMO award, so the Public Hospital Medical Officers (State) Award 2019. Obviously, it is quite a lengthy document. The relevant clause, just for the record, is clause 28, which is labelled "Secondment", and that is where the conditions being paid an increment and travel every seven weeks back to Sydney are covered. And then the other document is a NSW Health policy document, which is *Employment Arrangements for Medical Officers in the NSW Public Health Service*, and in there, paragraph 6, which is "Rotations to Country Locations", salary increase is reinforced and accommodation if rotating is also included there.

The CHAIR: Doctor, just with respect to the award itself, the Public Hospital Medical Officers (State) Award 2019, where is the clause for the rates of pay? I have got the allowances at the back.

Dr JONES: There is a separate document.

The CHAIR: On notice, could you provide the rates of pay, which probably is part C, I presume.

Dr JONES: I can provide that.

The CHAIR: Thank you very much. Just to confirm though, there are three documents: there is the one that is from the Royal Australasian College of Physicians [RACP]—is that yours, Dr Jones?

Dr SCOTT: That must have been mine.

The CHAIR: That is fine. So there is Dr Scott's, the award and the policy directive. Thank you very much for that.

The Hon. WALT SECORD: Dr Scott, earlier you said that the Tamworth Hospital services an area involving 200,000 people. How many operating theatres are there in the hospital?

Dr SCOTT: We have got five operating theatres, which run all day five days a week, one of which is just for emergency cases and not booked. The other four are for the elective procedures and semi-urgent cases.

The Hon. WALT SECORD: I would like you to clarify that because in the submission it says that Tamworth Hospital has eight operating theatres.

Dr SCOTT: There are rooms.

The Hon. WALT SECORD: But only five are funded. There are eight but only five in operation.

Dr SCOTT: Yes.

The Hon. WALT SECORD: What is happening to those other three operating theatres?

Dr SCOTT: Currently one of them is being used as some catch-up from the backlog from the COVID shutdowns, but otherwise that will be empty. Then they are used for storage and places to make a quiet phone call. That is the use at the moment.

The Hon. WALT SECORD: You have in total eight, and at worst times you are nearly using up to six.

Dr SCOTT: Five are allocated in a normal situation.

The Hon. WALT SECORD: The two or three empty ones are used for a quiet space, storage or if you have to make a telephone call. You could call up your wife, call up your girlfriend—that kind of stuff.

Dr SCOTT: For some people.

The Hon. WALT SECORD: Are you familiar with a concept called ghost wards or ghost operating theatres?

Dr SCOTT: Kind of, yes. My submission initially was targeted on the issue of ear, nose and throat surgeons to this region, of which we have none. Twenty years ago when I was an intern—

The CHAIR: Sorry, Dr Scott, what surgeons?

Dr SCOTT: Ear, nose and throat.

The CHAIR: ENT.

Dr SCOTT: ENT, yes. Twenty years ago when I was an intern here, there was an ear, nose and throat surgeon—did a wonderful job, retired and has not been replaced. One of the issues is that at the moment if an ear, nose and throat surgeon said, "I love Tamworth. I want to move Tamworth. I put my kids in school. I bought a house," the hospital I am not sure would be able to offer them operating theatre time, which for a surgeon is just their job. I am not sure whether they would be able to offer them a visiting medical officer [VMO] contract or a staff specialist contract. Certainly the award they would be offered would be identical to the award they would be offered at the hospital in the next suburb where they are currently living in Sydney. There is no incentive to come here. There is no guarantee. Why would you relocate? If it is already a huge cost to come to a country area, why would you come when there is that little guarantee that you are going to be able to do the work you want to do?

The Hon. WALT SECORD: These three empty theatres, is there enough patient need that if you had the doctors or you had the facilities you could fill up those three empty theatres?

Dr SCOTT: We could certainly use more. While we would like to deal with the backlog of the people who are waiting and we would like them to be seen quicker, because obviously that would be great, one of the big opportunities to use those theatres for would be to get new services to Tamworth.

The Hon. WALT SECORD: Such as?

Dr SCOTT: Ear, nose and throat, vascular surgery, plastic surgery, more oncology surgery and for all the things that patients at the moment have to travel to Newcastle. While Gunnedah is an hour from Tamworth, Tamworth is four hours from Newcastle or five or six hours from Sydney. These are long trips that could be avoided if there was more diversity of local specialists.

The Hon. WALT SECORD: But is Tamworth not one of the largest country cities in New South Wales?

Dr SCOTT: We have the busiest emergency department outside the metropolitan areas. We are one of the biggest hospitals. As you have heard this morning, plan B is always to go to Tamworth. We are Tamworth. We get a lot of referrals from Tenterfield out to Coonabarabran and Walcha and Murrurundi. All of these places, they come to us. We are struggling to have enough specialists and enough diversity of specialists to cater for them.

The Hon. WALT SECORD: What about the impact of Gunnedah Hospital on Tamworth? Would it not be easier for patients if they were actually treated at Gunnedah Hospital and admitted to Gunnedah Hospital rather than going to Tamworth?

Dr SCOTT: The staff, and in particular the GPs, I know in Gunnedah do an amazing job well and above and beyond what any other GP would be expected to do. They are priceless in terms of their value to the health system. But obviously if they could hang onto people here, they would steal people that we need to look after over

there. We try and support them as much as we can with keeping people here if they can, but with issues of admitting rights and who has got to look after that, it is piecemeal and patchy and inadequate.

The Hon. WALT SECORD: Can we go back to the three empty operating theatres. There are 200,000 people in the whole region. Is it not frustrating to see three empty theatres?

Dr SCOTT: Very frustrating. That is why I made the submission.

The Hon. WALT SECORD: What can the Berejiklian Government do to get doctors and get patients in those three ghost theatres?

Dr SCOTT: Looking after a patient in the country costs more than looking after a patient in the city. You cannot just apply the same award, the same funding models to Tamworth and Gunnedah as you do to Mona Vale and the North Shore. You need to have flexibility and management needs to be able to offer a package which is going to attract new specialists, specialists where they are most efficient to an area and so we can use those theatres to improve services.

The Hon. WALT SECORD: You said that you have been here for 20 years.

Dr SCOTT: Ten years this time. I did my first two years here and then I had to go back to the city to specialise for eight years and then back here after that.

The Hon. WALT SECORD: Were you born and raised here?

Dr SCOTT: No.

The Hon. WALT SECORD: Did you come here?

Dr SCOTT: I came here straight from university. I am from Canberra; my wife is from Nana Glen near the coast.

The Hon. WALT SECORD: You came here, you stayed and you loved it.

Dr SCOTT: I still love it.

The Hon. WALT SECORD: What attracted you to Tamworth?

Dr SCOTT: One of the incentive schemes to get doctors to the country is those medical students—to pay them. I could marry my wife at university, we got a scholarship and that supported us through the last two years of university. Then we had to repay that scholarship by coming somewhere country. We chose Tamworth for a few different reasons. We had a great time here professionally and personally and we knew we would always end up working somewhere like Tamworth once we specialised. Once we had specialised we looked around and Tamworth was the best fit for us at that time.

The Hon. WALT SECORD: What patients would you send from Tamworth to Sydney via the air services?

Dr SCOTT: Medically, as in they would be retrieved? Dr Jones might be better actually at answering that one.

The Hon. TREVOR KHAN: You should ask about Newcastle as well.

The CHAIR: John Hunter.

The Hon. TREVOR KHAN: John Hunter.

The Hon. WALT SECORD: I stand corrected. I meant Newcastle or Sydney.

Dr JONES: Obviously that will depend on their condition. Looking for, say, a special service such as in neurosurgery, cardiothoracic—the common thing would be someone who has had a brain injury, a head injury from trauma. The cardiothoracic—someone who has had significant chest trauma, someone who has had significant trauma, say, to their pelvis angiogram, again during an injury. To Sydney we would send people who have had acute spinal cord injuries, and probably the largest group we either transfer medically, or the patients will make their way down there, is actually burns surgery. Particularly as the winter months come, expect to see as usual large numbers of small children who have burnt themselves. They will usually make their way privately to Westmead Children's Hospital. Fortunately very rarely are they unwell enough to need medical retrieval, but definitely the service is provided there. Adolescent mental health services are based in Newcastle.

The CHAIR: Dr Scott, on the matter of the cost of treating patients, you said in an answer to the Hon. Walt Secord that the cost of treating patients, as a general statement, is more outside the major cities. Forgive me for my ignorance, but with respect to the calculus used by NSW Health and with respect to looking at its local

health districts [LHD], is that factored into the way in which the funding is looked at? If you do not know the answer, you do not know the answer. Those LHDs either mainly or totally exist out away from the major population centres, Newcastle, Sydney and Wollongong. I am wondering whether or not those are looked at through a lens where the treating of patients is X more per cent or some other formula for the determination of the cost which factors into the way in which the budgeting is done for that LHD. Can you shed any light on that?

Dr SCOTT: I am not sure. I think you are talking to Mr DiRienzo this afternoon.

The CHAIR: Yes, I just thought I would bottle it up. That is fine. Thank you, Dr Scott.

The Hon. EMMA HURST: Dr Jones, you talked in your opening statement and obviously in your submission as well about the inequitable treatment of junior doctors who actually reside in the regional areas. Are you finding that regional junior doctors are actually leaving out of frustration because of their concern about the difference in conditions?

Dr JONES: They often have to leave due to training requirements. But, as was also mentioned earlier, people who choose to live in regional centres often just get on with it. The ones who have chosen to spend most of their time in Tamworth but then wish to do, say, a subspecialty term in Newcastle because they wish to enter the surgical training program and they wish to do one of the subspecialty terms down there, they will often just stay with university friends and basically they manage to find a way around it.

The Hon. EMMA HURST: Do you find that probably the biggest area it is affecting is actually recruiting people into the area that will live in the area? Is that the biggest issue?

Dr JONES: Yes, it can be an issue. In my opinion, it also sends a view that if you go and work in a regional centre you are worth less than someone who is rotating from a metropolitan centre. I suspect that is the bigger issue—that it paints a picture that we are worth less because we live and work in a regional centre than someone who has rotated through a metropolitan centre. It also does reflect the previous view that to staff places regionally you had to send people from metropolitan centres. The idea that people would want to come and work in a regional centre just because they want to come and work and live in a regional centre is sometimes difficult for people to understand, and that we can actually be the place where people base their training and then—as in Dr Scott's case, to do gastroenterology—you do have to spend a significant proportion of time away.

But in my training program you do not. In terms of emergency medicine, you do not have to spend quite as much time away. But the idea that people could stay with us and rotate to a metropolitan site to do their extra training as opposed to being based in a metropolitan site and rotate to us is just a different mindset that those living and working in metropolitan centres do not always quite understand.

The Hon. EMMA HURST: With all that in mind, what sort of recommendations would you like to see come from this inquiry, particularly around the unequal pay and other incentives to ensure that there are people retained in those regional areas?

Dr JONES: To level the playing field in the first place. It needs to be level. It is not level at the moment. It then becomes a separate issue of actual incentives to encourage people to live and work and train in regional settings.

The Hon. EMMA HURST: Dr Scott, my colleague was asking a lot of questions about those unfunded operating rooms. I think your submission also talked about one of the ways to actually attract additional staff is to have more operating space. So when we are talking about an incentive package to encourage more people to move into the area, what needs to come first? How do we actually structure that? I know obviously we have all been talking a lot about the financial incentives, but there is more to it than that. So how does the Government actually approach this to build it and make it work?

Dr SCOTT: I think if, say, we were to use the case study of the ear, nose and throat [ENT] surgeons, you would go to the ear, nose and throat surgeons and say, "Look, this is how much operating theatre time we would like to give you a week. We are actively recruiting our second ones so that at the most you will be on call one in two. We guarantee that we are going to give you this much money to travel up to see your family in Sydney or to get an education, because obviously if you are the only one of a specialty in an area you cannot get your education in that area. We are going to maybe incentivise you financially by giving you an out-of-award package that will suit you and that we can make work as well. Here it is on paper. Please sign at the end." That is the way, rather than wait for them to come to you or put a job in a paper saying "We are going to give you the standard award and when you turn up then we can start talking about whether there is theatre time or not." That is what is happening at the moment and that is clearly why there is no-one here.

Ms CATE FAEHRMANN: Dr Scott, I just wanted to pick apart, a little bit, something in the submission of the Physician Group Tamworth Base Hospital, which I understand you are also a member of. You raise the

issue of basic physician trainees [BPT] and the lack of basic physician trainees in your submission—you wrote the submission, did you?

Dr SCOTT: No, Dr Stephen May did, who could not be here today. He is away. But I am happy to speak to it, yes.

Ms CATE FAEHRMANN: I quote from the last page of the submission, that the Hunter New England Health BPT network:

> …would like to expand registrar numbers in Tamworth, but is being blocked by senior executives who refuse to fund Tamworth appropriately.

The submission refers to multiple meetings, I understand, with the local health district, "who all agree that there is a clear discrepancy that must be addressed", but "nothing happens. There is no funding." Then the submission refers to the local executive and that it:

> …does not have any decision-making authority or financial power. This inevitably results in resources being allocated to the Hunter area rather than being allocated on equity and need principles.

So, firstly, there is a clear frustration that the local executive does not have decision-making authority or financial power. Could you just reflect on that? Because that is a change in the way in which our health services are managed, is it not?

Dr SCOTT: I guess there is a history behind this. You would be aware that the health service used to be very big and then they were decentralised largely and so most country areas are run by country hospitals. But ours is, I think, almost unique in that we have Newcastle as our head office, which is obviously very urban but covers a huge rural area as well. There is a sense amongst the doctors, our specialists, at Tamworth Base Hospital that local problems cannot be solved by local people because they have to be solved by the people in the head office in Newcastle. There is a perception that of course if you work one floor below the chief executive in Newcastle you are more likely to get his ear than some doctor, who knows who, out in wherever, who just has to rely on email and has never put a face to the name. So there is a frustration that perhaps local decisions cannot be made because of the way our area is structured.

Ms CATE FAEHRMANN: How important is it, from your perspective, to be able to have that local decision-making power over the health needs of your local community?

Dr SCOTT: It is very important. Yes, look, I think local problems are best solved locally for these sorts of issues. Because every geography is a little bit different and having no ENT but lots of whatever specialty might be different to how other hospitals are run. I think also the training colleges need to have some ownership of this as well. They are national, in general. They do not appreciate local issues and in my experience they are just as culpable because they make all these requirements about what training must look like and smaller hospitals find it hard to reproduce that. They are sort of designed around city hospitals. I think the document that ends up in front of the diagram shows what a disproportionate amount of trainees are in the cities as opposed to where the patients are, which is 30 per cent of them at least in the regional areas.

Ms CATE FAEHRMANN: You advocate the need for increased funding in Tamworth to the LHD, who seems to agree, but nothing of course can happen because it is not the LHD who—well, the LHD is deciding the funding, is that correct, between Newcastle and Tamworth?

Dr SCOTT: It is one of these awkward situations where the college just determines what those training requirements are but they do not fund any of the training positions. That is up to the hospital system to fund the training positions. Obviously, the trainees may be from Newcastle and want to stay in Newcastle. They are easily employed in Newcastle and so that is where they seem to be disproportionately retained and fewer of them—as Dr Jones was saying, it used to be this model of having to toss a few out to the country to do some work there. Well, we see a lot of people here. We could provide really good training. Our trainees like spending time with us, but we have vastly inferior ratios of trainees to patients than the city hospitals do.

The Hon. TREVOR KHAN: Can I just address that last observation, Dr Scott? Has there not been a meeting between Michael DiRienzo and local physicians in the last couple of weeks over this basic physician training issue?

Dr SCOTT: Yes. So that issue has improved recently with three new ones.

The Hon. TREVOR KHAN: Right. Well, just stop there—with three more. So Ms Faehrmann was asking you questions with regard to the position and actually between the time that this submission was made and now there are three additional basic physician trainee positions being created in Tamworth?

Dr SCOTT: Which is still well below what the ratio would be in the city.

The Hon. TREVOR KHAN: I am not doubting that. But the position is—I think the proposal was for four extra in the submission—three are coming to Tamworth.

Dr SCOTT: The proposal was for eight more. That would enable us to have a 24-hour service like Tamworth needs and other hospitals have.

Ms CATE FAEHRMANN: Thank goodness you put it in the submission.

The CHAIR: Just for the record, who is the gentleman you referred to and what is his title?

The Hon. TREVOR KHAN: Michael DiRienzo. He is the Chief Executive of Hunter New England Area Health Service.

The CHAIR: Okay. I am saying for the purpose of Hansard and the record, I think we need to know who that gentleman is.

Dr SCOTT: We are very grateful for that progress, but it came at the point where we basically had to tell the trainees' college that the conditions that they were being employed under in Tamworth were not fair on them and certainly not what the college was expecting. We had to risk being disaccredited as a hospital, which means our registrars would not be able to be credited for the time they spend with us. We had to risk putting that on the table, which is a big hand to play, for us to make this sort of last-minute move to get some more but nowhere near what we actually need.

The Hon. TREVOR KHAN: Sure. Were you aware that when the health districts were being restructured—a lot of them were broken up again—that actually it was the specialists, particularly in Tamworth, who argued against the breakdown of the Hunter New England Area Health Service? They did not want to go back to what had existed before.

Dr SCOTT: My information is different to that, but I have not got the numbers.

The Hon. TREVOR KHAN: I remember sitting in those meetings, doctor. I remember very well sitting in those meetings where they argued against a de-amalgamation.

Dr SCOTT: If Tamworth's problems were unique in rural New South Wales then maybe we could discuss that further, but I think the problem is widespread here. I am trying to stay at a bigger level.

The Hon. WES FANG: Thank you both for appearing today. Dr Jones, I just wanted to touch on your testimony first, if we could. When you are talking about the medical officers in the hospital that are employed by the hospital under the award that you have provided to us today, that is for residents, registrars and the like to actually come and work in the hospital, be based out of Tamworth and are employed at that hospital. Correct?

Dr JONES: Yes.

The Hon. WES FANG: When you are referring to those that are seconded, you are referring to doctors that are employed by a hospital or a health service that is outside of the area—potentially in Sydney or the like—that have actually paid for rent or a house or have their family based there and then are seconded to supply that medical service to Tamworth. Is that correct?

Dr JONES: It will vary. The vocational training programs will often rotate their trainees to Tamworth to provide a service. By the same token you will have, say, emergency medicine trainees rotating—sorry, when the trainees are rotated by the service in Tamworth, the training programs, they are also training. So Tamworth is providing their training and education as well. It is not just a service provision. When Tamworth-based trainees rotate to, say, Newcastle or into Sydney, which is pretty seldom because of the conditions, they are under the same conditions that those people from Sydney are—rotating up with their families left in Tamworth and paying rent in Tamworth as well.

The Hon. WES FANG: I guess what I am looking at is those that are seconded into Tamworth are doing so usually for a training provision that they are under, say, with the children's hospital or from John Hunter with one of their training programs. Is that usually how it is or are they actually just coming here to provide a medical service as per what the hospital would require?

Dr JONES: There is always a combination of training and service provision and definitely—we are a training hospital and so we are training every day. Both Dr Scott and I are training junior doctors who also in turn are training the junior doctors below them.

The Hon. WES FANG: The doctor that is coming under secondment and the doctor that is employed by the hospital, they are performing the same roles but they are effectively doing it under different circumstances.

One may be training for a position and one is actually working within the hospital. Is that correct? When you say that they are actually being paid differently for the same job, they are not really doing the same job are they?

Dr JONES: Yes, they are doing the same job. They are doing the same job. They are providing the same care to the same patients.

The Hon. WES FANG: While that is correct, they are under different programs and training. Isn't that correct?

Dr JONES: No. They might be under different specialty training programs, but within that same specialty training program they are providing the same care to the same group of hospitals—the same care to the same patients.

The Hon. WES FANG: I accept that. There has got to be an acknowledgement that people may be doing the same role, but they are doing it under different circumstances. That is what this award recognises. I just wanted to tease that out and see what it is that you considered was different in the way that the role was being provided.

Dr JONES: It is the same role and people who rotate elsewhere—so emergency medicine trainees who need to go and work in other locations, they have to work in a tertiary hospital. There is a requirement in the training program. If they rotate out, they will work the same role that their fellow emergency trainees will do in, say, that Sydney hospital or that Newcastle hospital, leaving their family in Tamworth and travelling back and forth. So they are doing exactly the same role but, by this award, they will not be provided any support for accommodation, they will not be provided flights back to see their family and they will not be paid up a grade. Whereas their colleague who is providing exactly the same service and being trained in exactly the same way will be paid that.

The Hon. TREVOR KHAN: What is the grade worth? If you are being paid up the grade, what is it worth?

Dr JONES: I would have to take that on notice to make sure I get it absolutely right. But there is also the accommodation costs, which is a major issue.

The Hon. TREVOR KHAN: Particularly going into the city.

Dr JONES: Yes.

The Hon. WES FANG: I guess the final part of that is: What is the solution then to actually make sure that people are paid on similar rates for the same job?

Dr JONES: If you are moving for your education or training and to provide a service, you should be treated the same way—be that if you are coming from Sydney and coming to Tamworth or if you are going from Tamworth and you are going to Newcastle or Sydney, you all should be treated the same. Your employer is basically being part of the role of moving you and so you should be paid the same. You should be paid the same allowances, essentially—for use of a term that people would recognise, allowances and conditions—if you are moving around the State to further your education and training and to provide a service, rather than what we have now.

The Hon. TREVOR KHAN: Who were the parties to the award? Obviously NSW Health is one of them.

Dr JONES: I would have to take that on notice in terms of the exact details.

The Hon. TREVOR KHAN: Has there been any representation—and this is not a criticism of you—made by you to the employee association with regards to your very legitimate concern?

Dr JONES: Yes. I have raised it in talking to the Australian Salaried Medical Officers' Federation [ASMOF] and also in meetings at State level with NSW Health. It was also raised by our State member in Parliament in 2018 following an inquiry from one of the other specialists at Tamworth.

The Hon. TREVOR KHAN: Taking into account that this is an industrial award, it is going to be between the parties. I am not being critical of anyone in that regard. It would require either the respondent unusually in their award—that being NSW Health—to either make an application to vary the award or the representative professional body to make the application. I understand what you are saying and the legitimacy of it. I am just wondering why that application has not been made up until this point.

Dr JONES: I understand that it is a difficult—I am not saying it is a simple issue. Part of it is the award and part of it is the policy directive. The award covers the salary and the flights and the policy directive, which is

not an industrial award, covers the accommodation issue. I am definitely not suggesting at all that it is an easy issue. It is more to raise this as an issue and that we have junior doctors who are being treated differently simply because they live in the bush.

The Hon. TREVOR KHAN: I know accommodation is available in Tamworth. Is that same style of accommodation provided, for instance, down at John Hunter or at the Mater?

Dr JONES: No.

The Hon. TREVOR KHAN: Really? So it all has to be on the private market down in that sort of environment.

Dr JONES: Yes.

The CHAIR: The point, Dr Jones, is that it has been raised and re-raised. The point you are making has been ventilated over a period of time.

Dr JONES: Yes.

The CHAIR: It is not a new issue.

Dr JONES: No, it is not a new issue. It has been recognised for a long time.

The Hon. TREVOR KHAN: I am not taking it that way either.

The Hon. WALT SECORD: In the submission here there is one sentence that jumps out at me, "There are long periods of time where junior staff do not have medical registrar." What does that mean?

Dr SCOTT: Which submission?

The Hon. WALT SECORD: It does not have a number, but it is page 2 of the submission if it was numbered. What does that mean? Does that mean these junior doctors are working overnight with no senior doctors?

Dr SCOTT: That has become a big issue. Most urban hospitals would have junior doctors working overnight and then there would be a registrar or a trainee from each of the main specialties and/or, inevitably, a medical registrar—at least one who would cover the issues that occur on the wards or through the emergency department overnight. Tamworth, until recently, did not have any medical registrar overnight. So after 9.30 to 10.00 o'clock at night when one goes home then we have always relied on the senior doctors in the emergency department and the intensive care unit to look after our medical patients after hours. Clearly they are getting busier and realising it is outside their zone as well. Recently there has been a stopgap measure to have some locum medical registrars overnight but it is inadequate and it is really why we need vastly more than the three extra medical registrars that have been given to us recently to actually staff a 24-hour medical registrar roster.

The Hon. WALT SECORD: How much experience would these junior staff have? Are these young men and women fresh out of medical school?

Dr SCOTT: Usually first, one, two maybe three years out of medical school. First one or two years, yes.

The Hon. WALT SECORD: The first one or two years.

Dr SCOTT: Out of medical school.

The Hon. WALT SECORD: And how much experience would a registrar have?

Dr SCOTT: Maybe the junior would be three or four years, maybe as many as six.

The Hon. WALT SECORD: So what does a junior doctor do who is working nine o'clock until eight o'clock in the morning? What do they do if they get into trouble?

Dr SCOTT: They would, until recently, have to go to the intensive care unit senior doctors or the emergency department senior doctors to get some advice. They are always welcome to phone up the specialists. Some issues can only be solved by people on site. That is the process that has worked so far.

The Hon. WALT SECORD: How long was the situation in place?

Dr SCOTT: Until the locum medical registrar overnight started in the last few months.

The Hon. WALT SECORD: How long was Tamworth Base Hospital—

Dr SCOTT: Without medical registrars overnight?

The Hon. WALT SECORD: Yes.

Dr SCOTT: I do not know. We would never have started them until then.

The CHAIR: Perhaps on notice if you are able to establish when that was that would be appreciated.

Dr SCOTT: In the 1800s.

The CHAIR: The 1800s? That is fine. On behalf of the Committee thank you very much not just for coming along today because I know you are very busy; but also we acknowledge your professionalism and the work you do on behalf of your communities. Obviously you are both exceedingly well regarded. I pass on our thanks to you—if you could pass on our thanks to your colleagues—for the great work you do on behalf of the citizens of Tamworth and the region.

(The witnesses withdrew.)

KATE RYAN, Private citizen, affirmed and examined

ELIZABETH WORBOYS, Private citizen, sworn and examined

The CHAIR: Thank you for making yourselves available. With respect to your submissions—and you both made submissions—Ms Ryan your submission, which is No. 239 to this inquiry, has been received and processed and is on the Committee's webpage. Ms Worboys, your submission is No. 501. All Committee members have had a chance to read your submissions. In your opening statement there is no need to go through in detail what is in your submissions. Just keep them reasonably short and that will open up the time for maximum questioning. I invite you both, starting with Ms Ryan, to make an opening statement.

Ms KATE RYAN: I am really pleased to have the opportunity to speak today. I am speaking as an individual working within the New South Wales public health system. I have been a registered nurse for 17 years, graduating from the University of Sydney in 2004 with a Bachelor of Nursing degree. Subsequently, and at my own expense, I have completed three graduate certificates in nursing education, intensive care nursing and, more recently, in diabetes education and management. I am now studying my masters in nurse practitioner studies through the University of Sydney and I am due to complete this course in November this year with the intention of becoming an endorsed nurse practitioner specialising in diabetes management early next year. At this stage, despite me investing my time to improve the public health system, there has been no reciprocation from NSW Health to create a diabetes nurse practitioner position for our area or any planning for this to occur.

I am speaking today to address issues around nurse practitioner recruitment and to promote the role of the nurse practitioner in regional and rural New South Wales. I see this as offering possible solutions to some of the issues facing clinicians and patients regarding their diabetes management in particular. There are several Medicare item numbers available for nurse practitioners to use in private practice, and in public health sites which have a 19 (2) exemption in place—I have tabled that document for your reference—nurse practitioners are also able to claim these Medicare item numbers.

The CHAIR: That is the document that is headed "Improving access to primary care"?

Ms KATE RYAN: Correct.

The CHAIR: Please proceed.

Ms KATE RYAN: Globally diabetes is the fastest growing chronic condition. It affects 280 Australians who are newly diagnosed every day. That is equivalent to one person every five minutes. Diabetes is currently the sixth leading cause of death globally. It is an expensive disease. It costs our economy an estimated $14.6 billion every year. The in-hospital costs account for about 43 per cent of this expenditure. So it makes sense to me to invest in an area that is targeted at preventing hospitalisations and complications associated with diabetes. Diabetes rates are higher for those living in remote areas, estimated at 12 per cent compared to non-remote areas at 7 per cent. The prevalence of diabetes increases as the level of remoteness and socio-economic disadvantage increases. Nurse practitioners currently practise predominantly in metropolitan areas. That is the second document I have tabled for your reference, the nurse practitioner statistics.

Sixty-six per cent of nurse practitioners are reported to be working in metropolitan areas. Nurse practitioners are part of the fabric in metro hospitals yet they are denied access in rural areas by a lack of resources and funding. Nurse practitioners help to allow their clinical colleagues, whether that be other nurses, general practitioners, specialists, et cetera, to function more efficiently. We are a team. One of my medical colleagues who also was asked to speak today but who could not be here provided me with what I thought was a really fantastic analogy for the situation. In metro and rural hospitals we are all being asked to play the same sport, for example, cricket, yet we do not all have access to the same team members. The rural sites are often going without their specialist bowler that we need to make an efficient team.

It is my strong recommendation to this hearing that more nurse practitioners be introduced into rural and regional New South Wales and that there is a geographical equity in the distribution of nurse practitioners across LHDs when allocating positions. It is time rural and remote communities had greater access to these services as your postcode should not predict your health outcomes. Thank you very much for the opportunity to present my views today.

The CHAIR: Thank you for that very concise and clear opening statement.

Ms WORBOYS: I too would like to thank you for this opportunity to speak. As I said, I have lived a rural lifestyle for the majority of my life. I am actually born and bred rural. I have become a clinician and a manager and had to deal with all the roles and responsibilities that that involves at a small site with one manager on site at any time. Recruitment issues, seeking and addressing accreditation and credentialling of medical officers

and nurses takes up the majority of my time as we do not have the staff to fill all vacancies. I encourage nurses to undertake further education to pursue advancement and help with this system to improve it. I, like Ms Ryan, have undertaken multiple courses in education to improve my knowledge so that I can work in a rural location. The smaller the site, the greater the need to be multiskilled. We cannot have junior staff expected to work on duty with one other nurse.

As a patient, the past six months have not been good to me but I have had the experience of going away and coming back to find my GP has left and I have no doctor and dealing with that. How other people in the town deal with that who do not have a background in health is worrying and concerning to me. As a carer to an ailing father and dealing with his health needs and ensuring that he has the appropriate health care that he requires is my greatest desire. We have been fortunate so far with how he has been dealt with but I see others who do not have that luxury—not being able to have their patient admitted to the local facility and being sent elsewhere to be treated without the family being able to go. It is a difficult time, it is difficult issue and I would like us all to work together to improve it.

The Hon. WALT SECORD: Ms Worboys, in your submission you say that in your view the rural health situation is the worst that you have seen.

Ms WORBOYS: Yes.

The Hon. WALT SECORD: How long have you been in the rural health system?

Ms WORBOYS: I have been a registered nurse for 25 years and a midwife for 20 years. I have only not worked in the rural system when I have been away training so that is probably a period of three years. But when I became a midwife the reason I became a midwife was that I could not get a position in a rural facility because they did not need generalists; they needed midwives. So I elected to undertake the training to be able to come back and be employed in my local town.

The Hon. WALT SECORD: When you say your local town, are you referring to Gunnedah?

Ms WORBOYS: Yes, I am.

The Hon. WALT SECORD: So you have been here 25 years?

Ms WORBOYS: Yes.

The Hon. WALT SECORD: Earlier the Hon. Trevor Khan, who represents the National Party—

The Hon. TREVOR KHAN: No, I don't. I happen to be.

The Hon. WALT SECORD: Okay, Trevor Khan, who was elected as a National Party member—

The CHAIR: I think we know how the questioning should be done, so let us proceed.

The Hon. WALT SECORD: He made the observation that for the past 30 years this has always been the situation in rural health. But you say you have never seen it—

The Hon. TREVOR KHAN: That is not quite what I said.

The CHAIR: Listen, let us ask the question.

The Hon. WALT SECORD: What do you see as the deterioration in what areas, and what do you think has caused that?

Ms WORBOYS: The deterioration has been not only the availability of medical services to the local town but also the ability to train and retain nursing staff to positions. When I came back 25 years ago we had 12 or 13 doctors in the town and, as I said, I could not get a job as a generalist nurse because they did not need them. But they needed midwives and I was willing to—you let me come back and get a position and I will go off and do the training and pay my own way. That is just me because I want advancement. But over time we have lost that. We do not have local people who go off and train and come back to their local towns. The system changing more to non-work-based type training has taken away positions that were filled by people whilst training. My current role is manager of Boggabri MPS. For us to take on a new grad registered nurse is very hard because it would mean having an extra position to ensure that they were supported and not left with trying to deal with the management of a facility after hours. They are just some of the issues.

The Hon. WALT SECORD: You are manager of the Boggabri MPS. Do you have an emergency department at Boggabri?

Ms WORBOYS: Yes, we do.

The Hon. WALT SECORD: Do you have doctors on duty at Boggabri?

Ms WORBOYS: We are fortunate that we do. But Ochre Health, who runs the medical centre in Boggabri, when our last GP and his wife, who was also a GP, left, they were unable to attract fully qualified general practitioners who had completed training. We have two training general practitioners at present.

The Hon. WALT SECORD: Sorry, two training or trainee?

Ms WORBOYS: Trainee.

The Hon. WALT SECORD: What does that mean? Are those junior doctors?

Ms WORBOYS: They are junior doctors. Usually what would happen is that there is meant to be a qualified member of the—sorry, I cannot remember, but the organisation that trains doctors. The RACGP.

Ms KATE RYAN: The Royal Australian College of General Practitioners.

Ms WORBOYS: Thank you, Ms Ryan. So there is no-one on site to do that role so they are being managed remotely.

The Hon. WALT SECORD: When you say "remotely" do you mean that two trainee doctors are being managed by telephone and video camera?

Ms WORBOYS: Correct.

The Hon. WALT SECORD: So these two trainee doctors, what do they do when they are in the facility and something urgent happens?

Ms WORBOYS: They ring Tamworth.

The Hon. WALT SECORD: They ring Tamworth.

Ms WORBOYS: Yes.

The Hon. WALT SECORD: Do they ring Tamworth very often during a shift?

Ms WORBOYS: They are on-call for, say, seven days, 24 hours a day, and they would probably ring at least once a shift—once, maybe two, maybe three times during a 24-hour period. It depends on our presentations to the emergency department. We average, or we were averaging, approximately 50 presentations per month, which was a gradual increase. I know it sounds like a small number but when you only have two beds and two nurses on duty it is a big workload.

The Hon. WALT SECORD: So you must experience or view the pressure that the trainee doctors and nurses are under. Are they under a lot of pressure in Boggabri?

Ms WORBOYS: They are at times, especially in areas where—for example, palliative care, which can be stressful and distressing for many people. We try to work with them and encourage them to seek assistance from Tamworth to get the advice that is needed because sometimes they are hesitant to acknowledge that they need assistance. Whereas if it is someone sitting in the room across from them it is very easy to go and knock on a door and ask a question. They will come to senior nursing staff and ask for their opinion. One of the areas in small sites that I think, supporting Ms Ryan, is nurse practitioners. That could be very beneficial.

The Hon. WALT SECORD: Okay, I hear you on that. Do you see a role for nurse practitioners to assist in MPSs?

Ms WORBOYS: Definitely.

The Hon. WALT SECORD: What kinds of presentations would appear at Boggabri? Would these be road accidents and things like that? What kinds of things would these young trainee doctors—

Ms WORBOYS: They could see anything from a small cut to a finger, to cold and flu symptoms to a cardiac arrest, to road trauma. We have a big mining industry in our area so we often have miners brought in with various injuries. We have a really good working relationship with NSW Ambulance at Boggabri—the staff there. They will utilise their skills and knowledge to determine if they feel that it is something that will need to go to Tamworth and we can avoid a step by going to Boggabri, they will not avoid us but move on.

The Hon. WALT SECORD: I understand. I do not know if you are aware but this is our sixth hearing in a regional centre. In other parts of the State involving MPSs we have had evidence that tea ladies and cleaning staff have to provide support in MPSs and in small hospitals where there are no doctors or they are understaffed. In your Boggabri situation have you had to resort to similar situations?

Ms WORBOYS: Yes.

The Hon. WALT SECORD: Can you give an example of what you have had to do?

Ms WORBOYS: We have had tea ladies or hotel services staff doing meals with our residents. We have 16 residents because—

The Hon. WALT SECORD: When you say "doing meals", you mean helping them eat?

Ms WORBOYS: Yes, putting the meal in front of them, helping them set up. They get to know the residents and they know what equipment they need. It is because nursing staff are tied up in the emergency department with what we would call a triage 3, 2 or 1, or there is one nurse trying to manage two dining rooms and so they are our backup while we are busy with the more acute episodes.

The Hon. WALT SECORD: We have also heard evidence in other areas where, in the MPSs and smaller hospitals, there have been situations where there have been no doctors at all. Has Boggabri experienced similar situations like that?

Ms WORBOYS: Yes, we have.

The Hon. WALT SECORD: When was the last time you did not have a doctor?

Ms WORBOYS: Admittedly, I have been on leave for the last six months, but before that there was a weekend that we had no doctor. I cannot give you dates.

The Hon. WALT SECORD: Was that last year?

Ms WORBOYS: Early last year between January and March, because both doctors were going to training and Ochre were unable to provide us with a locum, we went on a business continuity plan.

The Hon. WALT SECORD: What is a business continuity plan?

Ms WORBOYS: A business continuity plan is a plan of action of the steps that nursing staff will take while we have got no doctors on site.

The Hon. WALT SECORD: That must put a lot of pressure on the nurses.

Ms WORBOYS: It does. As a manager, I sit at home worrying about how my nurses are dealing with the issues, because I have stayed back and worked with them in emergencies and if I am here I am 40 minutes away to get to them to support them. I only have two nurses that live in Boggabri that I could call on and say, "Can you get up to the hospital to help those?"

The Hon. WALT SECORD: Just to give context, how far is Boggabri from Tamworth?

Ms WORBOYS: From Tamworth it is 110 kilometres approximately.

The Hon. WALT SECORD: So 110 kilometres if you were in trouble and you had to get to Tamworth?

Ms WORBOYS: Yes.

The CHAIR: With respect to those junior doctors dealing with the palliation of patients at the end of life, you said that they sometimes have cause to have to ring, or do ring, across to Tamworth for some discussion over the phone. Are they speaking across at Tamworth to a GP or a palliative physician or do you not know?

Ms WORBOYS: Palliative physician.

The CHAIR: So there is a palliative physician there in Tamworth?

Ms WORBOYS: Yes.

The Hon. EMMA HURST: Ms Worboys, you said you have been on leave for the last six months. Just a personal question, do you want to go back to work with the current conditions as they are?

Ms WORBOYS: Um, no—

Ms KATE RYAN: It is not a solid yes.

Ms WORBOYS: It is not a solid yes. When I actually went on sick leave—and it had nothing to do with the situation at work—I was stressed out and, as I stated, felt burnt out. Yes, I just do not know if I want to put myself back in that situation. However, I am a nurse by heart. You know, in a way I love the job but it has just got to the point where, as a manager at a small site, I am trying to work clinical shifts and do my own work and I am being pressured from staff below as well as senior managers. People have said that I look more relaxed while I am on leave.

The CHAIR: Probably true.

The Hon. TREVOR KHAN: You would hope so.

Ms WORBOYS: I thought, "Well, I have not exactly been off on holiday. So I would hate to see what I looked like before."

The Hon. EMMA HURST: We have heard quite a bit from nurses during this inquiry about feeling as though they cannot even take leave or sick leave because of the pressures in the role, especially when there is no doctor available. Is that what you are sort of worried about going back into?

Ms WORBOYS: Yes. The fact that we do not have a casual pool—if we have a nurse that is casual she is covering three or four hospitals in the area. It got to the point where I felt that every time someone looked at me they were going to ask me to stay back, work an extra shift or cover something coming up. Because they themselves are struggling—when, you know, I go to them and say, "Is there any chance you can stay back tonight?" So we are all in a similar situation.

The Hon. EMMA HURST: All near burnt out.

Ms WORBOYS: Yes.

The Hon. EMMA HURST: Ms Ryan, are you in the Gunnedah area?

Ms KATE RYAN: I live and work in Tamworth.

The Hon. EMMA HURST: What is currently happening with the community members in your area if they have diabetes?

Ms KATE RYAN: So Tamworth is lucky, I think, in that there is a diabetes centre. So we have three full-time physicians at the Tamworth Diabetes Centre. I hope I have got that right. I work there. We service type 1 diabetics, type 2 diabetics, women with diabetes in pregnancy or gestational diabetes. It is a service that is for children and adults so it is a wide scope for Tamworth. But we are also the referral site for smaller towns like Boggabri. If there is a child with diabetes in Boggabri, which we have, they come to Tamworth; Gunnedah, they come to Tamworth for specialist appointments.

The Hon. EMMA HURST: So you would like to see that really expanded so that everyone—

Ms KATE RYAN: Yes, I think in the business case that I have put together previously to propose a nurse practitioner for our role—it would be a role that would help in a couple of areas—one would definitely be in upskilling GP practices with their diabetes management. We have heard multiple stories today and we have heard multiple stories before about the lack of GPs or the difficulty of patients getting into GPs. A lot of GPs would agree that a big part of their workload is chronic disease management, of which diabetes is one of them.

The Hon. EMMA HURST: You also said in your submission that there is a deficit in GP knowledge and confidence in managing patients with diabetes. Obviously this is very concerning. Why is that the case and what needs to happen?

Ms KATE RYAN: I will clarify that it is not every GP that has a lack of knowledge in diabetes. There are lots of GPs that are really amazing at managing their patients with diabetes and they have got a vested interest in that, but there are also a lot of GPs that would like to be able to refer their diabetes patients to someone else for specialisation.

The Hon. EMMA HURST: And that is where that role of the nurse practitioner could provide extra assistance.

Ms KATE RYAN: Yes, where the nurse practitioner can kind of fill that gap. I mean, I have previously done some private practice in GP practices in Tamworth and that has been useful for the GPs there. They can refer their patients to me. It helps free up their time if the diabetic patients are not having to make appointments with the GP. But for a nurse practitioner, in particular, the added benefit—as opposed to a registered nurse who is a credentialed diabetes educator—is the nurse practitioner can prescribe medications. They can order pathology tests for that patient. There are 100 examples of that, where patients will come to see me in the hospital at Tamworth and all they need is a pathology form. I saw a person yesterday, but he has to make an appointment to get that pathology form from his GP and his GP is not available because they are in Gunnedah. Then there is this issue of how do I even get the pathology form to this patient for the simple test that they need that I know as a nurse practitioner I could just write.

The Hon. EMMA HURST: Just for the benefit of the Committee, are nurse practitioners doing this role in diabetes in metropolitan areas?

Ms KATE RYAN: Yes.

The Hon. EMMA HURST: Why has that not expanded to more rural areas?

Ms KATE RYAN: I do not know is the answer. I would love to see—there is a nurse practitioner position currently advertised in Lismore, which I was so excited to see, and I would love to see that in lots of other smaller sites.

Ms CATE FAEHRMANN: Ms Ryan, in your submission you talk about the current business models of the LHDs. You say:

> … Local Health Districts (LHD) with their current business models will (mostly) determine where budget is placed and more must be done to ensure transparency of funding, application and allocation of NPs across the acute and community sectors to ensure gaps in rural areas are addressed.

Now what input do you have, as a nurse practitioner, with the LHD to say, "Look, we need more nurse practitioners." Is there any avenue?

Ms KATE RYAN: What do you mean by what input do I have?

Ms CATE FAEHRMANN: You have said here that more must be done in terms of transparency of funding. At the moment, is there any avenue—and I think in your opening statement you suggested that your calls have been largely ignored—

Ms KATE RYAN: Yes, I found it frustrating.

Ms CATE FAEHRMANN: So what is the avenue? What have you tried to do?

Ms KATE RYAN: So a couple of things. I have tried to see if our current clinical nurse consultant position could be converted to a transitional nurse practitioner position. A clinical nurse consultant is different to a nurse practitioner. Both have advanced skills in diabetes management but the added benefit of a nurse practitioner is the high level of autonomy. You can practise more independently, prescribe, order diagnostic tests et cetera, and refer patients as well, which is a big bonus for the nurse practitioner role. So that was declined.

Ms CATE FAEHRMANN: It is declined. So who do you put that application or that request to?

Ms KATE RYAN: To Tamworth Hospital management.

Ms CATE FAEHRMANN: It says here as well you are wanting transparency of funding. At the moment what is not transparent about funding in your view?

Ms KATE RYAN: In terms of how nurse practitioner positions are allocated?

Ms CATE FAEHRMANN: Yes.

Ms KATE RYAN: I do not think that that is transparent. Every time there is a job advertised for a nurse practitioner—and I hate using the words "every time" and "all the time" but it feels like every time—it is a position that is in a metropolitan area. I mean Newcastle, Sydney, Brisbane, Melbourne, Canberra.

Ms CATE FAEHRMANN: Yes, that was raised, I think, in a submission in the previous session, the perception that more of the funding within this LHD is going towards Newcastle in terms of need.

Ms KATE RYAN: Yes, it does feel like that. I did ask management at Newcastle about how many nurse practitioners we have in our LHD. We are really lucky, we have 51 apparently, which is more than any other LHD in New South Wales. I did also ask how many of those nurse practitioners are working rurally compared with greater Newcastle. The answer I got was that it is 50-50, which I find hard to believe but apparently it is 50-50. But I know of only seven who work outside of greater Newcastle. I would have to check the names and locations of where each of the nurse practitioners work. I think I find that frustrating, that I am not sure how positions are—and, for example, there are eight nurse practitioners who work at the neonatal ICU at John Hunter, and I am not for a second saying that any of them are not worthy of that role.[1]

Ms CATE FAEHRMANN: Of course.

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[1] In correspondence to the committee, dated 28 July 2021, Ms Kate Ryan, Private individual, provided a clarification and correction to her evidence – "… I just wanted to confirm that there are currently 51 Nurse Practitioners working in our LHD and 15 of those work outside of Greater Newcastle. There are also 12 Nurse Practitioners in the JHH Neonatal ICU and in my original evidence I had said there were 8".

Ms KATE RYAN: It is a really important job but it is also a very specialised scope. So that is not a job where you can take that nurse practitioner and work in Boggabri or Gunnedah because there is no neonatal ICU in those areas.

Ms CATE FAEHRMANN: Ms Worboys, in your submission you state:

> What is the use of upgrading a facility if there is no clinical staff to work within the facility.

Which facility are you referring to again?

Ms WORBOYS: I am referring to Gunnedah district hospital, which has been fortunate to get funding for an upgrade. I suppose at the time I wrote that I was very frustrated as being a patient and the limitations to people being able to be admitted to the facility—the majority of people seen in the emergency department. It is great that they want to enhance skills and positions available by—the latest I have read is on renal and chemotherapy treatments, but you need to have the staff there who can perform the task. At the moment Gunnedah, like Boggabri, like Narrabri, is utilising agency nurses to fill vacancies. It is great to have a new facility but you need the staff on board and you need to be able to attract them.

Ms CATE FAEHRMANN: Yes, you are definitely not the first witness to have told us that.

The Hon. WES FANG: Thank you for appearing today. Ms Ryan, I wanted to talk about the role of nurse practitioners. Could you give us some insight as to what a nurse practitioner is able to do that, say, a nurse cannot and how can that help to alleviate some of the workload from doctors?

Ms KATE RYAN: A nurse practitioner is someone with advanced skills in a specific area. In Australia you have to have been working for a minimum of five years—I think they are now changing it to a minimum of three years—in a particular area to then get into the master's program. So you have a master's level qualification at university. The difference in what a nurse practitioner can do compared with what a registered nurse can do is in advanced assessment and diagnosis of patients, I always say, within their scope of practice. For me it is diabetes education and management. I would be able to assess and diagnose and prescribe medications and refer patients who have diabetes for their whole occasion of care that they have, if you like. That helps alleviate pressure from GPs who either are not current or up to date with where the diabetes medications are. Ten years ago diabetes was a lot easier. There were a couple of oral tablets and there was insulin. Now we have a whole host of oral tablets and other injectables that are not insulin and a whole heap of new insulins and it can be confusing. To have a specialist available to help GPs in that area takes some pressure off them. We know that the numbers for diabetes are huge and they are getting bigger.

The Hon. WES FANG: For a nurse practitioner in somewhere like Tamworth, which is where you reside at the moment, you have a diabetes clinic there already. I imagine that it would be beneficial for Tamworth, but in a place such as Gunnedah, where we are now, where they do not have those services, would a nurse practitioner in a location such as Gunnedah be of even greater assistance to the community than somewhere like Tamworth, where they have already got some of the services?

Ms KATE RYAN: Yes, absolutely. That is part of the business case that I have put together, that the nurse practitioner for diabetes would go to smaller sites once a month, once a fortnight, to do diabetes clinics to help with that.

The Hon. WES FANG: While not replacing a doctor, nurse practitioners in those roles in medium to small communities around New South Wales could provide a lot of those services which would normally fall onto a GP. Could that work?

Ms KATE RYAN: Yes. It is a gap-filling role, and that is what it was designed to be. But unfortunately at the moment the majority of nurse practitioners do work in cities. As the second document that I have handed in shows, it is 68 per cent or something.

The Hon. WES FANG: In your opinion, do you think if we had nurses who were trained up in order to become nurse practitioners with the required experience, would they be looking to move to areas like rural and regional New South Wales to practise and gain further experience?

Ms KATE RYAN: I would really hope that that would happen because the other issue, and it has been brought up by earlier speakers today, is that there is not a lot of professional development for nurses in the country. I have done this master's degree at my own expense and with the help of some scholarships, but I have done this on my own without knowing that I have a certain job at the end of it with NSW Health. Most people would only apply for the course, the master's course, knowing that they have a transitional nurse practitioner position, so they will have a job to go into. I think that having a pathway for nurses in the country to upskill is really important. I know lots of fantastic nurses who work in the country but they choose not to work for NSW Health for a whole

heap of reasons. A lot of that is burnout and they get bored with where they are working. They do not want to get paid the same as the person sitting next to them who is 15 years junior.

The Hon. NATASHA MACLAREN-JONES: I wanted to touch on agency nursing. When I worked as a nurse, I had a number of friends who chose to do agency work because of the flexibility of being able to work in different hospitals but also the extra loading they got. Has anything been looked at from a regional country perspective first of all into what can be done to move agency nurses to take up the full-time positions locally?

Ms KATE RYAN: I would not be able to answer that. I would have to get back to you.

The Hon. NATASHA MACLAREN-JONES: Or anyone that you have spoken to who is an agency nurse?

Ms KATE RYAN: I do not know of many agency nurse situations in country towns.

Ms WORBOYS: Boggabri agency nurses with us have enjoyed stays but also found it difficult. I do know of other facilities where they have had agency nurses come and they ended up staying on and taking on positions because they have enjoyed the experience, they have enjoyed the town, they have enjoyed everything. So yes, we do but they are few and far between. One of the other difficulties we have had is where we attract agency nurses, and even though I clearly state, "You will be expected to work across aged care, medical and emergency nursing," when they get to us and they see what they are expected to do and the workload and the staffing levels, we have had them leave.

The Hon. NATASHA MACLAREN-JONES: Do you have any suggestions of what more could be done to recruit nurses into country areas? Obviously we have heard from GPs about the challenges that they face and some of their suggestions. But from your perspective, what are some things from a State or Federal perspective that could be done?

Ms WORBOYS: Nurses do not get offered in towns the equivalent of incentives that people try to offer doctors to come to towns: the relocation, housing—

Ms KATE RYAN: Study leave.

Ms WORBOYS: Study leave. We are lucky if we have an empty room over at the nurses' quarters that we could put someone in. They are not offered to nurses. I think there needs to be a level of equivalency there for nurses to attract them to rural areas. Like Kate said, study leave, the encouragement to come and do courses or work in Boggabri and say, "Well, you know, I really enjoy it here. I want to do that advanced emergency nurse course to get my skills up to date," and we will try to support them.

Ms KATE RYAN: I think the other thing is nurses want to feel safe when they are at work.

Ms WORBOYS: Yes.

Ms KATE RYAN: And to feel, like when they are doing upskilling like at Boggabri**,** that they have got an incredibly intelligent and advanced workforce working with them so they can ask questions. I remember working at Wee Waa Hospital as only one of two registered nurses and I was first year out of my graduate year, so I was really junior. A lot of scary things come in at night time and there is only one other nurse there; there are no doctors. So that is a deterrent, I think, from people wanting to work in smaller places. That is why you do need things like nurse practitioners, which I talk about all the time, to try to upskill the workforce.

The Hon. WES FANG: Ms Worboys, I wanted to address some of the points that we were talking about earlier around Boggabri. With the doctors that you have got there at the moment, the trainee GPs—I am guessing that is what you were saying.

Ms WORBOYS: Yes.

The Hon. WES FANG: They are not just out of medical school, are they? They have actually been through the hospital process.

Ms WORBOYS: Yes.

The Hon. WES FANG: They are in the training program now for GPs and they are well within that training program, are they not?

Ms WORBOYS: They are. Part of taking on the position is that they must complete the training course. Both our trainee GPs at present are overseas-trained doctors. They have come with knowledge in other areas and done hospital experience in the metropolitan side of the hills, but coming to Boggabri was their first experience of being in a rural area.

The Hon. WES FANG: I just wanted to make sure that they were not new because some people could have had the impression that they were just—

Ms WORBOYS: Newbies.

The Hon. WES FANG: —trainee doctors as opposed to in the training program for GPs. So they have actually got some experience. Being overseas trained, they have got some overseas experience as well.

Ms WORBOYS: Yes.

The Hon. WES FANG: They are also supported through the telehealth program when they do require it?

Ms WORBOYS: Yes, they are. Personally, I encourage them to use telehealth and use telehealth throughout the facility. Even as being the patient myself, I think telehealth is a wonderful aspect that needs to be further developed and greater utilised by doctors and nurse practitioners so that we have got that contact.

The Hon. WES FANG: So you found that for Boggabri, for example, the support and the mentoring that it can provide, particularly to the trainee GPs that you have got, is actually a positive?

Ms WORBOYS: It is a positive, but it does not take away from them having the person there to observe them doing a consultation and assist them in emergency if there is something that they are not sure of. It would be nice that—something that has been lacking is the actual face-to-face contact. I have had discussions, before I went on leave, with Ochre about some issues we were having at the time about them coming out and spending time, more than a day with them—actually spending a week so that they are supported, they get some continuity of support and face-to-face—

The Hon. WES FANG: Mentoring.

Ms WORBOYS: —mentoring, yes.

The Hon. WES FANG: The last thing I wanted to address was—

The CHAIR: You had one; that is now the fourth. Walt Secord will have one final one to round off.

The Hon. WALT SECORD: Ms Worboys, you talked about the nurses leaving because of the pressure. What would be a circumstance that you can recall where a nurse just decided to leave?

Ms WORBOYS: Having the workload. So having two nurses and having your 16 residents—we are never a facility that is going to be empty because we will always have residents. So 16 residents, an acute ward that is full and an ED for us that is bopping. It may only be two patients in that ED but if you are a registered nurse on with an enrolled nurse that cannot do medications, then you are the person that is trying to get everything done and not having that doctor there, coming from a facility that may have had a doctor on site 24 hours a day, we have to call them in.

The Hon. WALT SECORD: So you would have a situation where you have two nurses with 16 residents and looking after an emergency department and an acute ward?

Ms WORBOYS: Yes.

The Hon. WALT SECORD: That is extraordinary.

Ms WORBOYS: Yes. As I left, the staff had gone to the union to ask for additional staffing, and they did get it but that is still only—I should not say only; any nurse is valuable. But it still may be a mixture of a registered nurse with two enrolled nurses for certain hours. It is not every shift. So on night duty it is still two nurses.

The CHAIR: Thank you both very much for coming along to give us the opportunity to question you and to elucidate on your evidence in what were very good submissions. On behalf of the Committee, thank you very much for the outstanding work you have done and continue to do in the community as registered nurses and people who obviously have a real passion and dedication to your vocation. Thank you very much.

Ms WORBOYS: Thank you.

Ms KATE RYAN: Thank you.

(The witnesses withdrew.)

BRIAN JEFFREY, Private citizen, affirmed and examined

EMMA PRIEST, Private citizen, sworn and examined

The CHAIR: Thank you both very much for joining us as our last panel this morning. We appreciate that very much. With respect to both of you, as you are aware, you have made submissions to the inquiry. Ms Priest, your submission stands as submission No. 619. It has been processed and forms evidence and has been uploaded to the inquiry's webpage. Mr Jeffrey, you have also made a submission, and yours stands as submission No. 412 to the inquiry. It has been processed and stands as evidence and has been uploaded to the inquiry's webpage. You can take it that the Committee members have read your submissions, so you do not need to go through it in detail in your opening statement. Perhaps just three or four minutes to set up the whole discussion, if you like, and then we will share the questions between the members joining us today. We will start with you, Ms Priest.

Ms PRIEST: Okay.

The CHAIR: Just take it easy. You can pause at any time to have a sip of water. There is no problem. Just take your time.

Ms PRIEST: How is it that someone who has no medical training had to tell a doctor and three nursing staff that my son needed to be put on fluids? My son is a type 1 diabetic, which is an autoimmune disease. Gastro bugs are an absolute nightmare for type ls. This was our first hospital trip after being diagnosed eight months prior. On Friday 18 December 2020 my son came down with gastro. I was unable to keep his blood glucose level to stay above 2.8. Normal is between 3.5 and 9. My son had thrown up five times before I took him to Gunnedah Hospital at 4.00 pm. He threw up another eight times while we were there and no fluids were administered. Yes, the locum doctor in the emergency was in contact with the paediatricians at the Tamworth Base Hospital about what should be done with my son. When an eight-year-old boy is unable to keep food or water down and levels are not being stabilised, the nurse or the doctor should have known to give fluids. Sorry.

The CHAIR: No, do not apologise.

Ms PRIEST: We were at the hospital for five hours and the only thing that was done was an hour before then, when I demanded that my son be put on fluids. We were finally taken to Tamworth Base via ambulance for two nights and, even though we were discharged, we were not told that my son's insulin levels were too high, and he stayed with low levels for two days. I should have been given a management plan while he was sick. I was not given anything. No-one told me that his insulin levels were too high and that was what was keeping him sick. I am sure there are more children and adults that live in Gunnedah with type 1, and for the doctors and nursing staff not to know what to do is not only frightening but it is an absolute joke. We do not go to the hospital unless it is something that we cannot fix on our own. We put our lives in the hands of these doctors and nurses and we are not being cared for appropriately. I should not have to risk my son's life driving to Tamworth Base 45 minutes away just for him to receive the right treatment. I refuse to go to Gunnedah Hospital for anything to do with my son.

The CHAIR: Thank you, Ms Priest, for that statement. Just take a break. We will return to some questions in a moment. Mr Jeffrey, have you got an opening statement?

Mr JEFFREY: First of all, thank you very much for inviting me here today and for allowing me to express my concerns. Just a little bit of my background. I have lived in Gunnedah for 30 years. I came here 30 years ago when I was appointed principal of Gunnedah High School. I was 15 years as principal, retired and have had another 15 years in Gunnedah. So I cannot consider myself a local because I have had only 30 years here, but I do have a little bit of a grip on the Gunnedah community and I really am concerned about the shortages of GPs in the town at the moment. As you have read in my submission, I was fairly focused on that as the single problem. I have given out a couple of documents for you today. The first one is information about Gunnedah Rural Health Centre. I imagine probably by now you will have had information about that and you will know that it is largely dysfunctional mainly because of the lack of GPs.

The CHAIR: Can you just identify the second document, Mr Jeffrey?

Mr JEFFREY: That is the one. In my view, GPs provide an essential service. I do not think we should regard them just as a part of the medical profession; they are an essential service and, in my view, they are what I call the Pied Pipers of the medical profession, because if a town has adequate or a good supply of GPs the other medical services will follow them. They will obviously get their referrals and the whole situation will improve. The frustrating part for me is that we have an excellent facility but we do not have the doctors which we need to bring people to that facility.

But rather than dwell on the negative, I would like to just talk to my second document there because I would like to highlight three key factors that I believe must be considered if we are going to sort this problem out. The first key factor is that I think we need one single organisation which is responsible for the provision of GP services. My correspondence with local MPs, with Ministers responsible for health at both Federal and State level, have shown me that it is very easy for them to sit back and wait for somebody else to fix the problem. I could call it buck-passing but it does go on, and in my letters I found that people have said, "Well, I will refer you to someone else." The whole situation falls through the cracks and nothing ends up being done.

So I do believe it should be a government organisation. The market forces that we are hoping will provide us with GPs are not working, and market forces seems to be, from all my communication, the way that GPs are supplied. But that may be a question that somebody might like to dwell on. The second key factor is obviously the long-term need for what I believe is more doctors in Australia. I have a letter from the Federal Minister for Regional Health, who says, "We know there are enough doctors being trained in Australia." I do not know where he gets his formula from because a lot of areas in rural Australia just do not have enough doctors.

I think that we have to have a dramatic expansion in the number of students going to medical school and training to be doctors. I have to say that I think students in rural areas need more encouragement. I know from my time as principal that there are many, many bright rural students who find actually going to university quite a daunting prospect and we are not getting the best out of that. I also believe that rural students are more likely to come back to rural areas to practise when they qualify. I am unashamedly in the court that says that every young Australian should have one free kick at a tertiary education, whether that is a free university, free TAFE, free apprenticeship, free job training—I think it is a right. At the moment it is a privilege, but it should be a right.

The third factor is the short-term issue of providing doctors. I think the pandemic has shown us the fundamental flaw of hoping that we would be able to recruit from overseas—it has obviously gone out the window with our boundaries being shut. So whereas our chronic shortage of doctors in Gunnedah might have been fixed by having some overseas doctors come to town, that has not been possible, and so the situation which I described in my original submission five months ago, really nothing has changed—if anything, it is probably worse than it was. Thank you for listening to what I have had to say. I would be delighted to field any questions that you would like to give me on my original submission, the comments I have made today and the two documents that I have circulated.

The CHAIR: Thanks, Mr Jeffrey, for a very cogent and thoughtful opening statement, which I am sure is going to stimulate some questions from the Committee members. Ms Priest, in regard to proceedings, what we normally do is we open it up to Committee members to ask questions, but I am well aware of the difficulty that you have had. I am sure Committee members will be thoughtful of that when asking questions, but I will ask you if you want to be available to have questions asked of you and will you be okay with that?

Ms PRIEST: I will try.

The CHAIR: I am sure you will be okay, but we respect the circumstances and that it has been most difficult. Is your son okay now?

Ms PRIEST: Yes.

The CHAIR: Your son is okay now. That is fine. I will pass over to members.

The Hon. TREVOR KHAN: Be nice, Walt.

The CHAIR: We are all nice around this table, thanks. Please proceed.

The Hon. WALT SECORD: Thank you both for your time and for taking time to put in some submissions. Mr Jeffrey, I do understand when you say that you have lived in Gunnedah for 30 years and you still do not know whether you are a local. I have lived here for 33 years and people say, "Did you just step off the boat?" I know where you are coming from. Ms Priest, thank you for your—

The CHAIR: Or "Are you American?"

The Hon. WES FANG: Aren't you American?

The Hon. WALT SECORD: I was born in Canada.

The Hon. WES FANG: Same difference.

The Hon. WALT SECORD: Ms Priest, thank you. If you do not mind, what is your son's name?

Ms PRIEST: Dylan.

The Hon. WALT SECORD: And is Dylan okay now?

Ms PRIEST: Yes, as well as a type 1 can be.

The Hon. WALT SECORD: Dylan is at school and doing normal activities that normal boys do.

Ms PRIEST: He had his ninth birthday last Thursday. He was diagnosed at seven so it is all still very new to us.

The Hon. WALT SECORD: When you reported to Gunnedah Hospital, were you aware at the time that he was diabetic?

Ms PRIEST: Yes. When he was first diagnosed?

The Hon. WALT SECORD: The essence of your submission, when that occurred?

Ms PRIEST: No. It was through COVID and my mum had noticed that he had lost weight so we went to the pharmacy and they pricked his finger and said, "You need to go to the hospital." It was sort of like a big rush. He had lost three kilos in four weeks and was just constantly going to the toilet and drinking a lot of fluids.

The Hon. WALT SECORD: He would be a little boy; to lose three kilos is a lot.

Ms PRIEST: Yes.

The Hon. WALT SECORD: When you presented to Gunnedah Hospital was there a lack of staff?

Ms PRIEST: When he was first diagnosed, everything was great. They knew we were coming because the pharmacy had rung and said this was the situation so they knew. When I took him back for gastro, the nurses saw to us straightaway; the doctor came to see us as well. I cannot fault the staff on the day. It was just the treatment. I did not know where I stood. This was our first time at hospital since he had been diagnosed. I did not really know what he needed, but I knew that giving him more fluids and more things to eat was not the answer. He was not keeping anything down. They gave him an anti-nausea tablet under his tongue and he brought all of that back up and continued to vomit. I just do not understand why we were there for five hours and nothing was done. I had to demand. I finally said that he needs to be on fluids because he was not keeping anything down. I am not medically trained to know that, but to me that is what he needed.

The Hon. WALT SECORD: Was the emergency department at the time busy?

Ms PRIEST: No. When we got there it was not. It did become busier, but we were seen to straightaway sort of thing by both the nurses and the doctor. It is nothing at all to do with staffing on that day.

The Hon. WALT SECORD: You would see it to be a communication problem? They were unable to hear what you were trying to explain about your son Dylan?

Ms PRIEST: They knew it all, but I think the doctor was in talks with the paediatrician at the Tamworth base and they were sort of saying, "Just wait it out. See how everything goes." But I mean, I do not know how many times somebody has to throw up before something is done.

The Hon. WALT SECORD: The doctor that was on duty at Gunnedah was on telehealth with Tamworth?

Ms PRIEST: Just phone calls.

The Hon. WALT SECORD: Just phone calls?

Ms PRIEST: Yes.

The Hon. WALT SECORD: Was it a junior doctor?

Ms PRIEST: He was just a locum. I do not know his name. I have not been back to the hospital. If I walked past him on the main street, I would not know who he was. He was just the doctor on the day.

The Hon. WALT SECORD: Have you complained to the health department or the HCCC or any bodies that are—

Ms PRIEST: This was my first thing and it took a lot to do it. But, I mean, there is more than just my son. I know eight other kids in Gunnedah that are type 1. I mean, it is not just my son.

The Hon. WALT SECORD: Is it a lack of paediatric services?

Ms PRIEST: It is a lack of staff not knowing what to do for a type 1. I asked the nurse, "What happens next?" And she said, "I have no idea. We have never dealt with type 1s." Because they do not. They send us straight to Tamworth because there is a paediatrician in Tamworth. They are always there. I would have happily

driven my son the 45 minutes to Tamworth knowing that he would get treatment straightaway. But with his levels that low, I could not drive and look after him.

The Hon. WALT SECORD: What would you do now if you had, heaven forbid, a crisis situation with Dylan? Would you go straight to Tamworth or would you go to Gunnedah?

Ms PRIEST: It would depend how dire it was. If I thought I was going to lose his life while I had to drive to get him there, that is not what I would do. But I would hope that we did not stay in Gunnedah very long and we were transferred to Tamworth. It is like going into a pet store thinking that you are going to buy dog food and they do not sell it. Gunnedah is not equipped. They do not know what to do for type 1s. There is no knowledge. There needs to be someone here. I mean, if Dylan was the only one in this town then fair enough; I could understand that we need to go somewhere else to look for the help. He is not the only one. There needs to be someone here that can help us.

The Hon. WALT SECORD: Thank you for your time, Ms Priest. Mr Jeffrey, in your submission you make the statement that Gunnedah has been allocated $50 million in the budget for a hospital upgrade but then you go on to say that this is "a total waste of taxpayers' money". You have a situation where you are upgrading a hospital but you do not have the staff in that hospital.

Mr JEFFREY: Specifically doctors, I would say.

The Hon. WALT SECORD: What do you base that on?

Mr JEFFREY: It cannot function as a hospital should do without doctors. I suppose I could use the parallel that it is like a pub without beer. Doctors are absolutely essential to the operation of a hospital. As much as I would be the first person to say it is wonderful that we are getting $50 million—or I think $50 million has been promised—for the hospital, we must make sure that we have got the doctors and maybe use $50 million to find a way of getting doctors to Gunnedah and to that hospital.

The Hon. WALT SECORD: Mr Jeffrey, it is not going to please you, but that is the recurring evidence that we are given. This is our sixth inquiry. We have situations where there are hospitals around the State that do not have doctors on the weekend or doctors for long periods of time. That statement that you based it on about the lack of doctors in Gunnedah, is that as a patient or is that from the community or is that from talking to medical professionals?

Mr JEFFREY: I would say myself as a patient, yes. I have been a patient at the hospital there. Yes, the community I think has an expectation, as Ms Priest would, that if you go to the hospital and you go to the emergency department, you should be seeing a doctor.

The Hon. WALT SECORD: I do not think that is an unreasonable expectation.

Mr JEFFREY: No. I mean, I did explain in my submission that the doctors in GP practices that we do have in town also have a responsibility to staff the emergency if they get a case occur. They cannot do that. They then leave a waiting room full of patients that are waiting for them while they go to the emergency and then have to come back again. It is just hopeless I believe.

The Hon. WALT SECORD: In your submission you make a statement which is quite obvious. You say, "Gunnedah Hospital should be staffed by full-time doctors."

Mr JEFFREY: Absolutely, and if the emergency department has not got enough patients for the day, then they can take the overflow from the GPs. Everybody should be able to phone up in the morning and get someone to help them if they are feeling ill.

The Hon. EMMA HURST: Mr Jeffrey, you say that you have lived in Gunnedah for 29 years. Something that has come up in the inquiry today is the fact that doctor shortages are not a new issue. In your submission you say that you have seen doctor shortages before but nothing as chronic as the present situation. What do you think has changed and how is it worse now than it has been in the past?

Mr JEFFREY: It has always been a bit of keep your fingers crossed when you phone up in the morning if you are feeling unwell. But you will not be told, "We are fully booked out today. Try your luck tomorrow." There has always been a little bit of a worry in Gunnedah, but now it happens. I have to go now to Tamworth for basic GP services.

The Hon. EMMA HURST: You said you travel a 160-kilometre round trip for prescription consultations.

Mr JEFFREY: Yes. Actually, during the pandemic I had a phone consultation. But I estimate this year that I will have travelled 1,000 kilometres to and from my GP just for basic services. I had the repeat prescriptions.

I had a flu vaccination. I had my first COVID vaccination last week. I have got to go tomorrow because I am 75 and I have to have a doctor's statement to say that I am fit to drive.

The Hon. EMMA HURST: What would happen if you were not fit to drive? How could you get to the doctor?

Mr JEFFREY: Well, you get the train from Gunnedah to Werris Creek at 10.15 in the morning. You wait in Werris Creek for about three or four hours. Then there is a train from Werris Creek to Tamworth and then you would need to stay.

The Hon. EMMA HURST: For a flu shot?

Mr JEFFREY: I mean, if you have got nobody to drive you, yes, public transport is—

The Hon. EMMA HURST: Is that happening to people that you know in Gunnedah? Are people having to take that train journey for a prescription or a flu shot?

Mr JEFFREY: I am not sure. That is the extreme case. I think, you know, you just hope somebody will be able to drive you over. But if you are really feeling sick it is not always easy to organise something like that. My point really is that there is no regular bus service and there is no—

The Hon. EMMA HURST: There is no direct route to catch public transport.

Mr JEFFREY: Not really. There is one bus that goes through from Tamworth station to Dubbo daily, once a day. But the time frame that that bus takes you there would mean you would probably have to stay overnight in Tamworth anyway and then you would have the accommodation costs as well as the travel issue.

The Hon. EMMA HURST: You also talk about the workload of GPs being unrealistic. There are already less GPs now than there has been for a while. Are you worried that if the workload is unrealistic we are going to see more burnout with the doctors that are now currently in place?

Mr JEFFREY: I regret I probably think that is the case. I mean, I hope it is not. But it is not fair putting unrealistic expectations on people in a job. You will burn them out. There is no doubt about that. I feel for the doctors that we have remaining in town because it is an impossible workload that they have. I mean, there are a lot of Gunnedah residents that are going over to Tamworth. At the practice that I go to, I know there is 50 or 60 Gunnedah patients now, so it is—you know, people are looking for alternatives. But, yes, I really do worry that unless we can come up with a way to increase the number of doctors in town they will burn out.

The Hon. EMMA HURST: Ms Priest, you said that your son's diagnosis was quite new. After the experience that you have had, do you feel safe in your community where you are and have you had conversations about making major changes, potentially even moving out of the area, because of the current situation?

Ms PRIEST: Not really. I mean, I am in a position where I can still take my son to Tamworth for all of his educator requirements. Ms Kate Ryan, that was talking earlier, is one of my son's diabetes educators so we see her quite often. I am happy to travel. We like Gunnedah. We should not have to move just to find somebody that can look after his diagnosis. I do not feel that I should have to move to the city just to find the people that can help him. We are happy in our town. We just need the support.

The Hon. EMMA HURST: Fair point.

Ms CATE FAEHRMANN: I have only got one question because a lot of my questions have been asked. Mr Jeffrey, I think you said that one of your interactions with doctors was via telehealth, is that correct? How are you finding that and what is the kind of general feedback about the use of telehealth generally here?

Mr JEFFREY: I would much prefer a face-to-face consultation. I think that is essential. They can be very clever on the telephone but they cannot take the blood pressure. They cannot look and see you and see how you feel, which I think doctors often do that. For the particular problem that I had at the time, which was mainly just getting repeat prescriptions, my doctor knows my health background. But I do have one medication which really should mean that I have a blood pressure test every time I see him and that was not possible. So it is second best, I would have to say, but better than nothing at all because I do not think I would be here today if I had not got my repeat prescriptions. You have to find a way to do it if you cannot travel or if we have a pandemic which means that the doctor's surgery does not operate.

The Hon. TREVOR KHAN: Mr Jeffrey, I think it is only during COVID that the Federal Government has allowed a Medicare rebate for over-the-phone consultations. I take it that you would be in favour of a continuation of that Medicare rebate for over-the-phone consultations, at least in regards to scripts?

Mr JEFFREY: Yes. I think, while we still have problems with it, yes. Definitely.

The Hon. TREVOR KHAN: You have got me on side. I think it is second best, but it is better than—

Mr JEFFREY: Yes, exactly. It is interesting that you mention that, because the chances of being bulk-billed in rural areas are pretty slim.

The Hon. TREVOR KHAN: You have got me onside there too.

Mr JEFFREY: I mean, my doctor was very good. I said, "How am I going to pay for this?" and he said, "We'll do it through Medicare." But, yes, bulk-billing is probably a city-based phenomenon these days. We do not see a great deal of it out here in the bush.

The Hon. TREVOR KHAN: Yes and you would be aware that is a problem that exists in Tamworth as well as Gunnedah, if you could get the appointment in Gunnedah?

Mr JEFFREY: Yes.

The Hon. TREVOR KHAN: I do not want to go through all of the material that you have raised because, as Ms Faehrmann says, a lot of it has been covered before. But it would seem to me that the points you raise with regard to general practitioners, you have been raising with Mark Coulton over a period of time.

Mr JEFFREY: Yes.

The Hon. TREVOR KHAN: Do I take it that a lot of that is with regard to the Medicare rebates that are available or not available in country areas?

Mr JEFFREY: No. My concern has been focused on the shortages of GPs and, in fact—

The Hon. TREVOR KHAN: Not what will necessarily attract them to a particular area?

Mr JEFFREY: The incentives that are proposed by Mr Coulton are not working, I don't think. That is the problem. We have got the evidence in our shortage of GPs. He gave me a lovely long letter with two pages of incentives, but I do not think they are generous enough. I do not think they are comprehensive enough. We need a lot more scholarships for young people to get into the medical profession. I think the present cohort of doctors who are leaving medical school this year or qualifying as GPs this year need to be given some really generous incentives to come to rural areas.

The Hon. TREVOR KHAN: I think one of the things that has been pointed out is that even if you take a—my kids have left home and gone off and disappeared to the city, never to come back. But I think even if you take a kid out of Gunnedah High School and send them down to Sydney uni or the University of New South Wales, the prospect is that they will find a partner in Sydney, or wherever, and the difficulty is getting them back because they have paired up or mated up in that environment. It is really training them in the bush, isn't it, that provides the greatest chance of keeping them?

Mr JEFFREY: It would be wonderful to have a facility in a rural area. Most of the universities obviously are in cities or regional centres. If there was a centre that was in a more remote area, I think that would be wonderful. It would bring attention to the importance of health in rural areas.

The Hon. TREVOR KHAN: Do you think the provision of scholarships in places like Armidale—I am not quite sure whether Charles Sturt University [CSU] does, but in the other regional universities that might be the way of emphasising and keeping those graduands in the country areas rather than allowing them to escape into the city.

Mr JEFFREY: Yes. I should make the point that I did mention in passing that university education can be quite daunting for a student in a rural area. They inevitably have to leave home. If their parents do not have relatives in the university venue, it means they have got to find their accommodation. The living away from home allowance—as it used to be known; I do not know what it is known by now—is not adequate, so they end up having to get a part-time job, probably spending as much time on the part-time job as they are on their university studies. It goes back to what I am saying that every young Australian should have a free kick at a tertiary education, probably funded, so that you do not have to eat Vegemite toast all the while. They are entitled to have a decent way of life at the same time as paying full attention to their studies.

The Hon. TREVOR KHAN: That is how I went first through university, but I think it is probably beyond the remit of this Committee. Ms Priest, it will come as no surprise that there are some people who are watching this inquiry. Would you be prepared to speak to somebody from Hunter New England Health to talk through your issues with regard to your son and the treatment that he received?

Ms PRIEST: Yes.

The Hon. TREVOR KHAN: I think we might see what we can do and somebody might get in contact with you, if that is all right.

The Hon. WES FANG: Ms Priest, in your opening statement when you talked about the experience you had with your son, when you left Gunnedah to go to Tamworth, did you drive your son at that point or were you transferred?

Ms PRIEST: He was transferred by ambulance.

The Hon. WES FANG: When you said that you drove, I was not—

Ms PRIEST: I drove myself because it was—

The Hon. WES FANG: You had a vehicle.

Ms PRIEST: That is right. We had to get home.

The Hon. WES FANG: I just wanted to make sure that you did not actually have to transfer your son and yourself.

Ms PRIEST: I do know another mum in town with a type 1 who had issues at the hospital with staffing and she actually drove her daughter to Lake Keepit, which is just before halfway here to Tamworth, and called an ambulance then because she was not able to be seen.

The CHAIR: Thank you both for making yourself available to come along this morning. It has been very valuable to have the opportunity to ask you questions beyond what was in your submissions. We obviously wish you, Ms Priest, and your son all the very best. We hope that he can get on to a stable footing with respect of his condition and I am sure that will be achieved and that he will go on and live a very healthy and long life. Thank you for very much for coming along. It was very heartfelt and it is very difficult to open up as you have done. We appreciate that very much. Mr Jeffrey, at 75 you are very bright and spritely, I have to say. Your evidence was very good and very much on point. We thank you very much for your contribution too.

Mr JEFFREY: I thank everybody for coming to Gunnedah. I hope you enjoyed your time here.

The CHAIR: I thank those from the public who have joined us. It has been very helpful. We would like to be here for longer if possible but we have got to head off to our next location. Thank you all for coming along and thank you to the media for coming along and hearing what we have to say. That concludes the session this morning. We wish everyone a safe travel home.

(The witnesses withdrew.)

The Committee adjourned at 12:18.