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

Virtual hearing via videoconference on Wednesday 6 October 2021

The Committee met at 9:15.

PRESENT

The Hon. Greg Donnelly (Chair)

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

The CHAIR: Welcome and good morning to everyone who is joining us today. This is the eleventh hearing of the Portfolio Committee No. 2 inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. The inquiry is examining health outcomes, access to services, patient experience, planning and capital expenditure in rural, regional and remote New South Wales. Before I commence I would like to acknowledge the Gadigal people, who are the traditional custodians of the land on which Parliament sits. I would also like to pay my respects to the Elders past, present and emerging of the Eora nation and extend that respect to other Aboriginals viewing this broadcast over the course of the day. We welcome you.

Today's hearing is being conducted virtually. This enables the work of the Committee to continue during COVID-19 without compromising the health and safety of members, witnesses and, of course, staff. As we break new ground with the technology, I would ask for everyone's patience through any technical difficulties we may encounter over the course of the day. If participants lose their internet connection and are disconnected from the virtual hearing, they are asked to rejoin the hearing by using the same link as provided by the Committee secretariat. Today we will be hearing from a number of stakeholders based in and around Tumut, Wagga Wagga and the surrounding areas, including local councils, the Country Women's Association and, importantly, community groups as well as Aboriginal health groups and private individuals. I thank everyone for making the time to give evidence to this important inquiry.

Before we commence I would like to make some brief comments about the procedures for today's hearing. While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the virtual hearing. I therefore urge witnesses to be careful about comments they may make to the media or to others after they have completed 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's terms of reference and avoid naming individuals unnecessarily.

All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the Legislative Council in 2018. There may be some questions that a witness could only answer if they had more time or with certain documents to hand. In such circumstances, witnesses are advised that they can take a question on notice and provide an answer within 21 days. Today's proceedings are being streamed live and a transcript will be placed on the Committee's website once it becomes available.

Finally, I will make a few notes on virtual hearing etiquette to minimise disruptions and assist our Hansard reporters. I ask Committee members to clearly identify whom their questions are being directed to and ask that everyone please state their name when they begin speaking to answer the questions. Could everyone please mute their microphones when they are not speaking. Please remember to turn your microphones back on when you are getting ready to speak. If you start speaking whilst muted, please start your question or answer again so it can be recorded in the transcript. Members and witnesses should avoid speaking over each other so we can all hear what is being said clearly. Also to assist Hansard, I remind members and witnesses to speak directly into their microphones and to avoid making comments when their heads are turned away.

PAUL MAYTOM, Mayor, Leeton Shire Council, sworn and examined

JACKIE KRUGER, General Manager, Leeton Shire Council, affirmed and examined

NEVILLE KSCHENKA, Councillor and Mayor, Narrandera Shire Council, sworn and examined

GEORGE COWAN, General Manager, Narrandera Shire Council, sworn and examined

The CHAIR: Welcome to all four of you. It is great to have you joining us today at our public hearing, albeit virtually. I have to say, in some sense I would like to be down in your neck of the woods. That had been our plan many months ago. The whole Committee was looking forward to coming down and spending some time there, but we are obviously having to deal with what is before us. Whilst this is not the same as being down enjoying your company and the beautiful area down there, we are doing it virtually. So we are looking forward to what we are going to be able to hear from you. First of all, I acknowledge the contributions through the respective submissions that have already been made. You are obviously well aware of this but the Leeton Shire Council submission stands as submission No. 633. It has been received, processed and stands as a submission, and therefore evidence, to the inquiry and has been uploaded to the inquiry's webpage. Equally, with respect to Narrandera's contribution—and thank you for that—that is submission No. 165. That has been provided, processed and stands also as a submission to the inquiry and has been uploaded onto the webpage. Both of those stand as submissions and obviously as evidence already provided to the inquiry. We thank you for those.

I invite both shire councils to nominate one representative—I presume it will be the mayor, but I will not risk being presumptuous—to make an opening statement. Once that has been done for both, we will then open up for questions. There are representatives on the Committee from the Opposition, Government and crossbench. Our practice is to share the time between ourselves to go through questions and go back and forth, which will take us through to 10 o'clock. I invite you to keep the opening statements reasonably short, if you possibly can, to open up the maximum time for questioning. I will pass over to Leeton Shire Council. Mayor Maytom, will you be making that opening statement?

Mr MAYTOM: Yes. A very good morning and thank you for the opportunity to address you this morning. As the mayor of Leeton shire, I represent a rural population of close to 11,500 residents and growing. I acknowledge the Wiradjuri nation this morning, on whose land Leeton shire is located, and acknowledge their Elders past and present. Leeton is the birthplace of the Murrumbidgee Irrigation Area and is arguably the most productive farming region in New South Wales. We are a busy and diverse community that contributes meaningfully to the economy of the State and the nation. Manufacturing, agriculture and education are our biggest employers. We have significant rice, cotton, citrus, walnut and beef processing plants in our shire. These are big businesses and several operate 24/7. Leeton also has three night schools and six primary schools. Two boarding schools draw students from far and wide. Our shire offers many highly skilled jobs, excellent options for a quality education, an incredible array of sporting facilities, an exciting arts and cultural sector, and a thriving business sector.

We have everything going for us as a growing and successful rural town, yet we find ourselves increasingly losing new retirees to the bigger regional centres like Wagga Wagga and Albury. When we ask why, we hear the same thing—"We want more reliable health and hospital services in our old age. Leeton is just not offering us that anymore." They go on to say, "Leeton used to offer us the health care we need. In fact, all our babies were born here and we never thought we would leave the town we love most. But today's medical services have eroded that significantly that we are left with no option but to move somewhere where the health services are more reliable." Commissioners, the situation is shameful in a country where we have the highest rate of doctors and nurses per capita. It is shameful that it is occurring in rural farming communities, which feed the nation, pay taxes and contribute significantly to the nation's wealth. Rural New South Wales deserves more than this.

Our local health concerns are not limited to retirees and the elderly. As the gaps in emergency services in Leeton become more widely known, parents of children who board in Leeton have been heard to say that they are considering removing their children from our schools, as they cannot be sure their kids will get the medical attention they deserve if something was to go wrong. Without a reliable health service, our community feels vulnerable and is vulnerable. All we ask is for fair access to quality health services. We consider access to decent health services to be a basic human right. Let me be clear that, as a rural community, we are not asking for anything unrealistic. We do not expect open-heart surgery in Leeton, or brain surgery or a specialist burns unit, but what we do expect are the basics. We expect to reliably receive basic treatment that saves lives and supports run-of-the-mill medical conditions.

Our community is that concerned that two public meetings have been called in recent years to discuss the situation. Council has also completed two community surveys in the last three years, and on both occasions

public confidence in local health services has come up as significantly wanting. In a rural population of 11,500, Leeton residents expect an ambulance to collect us in a reasonable time frame when our lives are at risk. We expect to arrive at our local hospital and be treated on site, not sent away, except under the most dire of circumstances. We expect a doctor that is a real-life doctor, not a doctor on the phone, to be available to respond when it is a life-and-death situation. We expect babies to be delivered at the hospital, supported by practised midwives and at least one experienced obstetrician. Five years ago 100-plus babies per year were successfully being birthed at Leeton hospital. Today it is less than 10.

In our submission we have provided the commission three examples of inadequate emergency services. A teenage boy with a head concussion at a local school waited 45 minutes for an ambulance and was not able to be treated at Leeton hospital because there was no doctor available. The decision to send him to Griffith hospital was questioned by a paramedic and the young man was subsequently flown to Sydney, which may well have saved his life. We provide the story of a 77-year-old man who passed away after an ambulance took 41 minutes to reach him even though his home was less than five minutes from the ambulance station. Had he known help was not immediately on its way, he would have arranged for his neighbour to take him to the hospital instead of waiting what must have felt like a lifetime. Finally, we provide the story of Leeton volunteers who are increasingly becoming the first responders to serious and sometimes fatal incidents due to the lack of available ambulance services. These people are not clinically trained but are being increasingly relied on to do work that is arguably outside their scope of practice as volunteer rescuers.

When we question what is occurring we find we have three ambulance vehicles in Leeton but only enough staff for one and a non-existent on-call system for backup. We also find that our ambulance service is often occupied transporting patients from Leeton hospital to base hospitals for routine assessments. In our view, ambulances should be available for real emergencies. When we question what is occurring with our hospital VMOs—that is visiting medical officers—we find there is no obligation for local GPs to be on the roster, and we find that a permanent CMO—career medical officer—cannot be attracted, as the pay is much lower than other States. We used to have doctors on call 24/7; now we are lucky to have a doctor available from 8.00 a.m. to 8.00 p.m., if at all. We sometimes find nurses managing emergency services alone, feeling unsupported, sometimes out of their depth and vulnerable. This, of course, can lead to burnout. It is disappointing when we find trained migrant doctors living in Australia and willing to move to the bush not being actively supported onto a pathway to achieve full Australian Medical Association [AMA] registration. This is a wasted opportunity.

When we question why our theatre has stopped being used despite a major upgrade, we are given too many excuses from the type of wall paint to the air-conditioning system, the theatre staff being out of practice and, most recently, the recovery room being marginally too small. These are all ridiculous excuses. As a rural community, we feel accountability is lacking, transparency is missing and genuine cooperation is absent. What is very apparent to us is that health services in rural areas are fragmented and there is a lack of coordination and flexibility between what is funded federally and what is funded by the State. To our community, health is health, and we are confused about why services have to operate in silos.

As Leeton Shire Council, we are strong proponents of community health service plans for each community. These health service plans need to identify community health needs and goals, respond to them holistically, and be transparent and accountable about service outcomes. These health service plans need local governance and local leadership, with full accountability, and should work in tandem with State and Federal services. The clinical and financial frameworks for these local health services plans need to allow for greater flexibility and more innovation. This is so important to our council and community that we have allocated $100,000 to advance this. We hope that this inquiry will go some way to addressing a health system that is broken and that new ways of working will be created that see more efficient and effective use of resources at the local level. Thank you, commissioners, for considering our plight as rural communities and recommending to government ways in which we can be assured of the level of basic health and hospital services we need and deserve. We look forward to responding to your questions today. Thank you.

The CHAIR: Mayor Maytom, thank you very much for what was a very thorough and frank opening statement. It contains much information, not just in general terms but very specific ones as well. I am sure that will lead to a number of questions from Committee members. After presentations today, would you be able to email that opening statement through to our Committee secretariat? That will enable us to get that into our *Hansard* with absolute precision. Thank you very much.

Mr MAYTOM: Yes, that is okay.

The CHAIR: I will move to Councillor Kschenka, the mayor of Narrandera. Will you be making an opening statement?

Mr KSCHENKA: Yes. Thank you to you and the Committee members for the opportunity to speak today. Before I commence I would also like to acknowledge the Wiradjuri people, who are the traditional custodians of the land, and pay my respect to their people both past and present. As mayor, I represent a community of 6,000 people, including a high proportion of Indigenous Australians. Six thousand might not seem many to people from the city, but bear in mind they are spread over many thousands of acres and, again, provide food and wealth for the nation.

We have an excellent local medical practice led by Dr Joe Romeo, a well-equipped and modern hospital, and two nursing homes providing aged care. We have a local ambulance service and council runs a community transport service. So all should be well. The local medical practice run by Dr Joe Romeo, who himself is himself a GP anaesthetist, recruits and trains overseas-qualified registrar doctors, who provide the primary health care to the shire residents. Those registrars require sponsorship, training and supervision, depending on their individual qualifications, experience and abilities. Changes to the Federal arrangements around overseas-trained doctors in November 2019 made that process more challenging. Training places have been limited and actually passing exams made more difficult. Simple things like language is a barrier, both in surgery and in exams.

There is little or no feedback provided to the supervisor by the examining body. Dr Joe Romeo loses out financially through reductions in the workforce incentive payment for time spent training these new doctors, and for lost time in actually seeing his own patients. I know you have heard this all before but no Australian-trained doctors have been recruited to Narrandera. More and more services are being centralised in Wagga Wagga and Griffith, resulting in residents having to travel for specialists, allied health and hospital services. The two Aboriginal medical services are located in Wagga Wagga and Griffith, with very limited outreach. That would be fine for people who can travel and can afford to pay.

Transporting patients to Wagga has its own problems, including sometimes overloading services at Wagga. When ambulances are used for the purpose of transporting patients, there is a risk that a local ambulance will not be available for an emergency and one will have to travel from another town, causing a delay in attending incidents, with potentially fatal outcomes. Mental health services in Narrandera are also very limited and the subject of many community complaints. Council's community transport service—this is to June 2021—has provided over 10,400 patient trips, 85 per cent of which are for out-of-town medical purposes, and 210,263 kilometres has been travelled by staff and our wonderful volunteers. It has 1,400 active clients supported by 7,465 volunteer hours.

The community transport service is not available for people once they enter an aged-care facility, which becomes a challenge for folk needing specialist care, including dialysis. The situation is typified by the difficulty in obtaining COVID vaccines in Narrandera. The town only last week received Moderna and reasonable amounts of Pfizer following many phone calls, emails and approaches to both Federal and State agencies. We greatly value the work of this inquiry, believing that health services are one of the most important issues facing rural New South Wales. Thank you. The general manager, George Cowan, and I will be happy to answer questions on council's submission.

The CHAIR: Thank you very much, Mayor Kschenka. Once again, a very detailed and frank opening statement. We thank you for that. I will move to questioning. We will commence with the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you, Mr Mayors and general managers, for your submissions and opening statements. Leeton Mayor, your submission shows a hospital under stress and a community that has lost confidence in its 66-bed hospital. How do you feel when people in the community raise with you that the operating theatres in your local hospital have been dormant since 2016? What do you say to them when they raise that with you?

Mr MAYTOM: It is very hard to answer the question because we get mixed messages from the Murrumbidgee Local Health District [MLHD]. As we covered earlier in our submission, there is excuse after excuse all the time. Essentially, they are seeing that when something like the operating theatre is not functioning—they see that as a threat to other services that may be existing in the hospital now. They feel that they will be moved on to the larger hospitals like Griffith and Wagga and then there will be a decline at our hospital, which could lead to further losses of other services. That is how the community feel about it. There was a big fanfare when that operating theatre opened. We felt encouraged that we were going to have a theatre in our local hospital that was going to take us well into the future. It took a few years and it has been lying redundant for all this period. It is very hard to explain to the community.

The Hon. WALT SECORD: What has been happening for the last five years? Have any operations taken place in the last five years in the new operating theatres?

Mr MAYTOM: My understanding is—I do not know the exact time of when the last operation was but it was many years ago. The doctors are going to Narrandera hospital—as the mayor, Neville, would probably recognise in Narrandera—and also to Griffith hospital. So, essentially, those procedures are carried out at either Narrandera or Griffith hospitals.

The Hon. WALT SECORD: What do local residents say when they discover that—for example, you highlighted the young man with the brain injury and a 77-year-old man who died waiting. What does the community say? What does the community want?

Mr MAYTOM: The community wants us, as a council, to do more to try and get outcomes and real outcomes. Myself, I have been on local health community councils for years and years—many years—and essentially we are a conduit for the community to the hospital and the health system. But, essentially, it is not working. We want to be a body of people like a council representing the community that says we can give them real answers and a real understanding of the pathway of where we are heading. At this moment, we are struggling to comprehend and understand. We are not seeing that real transparency we need to see. Give us a clear indication of what really is happening. Truly it is mind boggling to me as mayor to lead this community, and I cannot answer the questions.

The Hon. WALT SECORD: Mr Mayor, have you heard the excuse from the State Government that the recovery room was built 11 centimetres too small, therefore meaning that the operating theatre could not be used?

Mr MAYTOM: Yes, we have heard that. As I have said, we hear those things and it alarms us because we had three different reasons given to us why the theatre could not open. Now we have lost the staffing, or those that are adequately trained to be functioning there with the doctors when they do those operations. It is just going into a decline and we feel like we will not get it back.

The Hon. WALT SECORD: You have a 66-bed hospital with operating theatres that have laid dormant for five years. You have very little maternity services. I think in your submission you said that you have gone from 100 babies a year born at that hospital to less than 10 and no doctors at certain times.

Mr MAYTOM: The reasoning behind that is that there is no obstetrician. So if there is no obstetrician at our hospital, essentially they cannot take what they might consider a risky birth, as such. It is only what they consider straightforward births that they will take on. That could range between eight and 10, I understand, over the last few years, and that is with the midwife-led model. We were hoping that would be a temporary arrangement but, as it is now, the community are asking, "Why can't we get back to [inaudible] birthing at our Leeton hospital with an obstetrician and trained personnel available to help with those birthings at the hospital?" Again, it is one of those things that we feel that we are just having more and more fragmentation and things taken from the hospital. It is very hard to explain to the community. My children were born there. My wife's family were born there. We just see that we should have at least that basic position of saying you can have your baby here at our Leeton hospital. We have a population of 11,500 people and we just find it quite amazing that they say the new midwife-led model is adequate for our community. It is servicing our community but not the needs of our community.

The Hon. WALT SECORD: Mr Mayor, excuse the bluntness of the next question, but what is occurring at Leeton hospital? What services are being provided at the 66-bed hospital? If it has gone from 100 births a year down to eight to 10, operating theatres vacant, dormant, ghost wards—what is actually happening at that hospital?

Mr MAYTOM: That is probably a question you need to be asking the MLHD because it is a little bit hard for me to understand that outside that the basic patients are there with mainly minor illnesses. I do not even know how many beds are vacant up there at the present time. Obviously we have the emergency department, where people come in and sometimes are admitted. You would see in our submission that, in many cases, they are taken somewhere else, or they may choose to go somewhere else because they are fearful there will be no doctor on call. We have already come to a position of losing a lot of, I suppose, what the hospital should be doing for our community to now having a bigger threat because we are saying that maybe we do not have adequate staffing there to service the needs of our community. That in itself is posing a real threat to us as a community going forward.

The Hon. WALT SECORD: Mr Mayor, how do you feel when you hear that in Sydney there are $200 million or $300 million upgrades to hospitals and in your hospital you do not have births, you do not have doctors and you have ghost wards? What would you say to the new Premier about the need for rural health in your area?

Mr MAYTOM: I would certainly say that we need to have that transparency from our community in conjunction with the MLHD and question the people that know and understand what is happening. Do not just

put money into something and say, "Well, there's the money and the whole thing should be okay." Question and understand what the real needs are of our community and what we can do to improve the hospital services, and hopefully retain our hospital services that we have got now, because we are concerned. So, yes, money itself will not fix the problem. Money will help, but certainly it is this system that is not working as we believe it should.

The CHAIR: I thank the crossbench for allowing the Hon. Wes Fang to proceed with his questions.

The Hon. WES FANG: Thank you very much to both of the councils. They are councils that I know very well and which I have worked closely with in my time in Parliament. I really appreciate the effort that you have put into the submissions and also making yourself available today to share your experiences and concerns with health care. I want to ask each council in turn, obviously part of the issue is around the attraction and retention of doctors. We know that in Wagga, for example, we are starting to look at the model where we have a rural medical health training facility that will start to train doctors. Have you had the opportunity to have some input with regard to placements and offers of support to those schools to give those students the experience in regional areas that they need to be attracted and kept in areas such as Leeton, Narrandera, and even west of those two towns, into the future? We will start with Narrandera and Mayor Kschenka.

Mr KSCHENKA: Thank you. We have not had any input in that regard. We certainly welcome the initiative. How effective that will be, though, I do not know. Hopefully there will be incentives for those trainees to actually train in the bush, which is what I think Mr McCormick was alluding to, and then they might stay here. To answer the question, no.

The Hon. WES FANG: Leeton?

Mr MAYTOM: Can I pass over to the general manager to answer the question?

The Hon. WES FANG: Please.

Mrs KRUGER: Thank you. We are definitely aware of the initiative and applaud Murrumbidgee Local Health District for setting up the system and recognising that rural GPs need to be recognised as specialist doctors and supported in the same way as other specialists should be. In terms of direct support, in our submission we made reference to the fact that we have had migrant doctors say to us that they are interested to move to Leeton. They have full doctor's qualifications but they do not have everything that is required to be AMA registered. We have drawn those doctors to the attention of the MLHD for many, many months and asked for support for them to be put on a pathway. We are seeing a lot of doctors graduate in Australia but not many coming to the bush. When you have a trained doctor who is willing to live in the bush, what we really want to see is a pathway for them to close any gaps that they might have so that they can get full registration. At this point in time we have not quite seen that link through to the local hospital in Wagga that is putting on this new program. If we can get these ideas dovetailing together, it would be enormously helpful.

The Hon. WES FANG: I appreciate that my time is shortly to expire. I know my colleague the Hon. Natasha Maclaren-Jones has a question. Leading on from that, given that you have not been able to have any input into that program as such—we have heard, particularly yesterday, that a program around rural generalists where a GP is trained not only in being a GP but also in other services like obstetrics and anaesthesiology is important for smaller centres, I would imagine like Narrandera and Leeton. I am guessing that both councils would support that sort of training regime, that rural doctors have that more general skill base so that they can support a hospital?

Mr MAYTOM: Yes, we certainly would—from Leeton, yes.

Mr KSCHENKA: And also Narrandera would, indeed. That is part of the issue at the moment, that GPs are perhaps a dying race.

The Hon. WES FANG: I will pass over to my colleague the Hon. Natasha Maclaren-Jones. Thank you so much for both appearing today and making your submission.

The Hon. NATASHA MACLAREN-JONES: I do not have any questions at the moment.

The CHAIR: On that basis, we will move to the crossbench. I invite the Deputy Chair, the Hon. Emma Hurst.

The Hon. EMMA HURST: I have a question for Mayor Kschenka. In your opening statement you talked about the council's transport service. Certainly we have heard a lot from a variety of charities, for example, during our hearings for this inquiry that often where there have been gaps, other people are having to fill those gaps and actually fund the services as bandaid solutions. It sounds like the same thing is happening with your own community transport service. I am assuming that costs the council a lot of money and that it is difficult to have

the local community step in. What is the solution here? Do you feel that that is something the council should continue to pay for going forward or is there something else that should be done instead?

Mr KSCHENKA: I might ask the general manager to respond to that one because he is more familiar with the costings. It is a shared cost.

Mr COWAN: If I can just say, the community transport service that we run is jointly funded by State, Federal and council. It is actually delivered, in the main, by volunteers—so local people who volunteer their time. And, as you can see by the numbers the mayor provided, it is very extensive. An example of those—we have got five folk that go to Griffith three times a week for dialysis. That is a whole-day job. The volunteer leaves here at half past five, quarter to six in the morning, drives to Griffith, stays there all day and then brings those folk back home, and they do that three times a week. At the moment we are relying very heavily on those volunteers. How much longer that will last, I do not know. Across society, volunteering is shrinking. As these volunteers get older, it becomes more and more problematic.

The Hon. EMMA HURST: We also heard yesterday that the demand for services was also increasing. Is that something that you are worried about going forward? If the number of volunteers is shrinking, is there also potentially going to be a greater demand on this transport service as well?

Mr COWAN: COVID may have had something to do with this, but our trip numbers are up 50 per cent on the previous year—in the financial year to 30 June. So the need is definitely growing. The mayor mentioned that we have a large Aboriginal component in our community. Those folk cannot just drive themselves to Wagga and Griffith whenever they feel like it and they are heavily reliant on the service, so yes.

The Hon. EMMA HURST: Correct me if I am wrong, but I think in your opening statement you said that the transport service is not available for people in aged care. If I have got that right, I am wondering what happens there when there is an emergency? Is that when ambulances are having to be called in, or family members?

Mr COWAN: Yes. Typically, it is family members. I am actually dealing with an issue at the moment where one of those patients who requires dialysis is moving into an aged-care facility here. Once they become a permanent resident in aged care, they are not eligible for the community service because it is jointly funded by the Federal Government, as are aged-care facilities, so they will not allow us to cross-subsidise. So that falls back then on the family to do that transport three times a week to Griffith. It is really horrendous. We have approached the Murrumbidgee Local Health District about the possibility of having a chair or two installed in the hospital here. There is plenty of room, but the response we get back from them is that it is a staffing issue. The same with the birthing. So many staff these days are specialised specialist people and they are simply not available to come to smaller hospitals.

The Hon. EMMA HURST: Do you have situations where family members are not able to step in and do that transport? What happens there?

Mr COWAN: I guess that is part of the decision-making. I know that a number of folk, when they have got to the point of needing aged care full time, they have had to go to a service in Wagga or Griffith. They just cannot sustain living in a small community and travelling as much as they do because obviously their medical needs increase at the same time.

Ms CATE FAEHRMANN: Thank you both for appearing today and for your submissions. I want to go to Leeton council and maybe to you, Mayor Maytom. Your submission had a lot of information and was very valuable, so thank you for that. I want you to comment on a few things, given the evidence that you have given us in relation to Leeton hospital and the fact that, to be honest, it appears to be deliberately being run down. We have heard quite a bit of evidence from witnesses in relation to rural hospitals which is very similar. It does appear that there is almost a deliberate strategy to run some of these rural hospitals down to the ground. Would you agree with that statement?

Mr MAYTOM: Generally, the community are saying that. But we need to understand that I think $2.5 million is being spent at our hospital right now with the emergency department. Yes, that is great that is being spent in the emergency department but we are concerned about the other services of the hospital system that we are worried about. We do not even know what the budget is going forward. We do not see that sort of stuff anymore. That is why we need to develop this local community health plan, so that we fully understand what the 10-year plan is, if you like, of that hospital and the services that are linked with the hospital. We need to understand that better.

Ms CATE FAEHRMANN: This comes down to my next question. You mentioned in your submission the fact that the local health advisory committees no longer have a say in local health services planning. My

understanding then from your submission is that they did have a say and they no longer do. Do you know the history of that to inform the Committee about?

Mr MAYTOM: Many of our community and some councillors have suggested we go back to the old board system. They had the board that used to run and the board, these local members, had a say in what was happening. They had more information. Then when it went to the local health committee plan or the local health advisory committee—essentially it is supposed to be a link with the health system and our community. But it just does not happen. We do not seem to get that information that we need or have clear indicators on where we are heading for the future. I feel, to some degree, helpless that as mayor—and I am on that committee—we cannot, I suppose, answer those critical questions that our community are asking us to do. That is why we want to work in conjunction with the MLHD and understand better what the pathway is forward. We want to be a part of that pathway. We will do whatever we can to work with them to ensure that we have the adequate health services that we should have for our community. We are not just complaining about it. We are saying we believe we can have solutions if we can be more involved, and that would mean more transparent.

Ms CATE FAEHRMANN: Is that the council or is that basically most people, including health professionals and clinicians, in Leeton? They are trying to have input into health services planning and they are unable to because the LHD and primary health network are pushing back on that.

Mr MAYTOM: It is hard for me to answer what they are doing. That is why the local health plan we are talking about is to try and encompass the doctors and the services, the aged-care services and the ambulance—the whole. They all have combinations so that we get a better understanding. I just feel we are limping along and I just feel that if we can invest a bit of time in being a partner with MLHD and other agencies, we can help speed up the system to ensure that we have confidence within our community about where we sit going forward. At the moment there is very little confidence, unfortunately.

Ms CATE FAEHRMANN: Can I just check with Narrandera council, is that similar in terms of lack of access to health services planning by people at the local level? Do you have recommendations in that regard?

Mr KSCHENKA: We cannot just have health as a business, for example, and a numbers game. We need governments to understand how important our communities are to the whole of Australia. Sometimes we cannot get the numbers but—for example, a local organisation wanted to buy a dialysis machine and donate it to the hospital. But it was not going to be any use because we could not actually man it and have the people there to operate it. My question is do people understand the importance of the rural communities? Yes, we are only 6,000 people but what we contribute to the nation is extremely important. So it is not just a numbers game. Do you have anything to add to that, Mr Cowan?

Ms CATE FAEHRMANN: I have one last question, if I can, Chair. This is in relation to the Leeton submission, which highlighted the lack of registered nurses [RNs]. You stated that Leeton hospital is short at least five RNs on the wards alone, that existing nurses are working multiple shifts for extended periods, which, of course, leads to fatigue and burnout. Is part of this because of nurses leaving for retirement or fatigue and burnout? Why aren't the positions being filled? Would you care to expand on that situation?

Mr MAYTOM: We certainly do not get all that detail. We are aware of at least a couple of cases where nurses have chosen to leave the system. I am not going to speak on their behalf; however, they have given their reasons. I do know that there are two nurse practitioner positions that have been advertised for at least a couple of years, I think. One of the issues is that we are not filling the gaps up there for those qualified people to be there to service our needs in the first place. We need to get more information and understand what we as a council can do to try and halt that process. As I said earlier, the CMO position has been advertised for quite some time. We do not have any takers. We have locums that are coming in periodically. We do not know at any time—if we went up the hospital today, is there going to be a doctor there to service the needs of our community? We do not ever get the indication of what is happening at the hospital. Our community should be told. It should be aware. When we do not have a doctor available—unless it is an absolute emergency case—we should at least be aware.

Some people choose to then not take their child to Griffith hospital because they believe they are going to have a better chance. In fact, there have even been cases where they went to Narrandera because they thought they had a better chance of seeing a doctor. That is really where it is up to. We do not have enough accurate information for us to do what we want to do. But with our local community health plan that we are putting forward, we believe that we will get the relevant information, which will then give us a clear pathway and we can set a plan for the future. At this moment we are struggling to comprehend and understand what that plan is.

The CHAIR: That has brought us to the conclusion of the session. To the mayors and general managers, thank you very much for making yourselves available today. We know that you are very busy. The evidence has been very detailed and measured, but I can assure you that we can hear in your voices, dare I say, a cry for listening

to the needs in your communities, which you are representing very well. I thank you once again for your time and your submissions. I give a special thanks for you to pass on to all the outstanding volunteers in the communities you represent who are stepping up and assisting to deal with these matters. Their contribution is incalculable to helping their fellow residents and citizens in their communities with health and medical issues. We undertake to do the best we can as a committee to produce a report and recommendations that will improve their lots.

(The witnesses withdrew.)

ADAIR GAREMYN, Policy Manager, Country Women's Association of NSW, affirmed and examined

LINDA McLEAN, Branch Agriculture & Environment Officer, Country Women's Association of NSW, Hillston Branch, sworn and examined

The CHAIR: I sincerely welcome our next witnesses to our public inquiry this morning, who are from an organisation that is very historic in its time of being with us and also in the way in which it has represented and provided advocacy and services to our citizens living outside the major metropolitan areas. Of course, we are talking about the Country Women's Association [CWA], and we welcome the two representatives today. I acknowledge both of you, and I acknowledge that we have received submissions from both the organisation at large, the New South Wales branch, which stands as submission No. 445 to the inquiry. It has been received and processed as a submission to the inquiry and has been uploaded onto the inquiry's webpage. We particularly welcome the contribution from the Hillston branch, and thank you very much for the preparation of that. That has been received, processed and stands as submission No. 712 to the inquiry. As received submissions, they now make up formal evidence to the inquiry, and we thank you for that. We will perhaps get things underway with an opening statement. I am not quite sure whether you wish to share it between yourselves or do a single opening statement. What would you prefer?

Ms GAREMYN: I think we are going to do one each, Chair.

The CHAIR: Please. I think it is appropriate then, as the policy manager, if you could please proceed. That would be great.

Ms GAREMYN: Good morning, Chair, Deputy Chair and Committee members. Next year the Country Women's Association of NSW marks 100 years. It was formed in 1922 to address isolation and a lack of health facilities. At that time the members worked tirelessly to set up baby health care centres, fund bush nurses, build and staff maternity wards, hospitals, rest homes and many other types of community services. To this day, addressing a lack of rural health services remains a priority issue for the members of the CWA. We are very welcoming of this inquiry. We think it is something that has been needed for a very long time.

In our submission to this inquiry, we firstly present longstanding health-related policy of the CWA. Policy is democratically voted on at each year's State conference after going through a rigorous process of ensuring motions are valid, researched and relevant. Every year since its inception, health and health services for the bush has been a significant part of the agenda for the CWA. Some more recent issues put forward, for example, are seeking more public cancer clinics in regional areas; more services for perinatal anxiety, depression and support; more registered nurses; more enrolled nurses; more mental health clinicians and psychologist services; cardiac bus visits; more blood and blood products stored in rural hospitals; and the availability of maternity care and continuity of care for pregnancy. They are just some of these examples. There are many ways to start to address such a huge task. One idea that has come through the CWA of New South Wales is a rural loading incentive payment through Medicare, for example.

We have also surveyed our members for the purposes of this inquiry. We were flooded with examples and stories about people's experiences in regional health. We overwhelmingly heard about a lack of access, significant wait times for services and people faced with the impossible decision of staying on a wait list, which they do not know how long it will be, or uprooting everything to go to the city for treatment. A lot of the time there is no choice. It is interesting to note that over 52 per cent of our respondents do believe that the quality of care in the regions is on par to the city but there just are not enough medical professionals, staff, infrastructure, equipment to provide an equivalent level of care to that which they could get in the city. What this says to us is that the health professionals that are out there are doing an excellent job with very little resources and very little support. We are calling for a significant increase in funding for recruiting and retaining more permanent health professionals and staff, upgrading of hospitals and health services, reversing the decline in maternity services and birthing units from within hospitals, a significant increase in psychological services and many more. The issue needs ongoing review and evaluation in terms of health outcomes, and we are hopeful this inquiry is just the first step.

The CHAIR: That opening statement sits very nicely with the comprehensive submission that has been provided by the New South Wales branch, so thank you very much. I invite the next opening statement from the Hillston branch.

Mrs McLEAN: Thank you, Chair, Deputy Chair and members. The Hillston branch of CWA has a strong commitment towards health issues in our town, which has a population of approximately 1,400 people. The branch is concerned with women's health issues, mental health services, locum doctor and locum pharmacist availability, and the use of telehealth as the only solution for rural and remote services. It is unfair and inequitable

that an individual would have to travel up to four hours to Albury, bypassing Wagga as they have insufficient beds, in order to access specialised psychiatric care due to the nearest major centre, Griffith, not being able to provide that facility. Griffith has a population of approximately 27,000 people—large enough, I would have thought, to have a permanent psychiatrist on duty at the hospital. These lengthy trips to access medical services is extremely difficult on both the patient and their families.

Our branch is concerned by the apparent lack of psychiatrists and clinical psychologists in New South Wales; both are very real problems. Both State and Federal governments need to address how this problem can be fixed. Funds need to be made available to give incentives to young medical students and those already practising to take up psychiatry. There needs to be funds made available to these trained people as an incentive to move to regional New South Wales. There needs to be funds provided for beds for psychiatric care and funds available to those living in rural and remote New South Wales to access these services.

A system needs to be put in place that is unique to rural and remote New South Wales that allows for doctors and pharmacists to be relieved from their duties for much-needed downtime and/or professional development without leaving our towns vulnerable for lengthy periods of time. Telehealth is not the only solution for rural and remote medical services. I am sure if the city folk had to rely on telehealth for a majority of their health outcomes, they too would be reluctant to take up the service. Imagine if you had to discuss your personal health issues in a forum like what we have today. I am sure you would be hesitant to divulge what may be required. It can be difficult to build trust and rapport within these forums without a personal face-to-face connection first. Basically, CWA Hillston branch would like to see equitable access to services for all living in rural New South Wales in relation to the health outcomes. Thank you.

The CHAIR: Thank you very much, Mrs McLean. I have to say that is also a very good and clear opening statement. It fits very nicely to your six-page submission, which I have to say is very well written and is rich with information and detail, which I am sure is going to lead to some questions from Committee members. We will now pass to Committee members. We will commence with the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you, CWA. I acknowledge the historic and influential rural body that you are and why your organisation came about. Mrs McLean, do you find it strange that a hundred years ago the CWA was established to improve rural and regional health and you are still fighting the same battle?

Mrs McLEAN: It is strange that we are fighting the same battle, but things have improved along the way but not to the level that they should be in today's modern age.

The Hon. WALT SECORD: We have had evidence that hospitals are without doctors. We heard this morning of unused operating theatres dormant for five years, a reliance on telehealth, avoidable deaths, lack of medical supplies, including blood products, and no maternity services or very limited maternity services in communities. How do you feel when you hear that?

Mrs McLEAN: I feel very, I suppose, angry. It is just unfair.

The Hon. WALT SECORD: Ms Garemyn, how do you feel and what is the feedback that you get from your members across the State?

Ms GAREMYN: I guess I feel disappointed. It is sort of an unnecessary state that we are in. Members tell me all the time they feel like second-class citizens and, I guess, as Mrs McLean said, unfair. It is just plain unfair that there is this sort of treatment to people just because of where they live.

The Hon. WALT SECORD: This is not my view, but we have heard in other evidence to this Committee where people have said, "Well, you decided to live in a rural and regional community, and that's what happens when you live in a remote part of New South Wales." That is not my view, but that is what doctors have said that people have told them.

Ms GAREMYN: Yes, we do hear that as well. It is funny because you hear that but at the same time you hear about strategies to alleviate the traffic problems in the city, the overcrowding and that sort of thing. On the one hand, I think we want people to be moving to the regions but, on the other hand, they are not going to do that if there is not something as essential like health services to incentivise that. So it is disappointing to hear that. There is no reason why it has to be that way simply because of where someone lives.

The Hon. WALT SECORD: Mrs McLean, you raised psychiatric care. I understand that in south-western New South Wales there are huge areas where there is no psychiatric support in any sense—no mental health workers. Can you tell me what is your experience and what do your members tell you about psychiatric care in south-western New South Wales?

Mrs McLEAN: I can speak for the Hillston and the Griffith regions, south-west of New South Wales. If you have an issue and it starts from Hillston, you would go to Griffith. From Griffith, you would be seen by a doctor on duty and they would do, obviously, an assessment as to what is happening in your position, and then you would either be transferred to Wagga—Wagga would be the next place that you would go, and if Wagga does not have any beds available, you are transferred to Albury [disorder].

The Hon. WALT SECORD: How many kilometres or hours would that be from Hillston?

Mrs McLEAN: From Hillston to Griffith, you are talking 110 kilometres. From Hillston to Wagga is probably another two hours, so at least another 200 kilometres, and another hour on from Wagga to Albury. Taking that route, you are looking at probably another hour, hour and a half maybe.

The Hon. WALT SECORD: [Disorder].

Mrs McLEAN: Up to four hours or more to get to—if you had to go to Albury, you are looking at up to four hours at least.

The Hon. WALT SECORD: So what do families do if someone has to be four to five hours away from their family for a psychiatric care, psychiatric support? What does that do to rural and regional families and to people needing support?

Mrs McLEAN: Well, it disrupts the family. You would probably find that if that person does have access to a vehicle—most do but if you are on benefit or something like that, you might not have the means to drive yourself to Albury or Wagga to meet up with the family member who is having the psychiatric care. Therefore, they might not be able to travel all that way. So they stay in Hillston and the person who is receiving the care is unattended by family members. There is no outside input into this care situation. I am probably not explaining this very well.

The Hon. WALT SECORD: No, you are.

The CHAIR: That was very clear.

The Hon. WALT SECORD: You are very clear. Now, you talked about the challenges of telehealth. We know that in rural and regional areas, many areas, nurses are forced into a situation where on weekends they have to rely on telehealth. What are your views about telehealth?

Mrs McLEAN: My views on telehealth is that it is not the only solution. We need other outcomes. We need people to be able to access—people need people to communicate and to get their message across. Even the way the telehealth system is set up, you might have a screen that is quite large up on the wall and the person sits quite distanced from it. It is not like me sitting here at my desk with a personal laptop, just looking one on one. You would have probably maybe a bit more connection than that. So how the whole situation is set up—if you have got someone who is having psychiatric care or having an assessment sitting there just looking up at the screen, their mind might be wandering and you do not know what they are thinking. It is very hard to get them to try and focus on the situation that is in front of them.

The Hon. WALT SECORD: Ms Garemyn, you were nodding during that. Do you find similar experiences and feedback from your members about telehealth and psychiatric treatment by telehealth?

Ms GAREMYN: Yes, that is right. We hear that all the time. Telehealth is a good thing if it is there and there is no other option, but obviously it is not ideal and nothing can replace that face-to-face treatment, especially when it comes to psychiatric services, I think.

The Hon. WALT SECORD: In your submission, Ms Garemyn, you highlighted the need for improved cancer services. Can you give me some examples and some of the feedback from your members about cancer services in rural and regional areas?

Ms GAREMYN: Yes, absolutely. It was not uncommon for us to hear stories of people having to travel hundreds of kilometres—400 kilometres—to seek those services. What that means is, as Mrs McLean was saying, being away from family and being away from your business. A lot of people in rural areas run their own business and they do not necessarily have someone to replace them, so that means if a member of the family is away, the other members of the family are not necessarily going to be able to accompany them or be with them. I think COVID has highlighted for a lot of people how hard that is, to be away from family when you are undergoing treatment. So that is something that rural people do all the time pre-COVID. We heard lots of stories from all sorts of areas, and that was due to the lack of oncology services.

The Hon. WALT SECORD: Absolutely. Are you familiar with the Isolated Patients Travel and Accommodation Assistance Scheme [IPTAAS] program?

Ms GAREMYN: Yes. We did not overly hear too much. We did ask for feedback about that in our survey but we actually did not hear too much, which makes me think it is maybe not so widely taken up. I am not sure what the Committee has heard during the process.

The Hon. WALT SECORD: Mrs McLean, would you like to add something about that? You nodded during that.

Mrs McLEAN: Yes. With IPTAAS, people do take it up, but it is sometimes not offered. The patient has to ask themselves for IPTAAS access; it is not an automatic system that happens.

The Hon. WALT SECORD: You are familiar with the way the Committee process works—that we make recommendations to the Government. Would you feel that there could be recommendations involving publicising or increasing or improving the IPTAAS program?

Mrs McLEAN: Definitely, yes.

Ms GAREMYN: One thing we did hear was that the costs were not anywhere near the out-of-pocket amount experienced by people, so perhaps that could be part of the recommendation—its actual realistic costs.

The Hon. WALT SECORD: Thank you.

The CHAIR: We have just gone time—could we circle back if we can, the Hon. Walt Secord?

The Hon. WALT SECORD: Yes.

The CHAIR: Thank you very much. Can we proceed now to the Deputy Chair, the Hon. Emma Hurst.

The Hon. EMMA HURST: I wanted to start with a couple of questions to Mrs McLean in regard to some things in your submission. You noted that in 2015 you lost the services of both the visiting women's health nurse and the monthly visit of the Royal Flying Doctor Service. Why did these services cease and what has that meant for the community?

Mrs McLEAN: My understanding is the women's flying doctor service was ceased due to funding during a period of change of doctors as well—one doctor was leaving; another doctor was coming in. For the community, it upsets the community and it upsets the women with the flying doctor service being ceased because they would normally have regular every-five-week appointments that could be made available, and that is just not happening at the moment.

The Hon. EMMA HURST: Has the Government made any effort to reintroduce or make up for that loss of services?

Mrs McLEAN: I cannot tell you that. I do not know.

The Hon. EMMA HURST: Okay. That is all right. In some of your answers to my colleague Walt Secord, you talked about the travelling distance of 110 kilometres to the centre in Griffith, and that is the same as well for women who are giving birth, for example. We have heard horror stories of women giving birth on the side of the road. Is that a genuine fear for the women in your community who are pregnant?

Mrs McLEAN: Definitely. For those who do not have transport themselves, it is a genuine fear—and when I say "transport themselves", if they have to rely on somebody else to get them there, maybe like the ambulance or something like that, yes. It has genuinely happened—women have had babies en route to Griffith, yes.

The Hon. EMMA HURST: Does that deter women from moving into the area to bring up their families there? Do you find that there is any feedback that people are not willing to move to rural areas because of that fear?

Mrs McLEAN: I have not personally heard of that fear, but that does not mean to say that members of the branch have not.

The Hon. EMMA HURST: Just moving on to Ms Garemyn, in your submission you mentioned that a unit of O-negative blood should be available to all country hospitals at all times. This seems like a very basic request. Is this something that is not currently happening? Can you give us a bit more detail about that?

Ms GAREMYN: Yes, sure. This is something that we have actually been advocating for for quite some time, and the response—there are logistical issues in terms of how long the blood can actually be stored for. So it really is a very difficult task, but we continue to seek that minimum requirement for all country hospitals.

The Hon. EMMA HURST: So that is something that you have been asking for for a long time and it is still not in place?

Ms GAREMYN: Not as yet.

The Hon. EMMA HURST: Another recommendation was that every tertiary referral hospital in New South Wales should provide onsite or nearby accommodation that is affordable and also be wheelchair accessible. Is that one of the big challenges that you are experiencing? Can you talk a little bit more about this and what needs to actually be put in place for that recommendation?

Ms GAREMYN: Absolutely. I guess it is for people that are visiting and being able to have their family come and stay whilst they are seeking treatment. That is often not available or not the case. There are some really good programs out there, but we are just seeking more funding for those sorts of programs more broadly.

The CHAIR: Ms Cate Faehrmann.

Ms CATE FAEHRMANN: Thank you both for appearing. I just wanted to expand just a little bit on the questioning by Mr Walt Secord in relation to mental health services. Obviously often before the bed situation there is the access to psychiatrists and psychologists. Mrs McLean, I might ask you first: What is the access like and the availability and the cost for people who are seeking access to psychiatrists in particular?

Mrs McLEAN: Seeking access to psychiatrists, at the moment you need to go to Griffith. There is a mental health unit there on Yambil Street, and their psychiatrist is fly-in fly-out and it takes every two weeks. I guess that is through the health system, so you probably would not have the cost associated with that. But if you have to go privately, then the cost is—I do not know the exact cost of the fee today, but people have paid up to $700 to have access to online services for a psychiatrist. The mental health unit in Griffith tells you that if you want to access a psychiatrist and you have not been referred or you are not having an acute situation, you will not get access to that fly-in fly-out psychiatrist. You would probably have to go privately for a service.

Ms CATE FAEHRMANN: That is extraordinary. This is a situation where mental health issues are quite significant in the district. Is that correct?

Mrs McLEAN: Yes.

Ms CATE FAEHRMANN: It sounds like there is unmet demand. People would not be able to afford it, for a start?

Mrs McLEAN: That is right. If you are having to pay significant sums to go and see a psychiatrist, then obviously the patients have got to be willing and able to have someone get them there, and then they have got to pay the fee as well. I suppose with the online, they could be doing it from home and not having to travel anywhere, but it is just the availability of it. There was a surgery in Griffith that had a fly-in fly-out psychiatrist coming through and you could access Medicare for that, but that no longer, to my knowledge, is available.

Ms CATE FAEHRMANN: Ms Garemyn, do you have anything to say or add to that question?

Ms GAREMYN: We have this sort of story replicated, basically, around the State. I do have the statistic—and I can bring it up while we move on, if you like—about the percentage of our respondents that were able to access psychiatrist services. I will just quickly bring that up while we continue.

Ms CATE FAEHRMANN: Great. I did want to move on then to basically the availability of alcohol and other drugs treatment and services. What are the gaps—and I am assuming there are quite a few—particularly in relation to treatment services and rehab facilities in the district, Mrs McLean? We will go to you again first.

Mrs McLEAN: With the mental health unit, there is the drug and alcohol unit attached to that. I cannot tell you too much about that, but, yes, there is the drug and alcohol available in town. For Hillston, they do outreach but it is more of an on-demand service. It is not something that is regularly made available.

Ms GAREMYN: [Disorder].

Ms CATE FAEHRMANN: Ms Garemyn?

Ms GAREMYN: So 47 per cent of our respondents have access to psychiatry services. We define that as within their local government area [LGA] or within a hundred kilometres from their home. In terms of alcohol and other drug treatment services and support services, 39 per cent of our respondents could access those within their local government area or within a hundred kilometres from home.

Ms CATE FAEHRMANN: Can I check with your survey? It was excellent that you undertook that in consultation for this inquiry; it is incredibly useful. Was the question around the women participating in the survey, or was it for them and their families and partners as well?

Ms GAREMYN: It was open to anyone that lived in rural, regional or remote New South Wales. We did not limit it to just our members. But because we distributed it through our channels, obviously the respondents were largely our members, but it was open to everyone in regional areas, and we had over 850 responses.

Ms CATE FAEHRMANN: One of the other issues that we have heard about in the last couple of days particularly is the provision of—well, the lack of services, really, in terms of oncology services and the huge reliance that cancer patients have on volunteer organisations such as Cancer Council and Can Assist. Do you see that within your members as well? I do not know if the CWA also provides assistance in that regard in terms of helping your members when it comes to accessing health services. Would you like to talk about the essential role that volunteer organisations play in sometimes filling the gaps that are not being provided from the public and private health system? Ms Garemyn, we will go to you first.

Ms GAREMYN: Sure. As I was saying in my opening statement, that was one of the founding reasons for the CWA: stepping in where there is a gap. I am sure there are branches around the State doing these sorts of activities. For example, I know some of our halls have been used for hearing clinics or vaccination clinics recently as well. So the CWA continues to do that sort of thing. In terms of the question about oncology, I just thought I would raise as well we had 40 per cent of people from our survey responses that could access oncology services. That is quite a fair portion, I think, representing people that simply cannot access that type of service or treatment in any way. That is at least driving an hour just for that, so I thought that was interesting.

Ms CATE FAEHRMANN: I suppose most of the health services we are talking about really are not optional, but with cancer it is starkly not really an option as to whether or not you can access a service. We heard yesterday that in fact some people are refusing or having to forego treatment, having to make the tough decision to not go to treatment, because of cost and distance, and overall they just cannot do it because of those two things. Are you hearing those stories as well?

Ms GAREMYN: Absolutely. It is just too hard. It is too hard for people, and they just should not have to make this choice. Yes, we hear that all the time.

The CHAIR: I will move now to Government members. The Hon. Natasha Maclaren-Jones, will you take the lead?

The Hon. NATASHA MACLAREN-JONES: Yes. Thank you, Chair. First of all, I also extend my congratulations to all the work that the CWA do, particularly coming up to your 100 years. It is amazing and we have heard this morning—and Cate referred to it previously—about the role that volunteer organisations play, particularly at the moment, and the challenges that you have in keeping membership. So I just want to say well done with all the work that you have done. My first question is around training and development, particularly for recruiting of doctors and nurses and allied health professionals to rural and regional areas. In your submission, Ms Garemyn, you mentioned about fit-for-purpose training. I wanted you to elaborate on what needs to be done to the training that is provided to our young professionals or what needs to be looked at to encourage and ensure that they are retained in rural and regional areas.

Ms GAREMYN: I think there are a lot of different things that we could look at here. One of the examples that the members of the CWA put forward in the past is more of the rural-based scholarships for medical training. We had a discussion, I think, two years ago at our State conference about trainee aged-care nurses having to pay for their own training expenses while they were on their practice rounds. One of our solutions was that at least they should have their expenses provided for during training—those sorts of things. Everything needs to be looked at. Perhaps what you are referring to as well is that tailor-made approach. Often in the country in all professions, not just health, you might have someone quite junior out there maybe on their own. So it is really important that these people are supported with the learning opportunities that they would have in the city out in the regional areas as well.

The Hon. NATASHA MACLAREN-JONES: It has come up in previous hearings about the importance of nurse practitioners and also the desire for more of them. Do you have any comment or any feedback from your members about the work of nurse practitioners and whether or not there are particular areas they would like to see more nurse practitioners recruited for?

Ms GAREMYN: Across the board, I think our members tell us that there is often just not enough nurses to even provide a safe level of care. They are often young. As I was talking about, maybe they are on their own. There has been a lot of discussion recently about violence towards healthcare workers. If the environment is not safe and secure and supportive, we are not, unfortunately, going to attract any more. I would just reiterate that all of those things need to be looked at, and one of our biggest and strongest calls is just for more enrolled nurses and registered nurses in regional areas.

The Hon. NATASHA MACLAREN-JONES: My final question before I move on is just in relation to one of the statements you have made in your submission about the review of disparity of the prices charged across health professionals. Could you give some examples of that, and what are your suggestions in relation to it? I am mindful that a lot of health care and funding does cross over State and Federal boundaries, but this inquiry is looking at health in general, so, even though it could be Federal issues, it is good to get some of those things on the record.

Ms GAREMYN: What we heard from our members was just the disparity. Often it was unknown how much maybe a mammogram or a scan was going to cost, and it might cost one person a certain amount and another person a different amount. So I guess the ambiguity in all of the costs—not knowing how much something is going to be before undertaking the treatment, for example. I think what we would like to see is a review of all of that—you know, what is covered under private health care. We heard a lot of our survey respondents wondering what they are paying for. I know this is out of the remit of this inquiry, but it seems to be a big problem; people are paying money for private health care and not necessarily seeing any benefits to that. Even the costs through the public system, in terms of regional people, that was more about self-funded trips to bigger regional centres or the city to seek treatment and accommodation costs, time away from work, travel costs and those sorts of things. So, yes, that was definitely a strong part of what we were seeking to have addressed.

The Hon. NATASHA MACLAREN-JONES: I have a question just following on from that to Mrs McLean in relation to your comments in your submission regarding pharmacist funding and the model of funding for that. I am aware, again, that it is more Federal, but I am interested to hear what was the view of your members in relation to that.

Mrs McLEAN: They just wish that when a pharmacist is away for professional development or for leave of whatever time, that they have not so much access but there is funding available for that pharmacist to put another pharmacist on. I believe that at the moment they have to do it privately. Yes, it is a private business and they should pay for their private costs, but there needs to be some sort of assistance there so that, if they do need to take the time, the town is not left for a lengthy period of time without a pharmacist or a doctor for that case.

The Hon. NATASHA MACLAREN-JONES: Thank you. I have no further questions.

The Hon. WALT SECORD: Mr Chair, can we jump in for one question each?

The CHAIR: Yes. I propose a question across the three groups, commencing with the Hon. Walt Secord.

The Hon. WALT SECORD: I have a question to Mrs McLean. In your submission—and I thank you for your submission—you said that a woman's health nurse only visits every six months.

Mrs McLEAN: That is my understanding, yes.

The Hon. WALT SECORD: What kind of difficulties would that create in the community?

Mrs McLEAN: Well, it does not give choice, for starters. If the individual does not feel comfortable with the doctor on hand, then it is only every six months they are going to be able to have access to another doctor—sorry, another health nurse. It also puts pressure on—if there is an issue, people have to leave town to access other services elsewhere.

The CHAIR: Okay. I know the Hon. Walt Secord wants me to circle back to him, but I am not going to do that. I thank you both once again for the contribution, both with respect to the time made to prepare and make the submissions and the time available today that you have provided. We know you are both very busy. Once again, I acknowledge and thank the CWA. It is a wonderful achievement, with the centenary coming up. It was very interesting to me to hear those comments in the opening statement about the basis upon which the organisation was established in the first instance in terms of the issues that we have been discussing. It is very timely, and the organisation is very well known for its tireless work and advocacy. I can assure you that it is held in high regard by politicians of all colours in terms of the genuineness and the forthrightness with which it prepares its views and presents them to politicians for their consideration. So thank you very much. It is much appreciated.

(The witnesses withdrew.)

(Short adjournment)

MICHAEL HOLLAND, Co-founder, ONE - One New Eurobodalla Hospital, affirmed and examined

CATHERINE HURST, Private Individual, affirmed and examined

PATRICIA DAVID, Secretary, Unions Shoalhaven, affirmed and examined

The CHAIR: We thank you all for making yourselves available today. I acknowledge the submissions made to the inquiry. The first one is submission No. 17, standing in the name of One New Eurobodalla Hospital, or ONE. Thank you for that. It has been received, processed and stands as a submission to the inquiry, and it has been uploaded to the inquiry's webpage. Equally, I acknowledge the submission from Unions Shoalhaven. It has been received as submission No. 274, processed and uploaded onto the inquiry's webpage. Both of those stand as submissions and, accordingly, evidence to this inquiry. That has been very helpful for us.

You can take those two submissions as read by Committee members; they have all had the opportunity to read and study those submissions. So there is no need in your opening statements to go into the content of the submissions in detail per se but rather perhaps scope out some broad issues that you would like to put on the table—of course, pointing to points in the submission if you wish—and that will then lead to an ability for the Committee members to ask you a range of questions that you would particularly like addressed to you. We will perhaps start with One New Eurobodalla Hospital. I am just wondering, Dr Holland, did you want to share an opening statement with Ms Hurst or were you going to do one on her behalf? How were you going to proceed? What would you prefer?

Dr HOLLAND: I have given Cathy Hurst a copy of the opening statement, which she has endorsed, and she has her own prepared statement. So I can start representing both of us.

The CHAIR: Please do.

Dr HOLLAND: I thank the Committee for the opportunity to provide evidence in the inquiry. I represent a rural advocacy group who for the past three years have petitioned, and continue to petition, State and Federal governments for improvement in local health services. Our group is also represented today by Cathy Hurst, who has personal experience of the deficiencies of rural health care access for local cancer patients. The submission was received by the New South Wales Parliament 12 months ago. I will not reiterate its content as there has been no objective improvement in regard to the issues submitted. If anything, there has been a deterioration in the provision of safe maternity and neonatal care, which, in an untimely manner, has reached a crisis point in the month of this inquiry. Also, since the original submission, our community has been disappointed by the rejection of funding for local radiation oncology services specifically designated for our region by pre-election promises from the Federal Liberal, Labor and National parties.

The Eurobodalla has clinical and social needs that exceed our neighbouring regions with level 4 hospitals. This includes the largest number of vulnerable older population and Indigenous residents. Emergency presentations are 65 per cent greater and admissions are 25 per cent greater than our neighbouring hospitals, and our maternity service has the largest number of births for a rural maternity service in the LHD. Despite this, our community remains disadvantaged and will remain disadvantaged on the opening of the new regional hospital. The capital funding for the new regional hospital is inadequate and will result in reduced bed numbers—specifically in maternity, neonatal and paediatrics. The department of health maintains a policy of drip-feeding rural health services and prevaricates on the critical issue of opening the proposed Eurobodalla hospital with level 4 services. The current clinical services plan equivocates by the promise of delivery of certain services by 2031—some 10 years away. Our community expects immediate improvement in health services and equity of services in the new Eurobodalla hospital.

The CHAIR: Thank you very much, Dr Holland. I pass now to Ms Hurst. Would you like to add to or lend to the comments of Dr Holland?

Ms HURST: No, Chair. I won't at this point. I think Dr Holland has addressed everything.

The CHAIR: Thank you very much. I am sure there will be some questions, so thank you for that. We will move now to Mrs David. Do you have an opening statement that you would like to make?

Mrs DAVID: I do, thank you. Good morning to the portfolio committee and thank you for giving us the opportunity to speak to this inquiry. The availability of health services is an important issue to many people. Unions Shoalhaven engaged its community to test their views on the subject of the proposed redevelopment of the Shoalhaven district community hospital. The majority thought that the current Shoalhaven hospital has outgrown its size and capacity.

Responses for a greenfield site were: (1) the location and the impact this has on response times to get patients from their residence to hospital in an emergency situation—this impacts hugely on residents living in outlying villages and further south of Nowra, and at the moment compliance to best practice fails; (2) a need for separation of general emergency admissions from mental health emergency and Justice Health divisions is a must for best practice outcomes; (3) a better pathway is based on best practice outcomes and acute mental health; (4) detox and rehab services—no detox centre in Shoalhaven; (5) inadequate stroke services; (6) MRI and lack of neurology services in the public hospital; (7) a need for public orthopaedic ward at the hospital; (8) requires a specialised, updated cardiology department and update some stress test services; (9) shortages of medical and surgical beds—only 26 surgical beds at the hospital; (10) the highest waiting list for public surgery because recovery beds are not available, resulting in bed block; (11) a lack of GPs in the Shoalhaven is putting extra stress on our emergency department as well as a lack of bulk billing practices; (12) believe that a separation of the Illawarra and Shoalhaven into their own health districts is needed; (13) a need for closer links to the university; (14) traffic issues, including timely access; and (15) the public did not want the park land adjacent to be resumed—they wanted that to be left to the community.

The main problem that concerned people who saw that the redevelopment of the hospital was [inaudible] was basically the need to get this done now. They thought that a greenfield site might impact on the time and delay it unjustifiably. The Shoalhaven LGA is a large area that spreads over 125 kilometres. The population forecast for 2021 is 106,000 more, which trebles in holiday season. It is estimated to grow to 137,000 and more by 2051. Currently our hospital number of beds is believed to be averaged out to 175, of which 12 are only ICU. The intensive care unit is outdated and requires an upgrade. We are acutely aware of the need for a bigger hospital asap. On the current site is a multistorey car park run by Wilson car park. There is a cancer clinic and a GP clinic. The commencement date is not known, although it has been reported as commencing in March 2023 or sooner.

If this redevelopment is not due to be completed for seven to eight years, it seems ridiculous to not even consider a greenfield site further south, especially when Shoalhaven southern areas are placed at a distinctive disadvantage and places like the basin area, Sussex and Milton Ulladulla need to be included when planning service delivery infrastructure into the future. Milton Ulladulla Hospital is aging and poorly resourced, and the ED cannot cope with demand during [inaudible] season. The maternity services only provide ongoing antenatal leading up to birth, where they have to travel to Shoalhaven, and postnatal care after—definitely poor practice. Shoalhaven hospital could continue to run uninterrupted while a new hospital is being built. Once completed, the old hospital site would remain fully functional, with specialist care, an extension on mental health care, drug and alcohol centres and more.

The CHAIR: Thank you very much, Mrs David. That was a very detailed and frank assessment of matters in the Shoalhaven. We will proceed now to questions from Committee members. We will commence with the Opposition.

The Hon. WALT SECORD: Thank you, Dr Holland, Ms Hurst and Mrs David, for your submissions. They present a picture that shows that the South Coast and far South Coast have been neglected by the State Government involving health. I thank you for your frank assessments. Dr Holland, what is it like to be the only obstetrician in Eurobodalla shire?

Dr HOLLAND: It is a position that I have held for 19 years. This virtual contact is probably unique; you are actually speaking to a dinosaur that will soon be extinct. Health care will not be provided by single practising specialists in any region without adequate backup from credentialed and well-trained GP proceduralists. It has made my job sustainable. However, many of you would not understand or believe the hours that are put in on a routine week, being 96 hours on call continuously and, every one to two months, being on call for 264 hours continuously.

The Hon. WALT SECORD: That is extraordinary. What happens if there are complications or difficulties involving small babies and you are not around or you have worked 264 hours?

Dr HOLLAND: There is a team of GP obstetricians who are first on call. I provide second on call. Any complicated maternity case, I will attend. That includes every caesarean or instrumental vaginal birth and, also, if there are any maternal complications. For many years—it is a perennial problem that we have fought to get neonatal resuscitation services that are provided by a single practitioner in a situation where you do not ring one person and be referred to another person or referred to the other. This is where the crisis has arisen recently that, over a period of time, well-trained GP VMOs are no longer present on a VMO roster to cover these issues. These positions are regularly held by locum VMOs who may be general practitioners with varying degrees of skill in neonatal care, or they may be a physician who is a practising geriatrician or endocrinologist filling time in in the area.

The Hon. WALT SECORD: Dr Holland, let's cut to the chase here. Is this unsafe?

Dr HOLLAND: Yes, it is unsafe. In the past two weeks there has been over 20 births. Five babies have needed resuscitation or neonatal support during that time, and two of those babies have needed to be transferred outside our area.

The Hon. WALT SECORD: What does neonatal resuscitation mean?

Dr HOLLAND: Neonatal resuscitation may be a baby that is born unexpectedly with a very low heart rate or not breathing. It is the equivalent, in many situations, of CPR as you would do in an adult. That is a critical and life-threatening situation. Basically, all people who are involved in dealing with childbirth could be trained to deal with it—that includes the obstetricians and the midwives present. However, a midwife, doctor or obstetrician who is involved in the care of the mother cannot then be expected to take over the care of a critically ill newborn. It extends further to babies who deteriorate some hours after birth, where you need, again, someone experienced in newborn or paediatric care to continue to care for those babies who may be sick for other reasons.

The Hon. WALT SECORD: You have similar concerns about oncology cancer treatment in the region too, don't you?

Dr HOLLAND: I do not want to pre-empt Ms Hurst on this issue, who has her personal experience of this. The problems that we share in oncology services in the Eurobodalla are shared by most rural and regional areas when you consider that probably 50 per cent of oncology or cancer cases could benefit from radiation oncology but only a third of people take up radiation oncology services. In rural areas, that primarily occurs because of the inability to access services locally. The situation in the Eurobodalla is either to travel three hours to Canberra, three hours to Nowra or 4½ hours to Sydney.

The Hon. WALT SECORD: That is extraordinary. Would you mind if I asked, Ms Hurst, could you please give us a personal perspective on your cancer and your radiation journey?

Ms HURST: I would like to thank the Committee for this opportunity because you have probably heard lots of personal experiences from other people who have suffered with terrible things as well. I got diagnosed in March this year with having anal cancer. I was given the opportunity to choose between Canberra or Sydney. That was a bit of a dilemma. Whilst Canberra is closer, where was I going to stay and who was I going to burden with my staying there for up to six weeks? Sydney, I was told, had a very good multidisciplinary team, which is the new way of working with cancer and has better outcomes, so I am led to believe. In the end I chose to go to Sydney. I thought that was better for me because I could stay with my children and still do things. There is a sense of helplessness if you are just sitting around full of self-pity. So I went to Sydney and I had the choice of private or public. I ended up going with GenesisCare because they were able to facilitate times when I could go and things that worked best for me, which, obviously, in a public health system you cannot necessarily do because of the burden that is placed on them with all of the other patients.

I found out through friends, not through the medical fraternity, that there was actually a thing called the patients travel and accommodation assistance scheme. That allowed me to actually stay in Sydney on the weekdays and come home on weekends, which was marvellous and should be publicised more. It does not cover all of the costs but it covers some of them. I was also fortunate that my husband is self-sufficient and could look after our animals and our small business, which is Airbnb. And so the process began. Whilst I did not have as many side effects as a lot of other people have, towards the end of the treatment it became really difficult doing this travel.

Travelling meant that I had to be prepared for whether I was going to vomit on a plane, have diarrhoea attacks or anything, which is highly embarrassing and concerning. You get shaky just thinking about can you get on that bus for that long or the train or whatever it was you were taking. The difference between that and actually having a hospital or a facility in your region where you can drive yourself, have your 15-minute radiation treatment and come home—it would make all the difference to people. As I said, I was fortunate, but if you are a young, single person who had no support and had young children, what would you do? How would you survive? How do you get money if you are not working? There are all these other problems for a whole lot of people in regional areas that are not necessarily an issue in the cities.

The Hon. WALT SECORD: Thank you, Ms Hurst. Dr Holland, what excuses or reasons is the State Government giving for not providing radiation oncology services in Eurobodalla?

Dr HOLLAND: A tender was put in by private radiation oncology providers to provide bulk-billed services for radiation oncology using the proposed money promised by the Federal Government in 2019. The response was that the population base was inadequate to support radiation oncology services, with an estimate of a need of population of 400,000 to provide these services. This is in contradiction to the providers who do provide services to equivalent or smaller populations across Australia, including Mount Gambier, Geraldton and Gladstone in other States.

The CHAIR: Walt, I will need to move on. You can ask a question quickly, but I will need to move on.

The Hon. WALT SECORD: I will be very quick. Are you saying that there was a private provider willing to provide bulk-billing services but it was not followed up by the State Government?

Dr HOLLAND: That is correct.

The Hon. WALT SECORD: Thank you, Dr Holland.

The CHAIR: We may return to that, but we will move over to the Deputy Chair, the Hon. Emma Hurst.

The Hon. EMMA HURST: Thank you, Chair. I want to thank Ms Hurst for sharing her story. I know it is difficult to come here amongst a group of people who you do not know and share those details, so thank you very much. It is really useful for us as a Committee to actually understand what happens to people on the ground. I want to ask a question to Mrs David. My understanding, having read through your submission, was that there is a really strong community support for moving the Shoalhaven hospital to another location. Can you give us a better understanding about this, whether there was pushback about moving that location and if that has been accepted? And if not, why not?

Mrs DAVID: We started campaigning on this issue when it was first raised. We went out in the community and we spoke to a lot of people who attended the forums and everything like that and listened to what the concerns were. I would say close to 85 to 90 per cent of the people that we spoke to agreed that a greenfield site would be a better option for the Shoalhaven based on the proximity of the hospital, which they are saying is only going to be redeveloped. We understand that the location of the current hospital has got the cancer clinic plus a GP clinic. But we think that this hospital can be built better as a new hospital in a bigger location a little bit further down south to give it better access for people in the outlying southern villages and towns of the Shoalhaven, going all the way down to Milton Ulladulla. This gives them a better response time to get to hospital in emergency situations.

People have identified a greenfield site near the Falls Creek area because of access to the main highway and everything like that. We understand people's concerns, also, that if the redevelopment does not go ahead and there is a greenfield site, that they feel that this is going to impact on the timeline to get an upgrade of this hospital that is very much needed. While we support their fears and concerns, we also support the majority of people who want the greenfield site. We can see it working two ways. If the new greenfield site goes ahead, you have got the ability for no disruption at the old site while this is being developed. If it is going to take seven-odd years or something to the final completion of this project, then why this insistence on just the redevelopment other than we need it now? If it is not going to be finished in seven or eight years, then people are concerned that it is not the right viable option. For a community that is largely expanding, access in the southern suburbs needs to be considered, most definitely. That is our main concern.

The Hon. EMMA HURST: You mentioned the amount of time to actually get to the hospital with the current location compared to the proposed location. What are the time differences that some people are looking at?

Mrs DAVID: If you live in, let's say, the Milton Ulladulla area of the South Coast, that is an hour's drive to Shoalhaven hospital depending on traffic. If you are delayed for any reason, it can be a lot longer. If it is during peak holiday season, you could be stuck for up to two hours or more. Yes, you have the ambulances that are responding from those areas, but they still have that hour to get up there—and that is in a good flow of traffic and everything like that. And then you have got the outlying villages that do not have an ambulance or anything like that. They are relying on them to come from Vincentia or St Georges Basin or something like that. That impact can be quite huge. If you are having a heart attack or a stroke or something like that, we all know how important it is for the reaction time to get people to their emergency care in a best practice time. Those figures are not created willy-nilly. They are best practice figures and they need to be adhered to, most definitely. One of the main concerns that people have when you are living in such a vast LGA like the Shoalhaven is the response times for emergency situations.

The Hon. EMMA HURST: Thanks for that. Dr Holland, we have heard a lot in this inquiry about the difficulty of attracting staff to regional, rural and remote areas. Do you have concerns going forward about making sure that any new hospital, when it is eventually built, will be fully staffed and will be staffed when it is open and ready to go?

Dr HOLLAND: Yes, I do. In my personal experience—my contract with the LHD ends in 21 months. Every time my contract has been renewed, I have reminded them of the need of succession planning and recruitment. Specialists do not grow or fall out of trees. They need a succession plan to attract them to new hospitals. With most professions, most professionals are not attracted by money. You would not come to the

country if you wanted to make money. They are attracted by the overall terms and conditions and the professional satisfaction of the work that you do. I must say, and you probably heard before, that most rural and regional doctors find more satisfaction in their care than metropolitan doctors, but you cannot attract people with inadequate bed numbers and inadequate staffing from specialised nurses, midwives and allied health. If you build a hospital that is 50 per cent smaller than it should be and you don't start recruiting people years before the doors open at that hospital, you will open it as a dysfunctional hospital.

The Hon. EMMA HURST: In your submission you also talk about innovative contractual arrangements necessary to attract general practitioners and specialist VMOs. What are you envisaging in regard to an innovative contractual arrangement? What does that involve?

Dr HOLLAND: Traditionally, doctors would be employed as visiting medical officers, either on a sessional or fee-for-service basis, or they may be employed as staff specialists. I think in many areas you need to have different contractual arrangements where people are paid not by how much work they do but by how often they are on call. Their work needs to be—my own position, particularly, is made sustainable by the support of GP proceduralists. In rural areas, you can have one or two specialists who can be on call every one or two nights, as long as they have adequate GP proceduralist backup. That applies for obstetrics, it applies for paediatrics, it applies for mental health and it applies for general medicine.

Ms CATE FAEHRMANN: Thank you all for appearing today. I will start with you, Dr Holland. Your submission makes the point that the Government has said, and I think you mentioned it in your opening statement, that the Eurobodalla Health Service Clinical Services Plan will not be ready, if you like, in terms of its development until 2031. That is what the Government or the LHD has said. Is that correct? Where has that come from?

Dr HOLLAND: There are various manifestations of the clinical services plan. I was the VMO representative on the design of the clinical services plan. The clinical services plan 2019 does not reflect the clinical services plan 2020, which was signed off by our chief executive. In fact, there has been a progressive reduction in the number of general beds and emergency beds. Maternity beds have been reduced from seven beds to three beds and paediatric and neonatal beds have been reduced. The Minister for Health has equivocally said that work on this new hospital will start within the term of the present Government. That could be sometime before March 2023 and he would still be telling the truth.

The clinical services plan describes a long-term plan to provide services up to 2031. In other words, you could open that hospital, which the community expects to have level 4 services—level 4 services imply that you have an intensive care service. According to role delineations of clinical services, no other service comes up to level 4 or level 3 without a level 4 intensive care service. So you may open the doors, but they are not committed to fulfilling the full level 4 service until the end of 2031. We may be lucky; it may happen before. But I am sure it won't without community pressure on them.

Ms CATE FAEHRMANN: We have been reflecting in this Committee a bit about the various promises for a fantastic health service over the last 10 or more years. There is the New South Wales Government's State health plan "Towards 2021"—of course, it is now 2021. At the time this was written, the foreword from the then Minister Jillian Skinner says:

> … the NSW Government began a process of change in 2011 to build a 21st century healthcare system to really deliver on our promise of 'Right Care, Right Place, Right Time' …

It is now 2021. I might get your opinions on whether the New South Wales Government has actually achieved that "right care, right place, right time" promise.

Dr HOLLAND: From my perspective, if you look at the population size of the Eurobodalla, the number of older residents, the size of our Indigenous community—of which a large proportion are in the younger age group and make up 10 per cent of our maternity service—and if you look at the fact that the number of births in the Eurobodalla is the largest in the rural segment of the LHD, why are we waiting in 2021 to get a level 4 service that includes adequate maternity services and adequate neonatal services? We have children waiting 12 to 18 months for a routine paediatric consultation and we have no paediatricians. I think this is a problem that is shared across the whole South Coast. It is not a Eurobodalla versus Bega issue. Medicare should provide medical services in an equitable and accessible manner, and these services should be provided across the whole far South Coast of New South Wales for equity. That includes the need for paediatric services and it includes the need for radiation oncology services, which will benefit people from the Victorian border up to Milton Ulladulla.

Ms CATE FAEHRMANN: I will go to the other two witnesses in a second to answer that, but considering we have had this health plan that said back in 2011 that we would have the "right care, right place, right time" by 2021 and now you are faced with another plan with promises for something in another 10 years'

time, I can understand it would be quite difficult for you to believe in this promise. Why is it not done now? They have had so long to do it.

Dr HOLLAND: There is some frustration on the process of delivery of health care on the South Coast. Without making it sound like Bega envy, the building of that health service was not in the right place at the right time when you simply look at the fact that our emergency presentations are over 60 per cent higher than Bega and our admission rates are 25 per cent higher. Without being cynical, there was a win-win situation for both sides of politics on a Federal and State level with the decision to build South East Regional Hospital. That was partly compounded by the divisions in our community about trying to build a single, uniform hospital. To be fair, I have been here 19 years, nine years of which have been under a Labor State Government and 10 years have been under a Liberal State Government. I believe there should have been action well before now.

Ms CATE FAEHRMANN: Thank you. Ms Hurst, would you care to comment about the "right care, right place, right time" promise. Was that the situation for you?

Ms HURST: Five years ago, I returned from Papua New Guinea and came back to Canberra. It was too cold and I moved down the coast. I had not given any thought to things like health care; I just knew I did not want to be cold anymore. But coming down here, I realised, with my situation, how lacking the services are down here. Things like having a PET scan diagnosis, I had to go to Nowra. I always seemed to have to go somewhere for the treatment. From my perspective, we have not got the services at the right place at the right time. I cannot talk about the history because I was not here at the time.

Mrs DAVID: I think if we look at it in respect of what has occurred within the Shoalhaven hospital in that 10-year period, they got a bloody good multistorey car park, there was an upgrade to the ED, I believe, and there was a cancer clinic built for it. But the overall expansion in regards to surgical beds and all that type of thing—the clinical services and that have been woefully left behind. In fact, people have to travel to Wollongong to get any broken limbs set, and it has only just been recently that they have started to open up a ward that will deal with that type of thing. I have not actually seen how it is running as yet or anything.

I have just noticed they have made an announcement in the last week or so about stroke services coming on line, but whether that is actually occurring at this moment in the current hospital, I am not too sure. When you read all of the submissions that have come through on this inquiry, the whole regional, rural and remote areas are woefully lacking in support and the care that they need to be provided to the communities. It should not be happening. The other thing is, with the lack in some of our regional areas of GPs and everything like that, the stress that this is putting on our emergency departments to take the excess load because some of these GPs do not work weekends and public holidays and all that type of thing—in peak holiday periods, this is just a huge impact. It is something that needs to really be looked at in regards to all regional, remote and rural areas. We are just not coping with the community stress all the time, not just for the population but for the nursing staff and doctors and everything within our hospital. It should not be [inaudible].

The CHAIR: Thank you for that. We will move now to the Government's questions. The Hon. Wes Fang, were you going to kick off? Or was the Hon. Natasha Maclaren-Jones going to?

The Hon. WES FANG: Thank you, Chair. I am happy to kick off. Obviously, if the Hon. Natasha Maclaren-Jones returns, we can see if she has got some questions as well. My apologies, I was not here when you started giving your evidence. Please let me know if some of what I am about to ask has been covered already. I wanted to start with the hospital situation itself. Obviously, we have spoken about the Bega situation with their hospital. With the provision of services into the future, has there been coordination between the LHD and the areas with regard to duplications, provisions and how the services are going to be integrated with the community? I will start with Dr Holland.

Dr HOLLAND: Thank you, Mr Fang. The design of the clinical services plan is to basically provide the proposed services across all clinical streams going into the new hospital. Every hospital should basically have the provision for care for the older population; for women having babies; for women's health generally, which is restricted on the South Coast with the number of options that are available; and for children, our most vulnerable. Medicine and surgery, that is what we get our degree in, so that is a no-brainer. Our concern is rationalisation of medical services where a hub and spoke model is developed to say it is good enough for a rural population to travel 1½ or two hours to have your hip replacement done, even though there might be more hips and knees in the population that you live in. We are awaiting a coastal network plan to be developed by the Southern NSW Local Health District. Our group is concerned that it will follow the same pattern as adult mental health services, where our residents with mental health issues will simply be transferred to industrial-size inpatient services rather than having their care closer to home.

The Hon. WES FANG: But at this stage there has been no engagement or confirmation that there will be division of services between the hospitals? Do you have any indication that is what is being discussed?

Dr HOLLAND: I can tell you on the basis of women's health services, there has been no discussion of how women's health services will be provided following the end of my contract in 21 months' time. There is no design for hospital-based outpatient services for women. A model of care needs to be developed to provide these services which are currently provided from Milton Ulladulla down to Eden. The number of theatre spaces has been reduced. As far as I am aware, there is no plan for recruitment of orthopaedic surgeons to do major orthopaedic surgery in the region, which they cannot do without level 4 intensive care services because of the need for postoperative care. These deficiencies go across all clinical streams. You cannot recruit a paediatrician if the clinical services plan says you are only going to have two paediatric beds. What paediatrician would come under those conditions?

The Hon. WES FANG: I could imagine that you would potentially have a private paediatrician who services the town doing private paediatrics and then would operate in a VMO arrangement. Would that not be something that would be suitable? Even with two paediatric beds, potentially with two paediatricians, a one-in-two roster would be, I would think, something that would be an attractive position and lifestyle for somebody, particularly in the beautiful part of the world that you live in.

Dr HOLLAND: It is a beautiful part of the world that we live in, but you can feel like you are living in a beautiful jail if you are on call 24 hours a day, seven days a week and cannot go anywhere. Those things do not attract people in terms of the quality of life. If you are on call, you cannot have a surf and you cannot go up to Canberra and watch the Brumbies or the Waratahs play. You are restricted to a 20 minute circle around your area. Currently, there is no private or public paediatrician in the Eurobodalla. Our children have to go for admission to Bega, Canberra, Nowra or Sydney. They are waiting 12 to 18 months for an appointment.

The Hon. WES FANG: I was just going to say that I have experience with people in paediatrics in particular and the difficulties of on call rosters, which is why I actually said if you had two of them and you had a one-in-two roster, it would potentially allow you to have the paediatricians in the town. With two beds, you would still be able to provide that service. Is that the sort of thing which is being discussed around making the provision of services within the town for day-to-day paediatrics but then having those people potentially on a one-in-two on call roster for the hospital? Has that been discussed and looked at through engagement with the clinicians?

Dr HOLLAND: There is a director of clinical services in paediatrics who is linked with the South East Regional Hospital paediatrics service. That director agrees that two paediatric beds will not sustain a paediatric service. You will not attract clinical nurse specialists in paediatrics to staff two beds, you will not have the professional satisfaction for any specialist to cover two beds, and the issue of having two people is that two people on call becomes one person on call when one person gets sick or goes on holidays. The minimum sustainable, and what should be the minimum sustainable of on call in any specialty safely, is no more than one in three on call. You can achieve that with two specialist paediatricians or obstetricians and backup with GP proceduralists with special skills in either paediatrics or obstetrics.

The Hon. WES FANG: But haven't you really hit the nail on the head with the issues that arise for professionals such as specialists in medical fields, where they may move somewhere and provide not only a private service by day but also be on call, whether it be a one in two or one in three. They are not able to actually sustain the skills which they have, whether it be through their training through one of the children's hospitals where they might get ICU time and duty and they are not able to actually sustain that level of skill. Given the patient load and the lack of variety, they are unable to maintain those skills. Can you see that that is potentially part of the problem when you have a one-in-three or one-in-four roster in a smaller community? There is a dilution of the number of patients that you see in [disorder].

Dr HOLLAND: Let me speak to private practice in the first place. Private practice in rural areas is a false economy. I am sitting in my room—

The Hon. WES FANG: [Disorder]

Dr HOLLAND: Yes?

The Hon. WES FANG: Sorry. My screens are frozen. Am I on—

The CHAIR: Please proceed, Dr Holland.

Dr HOLLAND: Private practices in rural areas are a false economy. I am providing a service here in my own funded private practice, which patients have to pay for. It simply is the fact that these services are not provided through outpatient clinics in rural and regional hospitals. It is a diversion of the cost to the patient. Often

the argument is, "Well, you charge the patients as much as you like because they would have to spend a day travelling somewhere else to see another specialist." Most specialists in rural areas have some moral and ethical objection to that principle. You do not come to these areas to make lots of money. You can come to regional areas to have very rewarding and broad clinical experience, as long as you have adequate training before you come here. The other alternative is to see every tumour or gynaecological condition and then, once again, say, "Well, this needs to be treated in a metropolitan area." My own college has not really taken up the baton on this issue of well-trained procedural obstetricians and gynaecologists that can basically perform most forms of surgery and services in rural areas. You would need an adequate hospital with adequate beds and adequate service capability definitions to provide those.

The Hon. WES FANG: I am just going to ask if any of my colleagues want to jump in with any questions.

The Hon. NATASHA MACLAREN-JONES: I am okay. Like Wes, I am having connection problems. I am missing quite a bit of this.

The CHAIR: I do apologise for this. Wes, did you want to ask a final question to round things out?

The Hon. WES FANG: How much time do I have left? I was not sure if I was cutting people off.

The CHAIR: You have pretty much had all of your time, but there has been a little bit of disruption so I am happy to give you another question.

The Hon. WES FANG: I will put any other questions I have got on notice, but thank you. Apologies for the technological issues. My screens keep freezing.

The CHAIR: That has been acknowledged. We do not hold you responsible for that. I will conclude now by thanking our witnesses. Dr Holland, thank you for some deep and rich insights into matters of health. You obviously bring much experience and insight, which has been very helpful to the Committee and we appreciate that. Thank you, Ms Hurst. It is not easy bearing one's soul, so to speak, in public like this. It has provided us with a very specific case study around which there is detail, which I am sure will help inform our deliberations over the preparation of the report and its recommendations. To Mrs David, for the work you do down there with your constituents, thank you very much. That survey work which has produced those comments that informed your opening statement and your submission will be very helpful. Once again, thank you to the three of you. We appreciate the contributions you have made. That brings us to the conclusion of the session this morning.

(The witnesses withdrew.)

(Luncheon adjournment)

JOHN FERNANDO, Chairperson, Riverina Murray Regional Alliance, sworn and examined

GREG PACKER, Delegate for Wagga Wagga, Riverina Murray Regional Alliance, sworn and examined

STACEY O'HARA, Committee Member, Murrumbidgee Aboriginal Health Consortium, affirmed and examined

The CHAIR: Good afternoon, everyone. We are returning to today's public hearing for our afternoon session. Thank you for rejoining us. I welcome Mr John Fernando, Mr Greg Packer and Ms Stacey O'Hara. Thank you very much for making your time available. It is great to have you. Could I acknowledge the submission that has been made standing in the name of the Riverina Murray Regional Alliance. It is submission No. 263. I am able to confirm that it has been received, processed and stands as a submission to this inquiry, and it has been uploaded to the inquiry's webpage. It now is evidence that we are going to be relying on as a Committee as we deliberate on our report and recommendations.

This afternoon provides us with an opportunity to add additional evidence from yourselves by hearing from you directly. The way we would like to proceed, if you are agreeable, is that we will ask you all to make an opening statement if you are able to do so. You may have pre-arranged for an opening statement to be made. It does not need to go through the content of the submission because you can take that as read. We have that already. But if you want to make an opening statement to set things up nicely, once that is done we will share between ourselves questions that we can hopefully have a dialogue with you over. Does that seem to be a reasonable way to proceed this afternoon? Thank you. In terms of the opening statement, I do not know whether the three of you have coordinated and there will be three separate ones or if Mr Fernando will do one and then perhaps Ms O'Hara will do one. How have you got it arranged?

Mr PACKER: Mr Fernando can do mine and his because we both represent the same community and he is the chairperson of it.

The CHAIR: Thank you very much, Mr Packer. Ms O'Hara, are you able or willing to give an opening statement this afternoon?

Ms O'HARA: Yes, I am.

The CHAIR: Great. Thank you for that. We will commence with Mr Fernando.

Mr FERNANDO: Thank you, Committee members, for hearing me today. Riverina Murray Regional Alliance would like to just make the opening statement that the health services in our region have diminished over the years and one of the main things for us is to possibly address that issue of medical care and treatment in our regional and remote areas across the Riverina Murray region. I am hoping the Committee can take on board some of the views that we have presented, and also support the good work that our Aboriginal medical services [AMSs] are doing in our communities and supporting them, especially during the current COVID climate that has impacted western New South Wales and a little bit, not as much as western, I suppose, in Riverina Murray. But they are doing a great deal of work with limited resources, as we know, and that also goes for our local hospitals in our smaller communities, which are lacking, I suppose, in services and personnel. So my opening statement is that I highlight that sort of scenario for the Committee members that, yes, we do have smaller communities out in our region and, yes, there are doctors and nurses out here but they are a very limited resource that are invaluable to our communities. Thank you.

The CHAIR: Thank you, Mr Fernando. That is very good, it sets us up nicely for questioning and adds some additional information to the content of your submission, which is very useful, so thank you. Can we move now to Ms O'Hara? Can I invite you to make an opening statement?

Ms O'HARA: Okay. I am mindful of the time for the opening statement so most of the information relating to the Murrumbidgee Aboriginal Health Consortium has been tabled. I also need to acknowledge the traditional owners of the land we work on, the Wiradjuri people, and pay my respects to Elders past, present and emerging. The health status of Aboriginal Australians is well documented. We are one of the most vulnerable groups in the country, with health standards way below that of other Australians. To us, health is not just the absence of disease or illness; it is about holistic wellbeing, and often what impacts us as individuals also impacts our family and our communities.

On average, our men continue to die 8.6 years earlier and our women die 7.8 years earlier than non-Aboriginal Australians. Accessing health services in the bush has always been a challenge for Aboriginal people. Where mainstream services are available, a lot of our community are reluctant to access them due to a past history of being excluded and marginalised. But perhaps the biggest obstacle is the actual lack of local services, particularly in our more remote communities. A lot of communities need travel to access services and, in some cases, do not have the means to travel the 200 or 300 kilometres, particularly those who rely on Centrelink

payments. Even those in paid employment often have exorbitant living costs and must prioritise whether or not accessing medical treatment is more important than feeding the family or registering the car.

Local Aboriginal medical services have partnered with the primary health network in the implementation of a chronic disease program. This program assists with transport, accommodation and consultation costs for clients with a diagnosed chronic condition. Unfortunately, the bucket of money allocated to this program is spread very thinly on the ground and is often expended before the funded period expires. We have also partnered with the NSW Rural Doctors Network to bring specialist services to Aboriginal medical services. This is working well, but again funding needs to be increased to either expand services or increase the frequency of existing services to meet the growing demand. Working in partnership with our local health district, Primary Health Network and the NSW Rural Doctors Network has allowed us to make some real progress in addressing health issues for our Aboriginal communities. We are on the right track but there is still some way to go before we enjoy the same standards of health as other Australians. Thank you.

The CHAIR: Thank you very much, Ms O'Hara. That equally was a very clear and concise opening statement, which I am sure will elicit questions from the Committee members as we progress. Just to confirm, we will share the questions between ourselves: Opposition, crossbench, Government. We have got our witnesses until 1.55 this afternoon, so we will get things underway. I invite the Hon. Walt Secord from the Opposition.

The Hon. WALT SECORD: Thank you, Mr Chair, and thank you, Mr Fernando, Mr Packer and Ms O'Hara for today's appearance. Ms O'Hara, you made mention in your opening statement that a person would have to make a decision involving accessing medical treatment versus feeding the family or registering the vehicle. We heard evidence earlier that in rural and regional areas, non-Aboriginal patients make the same decision involving cancer treatment. You have highlighted that in fact the challenge might even be fiercer. What is the experience of Indigenous people accessing cancer treatment, chemotherapy, radiation, things like that?

Ms O'HARA: I suppose it would be the same as for non-Aboriginal Australians. It is just that we do have some agencies that help, like local support groups, Can Assist and a few others that will assist patients who need to travel to Sydney for treatment or to Wagga Wagga, which is a two-hour trip from Griffith; obviously our outlying communities it is further. So if local support is not available, then people just do not make those trips and miss out on treatment.

The Hon. WALT SECORD: Mr Fernando or Mr Packer, do you have anything to add on cancer treatment for Indigenous communities?

Mr PACKER: Yes, it is Mr Packer here. I would just like to make some comments around that. There are not a lot of Aboriginal positions within that service. We have got hospital liaison officers in our hospitals but there is no specialised Aboriginal-identified positions in that area and I have noticed that we have started to get a lot more Aboriginal community members now that are getting cancer and they have just got no support when they get in there; they are dealing with non-Aboriginal people, and all of those people have got compassion and everything but it is just around the cultural heritage side of things. They are just not getting around the cultural aspect of it. They are not getting that sort of service.

The Hon. WALT SECORD: You realise that we make recommendations to the Government on the evidence. What would you like to see in regard to Indigenous treatment?

Mr PACKER: Me personally, I would like to see more Aboriginal positions within that service and a lot more health promotions out there to Aboriginal communities around cancer for the community, a lot more education.

The Hon. WALT SECORD: Thank you. Mr Fernando, in your opening statement you talked about the challenges of smaller hospitals. When you were talking about smaller hospitals you were talking about multipurpose services [MPSs] and district hospitals. Is that right?

Mr FERNANDO: Yes, that is correct.

The Hon. WALT SECORD: Give us a bit of an insight into the challenges of treatment from an Indigenous perspective at those smaller hospitals.

Mr FERNANDO: I know of a lot of incidents where someone has gone to a local smaller hospital and they have seen the doctor and because their injury or their concern at the time cannot be treated right then and there, they are directed to travel, like Ms O'Hara said before, 150 or 160 kilometres to a more regional centre such as Griffith or Wagga to receive that type of treatment. We always go back to the component of if you are living out west and the higher the cost of living, you have got to make that choice where you either register the car or seek treatment for the injury of that person or the family member.

The Hon. WALT SECORD: What kind of injuries are you talking about?

Mr FERNANDO: Anything like a broken bone that could be set or stitches, major stitches. We have got small kids of people who work in the rural industry, in agriculture. Some of their injuries can be very extensive and cannot be treated at a local hospital, so they have to be transported maybe an hour-and-a-half, two hours, to a more regional setting with specialists or doctors in those areas where they can be assessed and treated appropriately.

The Hon. WALT SECORD: I will ask all three of you this question. We have heard evidence and concerns expressed as part of our inquiry about the challenges of telehealth, which is a small hospital where there is not a doctor available and a nurse would get a camera or get a screen, laptop, and relay information to someone else in a larger hospital in Sydney, Wollongong or Newcastle. Do you have concerns or have had reservations expressed to you or problems with telehealth involving Indigenous clients? Ms O'Hara?

Ms O'HARA: During COVID we had to close our doors at the medical service here for a few weeks, so telehealth was the only option that we had and we found that clients just were not comfortable with telehealth consults. We have just seen a big drop in people that were not accessing any GP appointments even at a local level because of the telehealth and it is just that—I do not know whether it is a communication issue—I think Aboriginal people are more comfortable sitting across the other side of a desk and having that conversation with the GP. So we just had to open doors back up and just make sure that all our COVID-safe stuff was in place, and we have seen an increase immediately in Aboriginal people coming back into the building and accessing.

The Hon. WALT SECORD: Mr Fernando and Mr Packer, I will ask you the same question. But back to you, Ms O'Hara. What was the drop in patient visitation when you had to resort to telehealth? Was it noticeable? Was it significant or was there a complete drop-off?

Ms O'HARA: From each doctor seeing between 17 and 20 clients a day, that probably dropped down to about four.

The Hon. WALT SECORD: A significant drop. That would be people who should see a doctor who simply just did not.

Ms O'HARA: Yes.

The Hon. WALT SECORD: Mr Fernando and Mr Packer, what was your experience or the relay of information to you involving telehealth?

Mr FERNANDO: Just in support of Ms O'Hara's comments, I think the scope of telehealth is one that is an available service but as Aboriginal people we like to speak to the person on a one-to-one basis and there is that clear, distinct disconnection in having that face-to-face chat with a doctor or medical practitioner. I think, like Ms O'Hara said, people seeking medical advice or treatment has significantly dropped across the region, not only in the bigger centres but definitely in the smaller centres where they cannot access a doctor unless they get online with a phone call or a webcam based at a health centre that may be open at a certain time and may close at a certain time.

The Hon. WALT SECORD: Mr Packer, anything to add that you have heard or picked up involving telehealth?

Mr PACKER: I agree with what has been said but I think there is an issue around if you have got a person in Sydney talking about, say, an injury or something like that and he is relaying it to, say, a nurse or something, I believe that they are not getting the level of care that they really need to because you are relaying it from a doctor to a nurse to a patient. I think that is a major issue.

The Hon. WALT SECORD: Absolutely, thank you. Ms O'Hara, what has been your engagement with the Murrumbidgee Local Health District? How do you feel about communication with the local health district?

Ms O'HARA: We have a good—you should not say that relationships with the local health district are based on people in roles, but in the past I have found that we have not enjoyed a good relationship with our local health district. However, in recent years we have seen an improvement in that because different people come into roles and they just get along better with our staff here and they make a bit more of an effort, I suppose, than what has been shown to us in the past.

The Hon. WALT SECORD: Can I ask all three of you about the area of palliative care in rural and regional areas from an Indigenous perspective? Are there palliative care services in your local health district and in your areas of responsibility? Ms O'Hara?

Ms O'HARA: Yes, we have got local palliative care services, but there is an Aboriginal-specific program established in Wagga.

The Hon. WALT SECORD: Mr Fernando or Mr Packer, do you know anything about that and can you tell us is it successful, unsuccessful, any areas of improvement?

Mr FERNANDO: Yes, I can add to that. We recently became aware of an Aboriginal palliative care worker who was initially only employed on a part-time basis. I have since been informed that that person has been put into a full-time position. But the concern for me, and I think for Ms O'Hara and our region, is that it is one person covering the Riverina Murray area and we all know we may all need palliative care at some point in our lives and we have got one person covering from Deniliquin in the north-west of that corner, going right up to Tumut, Cootamundra and all the towns in between—Griffith, Hay, Albury and possibly Wagga. We have got one person covering that whole region and, especially in the scope of the palliative care component of health, I think it needs to be increased. Also I think they need to work more closely with our AMSs. We have three AMSs across our region and I do not think there has been much cooperation, I suppose, in this area with our AMSs from MLHD, but that is improving because personnel have changed. I know that one of the things at RMRA, which is a shortened version of our title, is that we are pushing for our region that we need to be collaborative in our approach to how we provide services to our community and supporting our communities and our AMSs.

The Hon. WALT SECORD: One last question—I am mindful of the time. COVID vaccination rollout, have you experience problems down there? Are you getting supply? Are you getting it to the communities? Ms O'Hara?

Ms O'HARA: I suppose an issue initially was we were getting 120 doses a fortnight. That has now increased to 420 a fortnight and we are just going crazy at the moment and jabbing everyone. We have really ramped it up.

The Hon. WALT SECORD: Mr Fernando, Mr Packer, anything to add or is it similar to Ms O'Hara's view?

Mr FERNANDO: It is very similar to Ms O'Hara's. RivMed is the AMS based in Wagga. We were at 120 per fortnight. That has been increased to 400. We are also now running Saturday clinics to get the community in and get their first dose and hopefully the second dose, which is starting to happen.

Mr PACKER: We are getting sort of 60 people through those clinics on the Saturdays and Sundays too. The first day we had 60 clients come through to get the jab, so it has been successful, those weekend ones.

The Hon. WALT SECORD: Thank you.

The CHAIR: Thank you for that feedback, that is very helpful, Mr Packer. We will move now to the Deputy Chair, the Hon. Emma Hurst.

The Hon. EMMA HURST: Thank you, Chair. Ms O'Hara, in your opening statement you touched on past history and we have also heard from other witnesses in this inquiry about culturally safe services. Can you expand on that and what recommendations we should be putting down to the Government to make sure that the services are culturally safe and comfortable?

Ms O'HARA: Culturally, this training has been around for a long time for mainstream organisations—I know the local health district has done it over a number of years—but you cannot change people's attitudes. You can have all the cultural awareness training on earth but at the end of the day you cannot change attitudes of people who just are not comfortable working with Aboriginal people. So I think to make services and programs more accessible for Aboriginal people, it is the Aboriginal employment—having Aboriginal people employed in certain roles. In a hospital it does not have to be the cleaner or the cook; start having some reception staff, front-line staff, so that when Aboriginal people walk into a building they feel a lot more comfortable. I think that is one of the first steps.

I noticed at Griffith—I do not know if the program still runs; I am not aware that it does—mental health is a big issue and there used to be mental health trainees. The local community health centre recruited the person and then put them through the Bachelor of Mental Health through Charles Sturt University in Wagga. It was a three-year course and that person still got to see Aboriginal clients with mental health conditions while they were going through that training. Just the amount of Aboriginal people that then were getting the necessary help they needed because the clinician was an Aboriginal person was really good to see.

The Hon. EMMA HURST: I guess that also goes to your comments earlier, and Mr Packer's as well, and I know you were talking about cancer, but I know in the alliance submission you also talked about access to drug and alcohol treatment, for example, and the fact that none of it is being provided by Aboriginal people.

I guess your comments before were about making sure that there were Aboriginal people working in that cancer area, but it is broader than that, is it not?

Mr PACKER: Yes, it is. It is really around cultural competencies for all staff. I would like to get it to a stage where everyone across the board gets cultural competencies and we can all work together, but I think that there is a huge gap between Aboriginal clients to mainstream clients, or white clients—whatever you want to call them. I just think there is a major gap. Even now, my sister went into hospital the other day and she is up there and she is 70 years of age and she is not allowed to have any family around her and she is really finding it very difficult because she has got a large family and she is in hospital and at this stage she could look at losing her leg. To know that we cannot get up there to see her, that we just talk to her on the phone, it is very hard, and it is around the cultural stuff, because of family ties and all that.

Speaking of isolation and all that sort of stuff, you can be in a remote area and be isolated but you can live in a town like Wagga Wagga with 65,000 people and still be isolated. There are not a lot of Aboriginal people out there that are working. There is work like in government and all that sort of stuff but most Aboriginal people live from week to week and they cannot budget and save money for any emergencies that come up in their lives. If you want to look at improving health, I think if you live in Hay and you have got to go to Wagga and they say, "Go, and whatever money you spend, save all your receipts and all that and we will reimburse you." It should be around the other way where if someone has got to go somewhere, they can put in and get some travel allowance before they go to get there. At the moment they are not getting there.

The Hon. EMMA HURST: Yes. Your submission also stated about Aboriginal people could be traumatised by needing to attend services that are not on country. What is the best way to address this? Is it about making sure that there are services available as much as possible and prioritising certain services and certain areas?

Mr FERNANDO: I can answer that. John Fernando speaking. One of the components for RMRA in negotiating with the New South Wales Government under our accord process is a cultural recovery and healing centre that we have looked at. Any alcohol and other drugs [AOD] healing or rehab centre is basically a mainstream service that is being provided. We know there is one in Wagga and we know the waitlist for that is about three to four months for someone to actually get into it, but it is a mainstream one; it is not culturally safe for some of our people who go in there. For them to attend a culturally safe one, you have to travel 230, 240 kilometres to Cowra to Weejali from Wagga. That is just Wagga, and the next one I think is Oolong over in Nowra. We are working with the New South Wales Government and we are conducting a feasibility study at the moment to build our own cultural recovery and healing centre on country here for our people because we know we do have people here with a lot of AOD issues and one of the biggest ones for them now coming through is mental health.

I know Ms O'Hara has talked about Aboriginal health. We need staff to be trained up in those fields coming through the health system because we need our own people to look after our people in our region. Hopefully if we are able to get this cultural recovery and healing centre up and running and on country, we can start filling those vacancies with local qualified people who have been through the system and now they can work on country and support their family, their friends and their relations possibly in the future.

The CHAIR: Cate Faehrmann.

Ms CATE FAEHRMANN: Thank you, Chair, and thank you all for appearing and for the very excellent work you do supporting your communities and advocating for your communities. I just wanted to pick up, Mr Fernando, on the excellent idea, the excellent proposal that you have just been talking about in terms of a cultural recovery and healing centre. Could you tell the Committee, if you are able to, where that is up to, the reception it is getting, whether you think it is going to be approved and what more we could potentially do to support it?

Mr FERNANDO: Yes. We are in the infant stages at the moment. We have just had a tender process went out and we have engaged a company called Ngurra access company. I think they are based in Sydney but there are connections with some of their workers who come from our region because they claim Wiradjuri as their home country. These guys are going to be working with us and MLHD, the Murrumbidgee Local Health District, and Regional NSW and Treasury, looking at visiting our communities, because RMRA is made up of 10 communities across our region and they are going to visit all those communities and ask the questions about how do they feel about AOD services; mental health; what is in their community that works; what does not work; what would they like to see? We are hoping to build a proposal with their help. They have been given, I think, six months to develop this proposal because it is part of our accord negotiations under ngunggiyalali with the New South Wales Government.

This is one of the things that we have put forward as one of our priorities because it is a holistic approach. We can treat not only the person who is having those issues but also look at supporting the families around them, because, as we know, if someone is in treatment, they have got to go travel 300 kilometres away to be treated and it is very lonely and it is very hard for them to stick at it for 12 weeks to get through the program. If we got one in our region it may be a daytrip for them with support services. Bring them in after three or weeks after they have done the initial hard yards and offer that support to them to continue and come back to their family a better person and, hopefully, address some of those issues and be a more constructive community member in regards to not committing—we know people with those sorts of issues. They tend to be picked up by the criminal justice system very quickly for minor things and that just escalates. We call it the trifecta: one, two, three. You are stopped, you are searched, you resist, you go bang, bang, bang and are now part of the criminal justice system, which is unfortunate. If we can address some of the AOD issues, mental health, in our local region I think that will have a big impact not only on that person but the community as a whole across the region.

Ms CATE FAEHRMANN: Thank you. I am sure not a single member of the Committee thinks otherwise that this sounds like an incredibly important thing to support for so many reasons. So thanks for bringing that to the Committee's attention. I wanted to ask you about the 10 priorities as well that the alliance prioritised in the regional priority plan for 2018-2021. How are those priorities going? It is now 2021. Have you seen any substantial outcomes in those priorities, because you have listed them in the submission? Now that it is 2021 is it all pretty much the same in terms of those priorities?

Mr FERNANDO: I think those priorities are a work in progress. We are working with the agencies that we are dealing with—State government agencies—and there is some stuff that we have an influence over or some sort of commitment to, and working with those agencies to change the way they work with our communities and our Aboriginal people is one of the ways we do that. Through our accord process this is the stuff that we are changing. We have spoken to Regional NSW and we have put on the table that their staff and other government agencies have to attend a co-designed Aboriginal cultural competency training package, like a one-day package, where their staff come to. That has opened up a few eyes but, as Mr Packer and Ms O'Hara have relayed before, we can give all the training we want but people will have their own personal views. But that is okay; we can just keep plugging away, and changing the culture of the agency will eventually change the culture of the people who come through that agency.

Ms CATE FAEHRMANN: Can I check in relation to that then? You spoke about the relationship with NSW Health before. For something as specific as that regional priority plan, who within NSW Health—which part of the department—do you have direct discussion with and continuing contact with in relation to progressing that plan within NSW Health?

Mr FERNANDO: Within NSW Health we speak with the director for MLHD; I think her name is Jill Ludford and she is the CEO for MLHD. We would meet with her for our ngunggiyalali accord process once every four months, I think, and we go back to our priorities, looking on a scheduling, and then we identify stuff that we need to work on. The cultural recovery and healing centre was one of the major ones for us in that regard. There also is the healing of our communities. We had a healing forum a few years ago. They were a big part of that, as were our communities, and every time we speak with them we are about opening up opportunities for our communities, and one of the biggest ways for that is for us to encourage the advertisement of Aboriginal-identified positions and we need to start targeting some of those industries or those occupations that are emerging, especially around mental health and possible cancer treatment down the line, because we know full well the Aboriginal person will suffer a lot more illnesses over their lifetime than the normal person and it will impact them more greatly if they are not treated and looked after during their lifetime.

Ms CATE FAEHRMANN: I do have one more question. It is specifically about the recommendations. I might go to you, Ms O'Hara, to share things around, but it is specifically in relation to the lack of Aboriginal health professionals—you have highlighted that this is an issue. Can I ask the specific recommendations that you may have put to the LHD or NSW Health to attract more Aboriginal health professionals, but people to train in those professions. What is lacking and what recommendations can we make in that regard, do you think?

Ms O'HARA: At the Griffith Aboriginal Medical Service in particular what we do is when we employ people we understand that they might not be coming in with the necessary skills and experience to work within our Aboriginal communities, but then certificate IV in primary health care is the minimum standard that we require our staff to undertake within the first two years of employment. The Aboriginal Health College was good. They used to run a lot of courses: diploma in counselling, diploma in AOD services and they did the certificate IV in primary health care. But there was an issue with the college so there was a bit of a break in training for a bit, so our staff at the moment are just doing those through TAFE NSW.

But, like I said before, the more high-end psychological, mental health training is what we are really after. There used to be nurse cadetships, for example, where Aboriginal people went in and worked within the hospital system and did their nursing as part of the on-the-job training. It is those sort of things where people can actually earn some money as well as gain the skills and the qualifications while they are working, so they are still actually supporting their family but then they are gaining the necessary skills to make a difference in all their communities across the region.

The CHAIR: Thank you very much. I will move now to Government members. Before they start, if someone from the secretariat could let the next panel of witnesses know that we are running a little bit behind, but the Government must get its full allocation. We will get underway. Who would like to take the call from the Government?

The Hon. WES FANG: If you do not mind, I will kick off the questioning. I just wanted to thank all the witnesses for appearing today. I know many of you through my work in the local area. I wanted to start with Mr Fernando. We know that health care is so often tied to prosperity. Mr Fernando, can you talk about how there is a need for making sure that Indigenous youth, particularly in the Riverina, are able to access not only proper health care but also jobs and education in order to ensure that they have the tools moving forward to be able to increase their participation in the community and also their prosperity moving into the future and how that affects their health in later life? I am not sure if I have got you because I just had all the screens freeze.

The CHAIR: We can hear you okay, Wes.

The Hon. WES FANG: Everything has just frozen. Mr Fernando, do I have you?

Mr FERNANDO: Yes.

The Hon. WES FANG: I have got you, yes.

The CHAIR: Do you want the question repeated, Mr Fernando?

The Hon. WES FANG: I was not sure whether I was still broadcasting or not.

Mr FERNANDO: I think I got the gist of the question. Basically, you are speaking about youth and how health impacts on their prosperity leading into later life. Is that correct?

The Hon. WES FANG: Yes, and how important it is to get a good start early and that is supported by not only health care but the other factors as well.

Mr FERNANDO: My take on that, Mr Fang and the Committee, is that we need to support our youth early, in the early stages of life, by providing the medical services for them to continue to not only get strong and fit and able to eat a healthy breakfast and come from a good family unit, but to go to school, learn what they can at school, because I know even from my background I had a bit of a disjointed background but I had a supportive aunty and uncle who made me go to school and get an education because I know the value of an education. To do that you need to be healthy and you need to drink your milk, eat your sandwich and lunch and not skip, and stay away from the junk food, which is prevalent across our region.

The Hon. WES FANG: What are some of the risks that we might see with the youth, particularly with your experience with Indigenous youth, if they do not have those opportunities? I notice that you talk about the lack of, for example, facilities for rehabilitation or drug and alcohol problems. If they fall into that trap, how hard is it to get them to recover, particularly with cultural issues around rehabilitation and the like?

Mr FERNANDO: Culturally, just for the Committee's notice, I have got 20 years with Corrections, so I have been down that path in the adult system; I have seen them come through the juvenile system. If we do not offer those kids the opportunity to make positive changes in their life at that stage—and one of the big things is the use of AOD substances, you know, alcohol. The good one for us is the yarndi and not so good now is the harder drugs which is ice, which is prevalent in our communities. If we do not have the counsellors or the AOD workers or the social and emotional workers supporting that family and kids, how are these kids going to go to school and learn when they are all over the place trying to survive, I suppose, in an environment that is not conducive to them?

The best way for us is to support our medical people and give them some shining lights, give them some role models. We need to see Aboriginal faces and bodies in our health service so these kids can aspire to be nurses, doctors, counsellors, because at the moment when they go to a mainstream hospital, all they see is a lot of non-Indigenous people—doctors—and they also see a lot of overseas doctors there who are working when the opportunity is there for Aboriginal people. They are saying, "Why aren't we getting the same opportunity?" That is because we don't have the backing, I suppose, of the family unit, which is impacted by mental health or AOD. We need to support our health services in our regions. I know the smaller regions, we lack that type of service,

that sort of support. We definitely need to increase the numbers of health workers within our AMSs to give these young kids a goal to say, "I can do that." Let us move on and maybe if they train up enough they can move onto the mainstream health system and make changes internally as opposed to externally. I hope that answers your question, Mr Fang.

The Hon. WES FANG: I don't know; look, it does. I am just trying to tease out—obviously there are issues around the provision of culturally appropriate drug and alcohol supports and rehabilitation in rural and regional areas, particularly for Indigenous populations. But in the first instance—and I was keen to know your experience—is it more important that we try to provide them a strong start with education, with employment, with prosperity in order that they do not go down that path in the first instance or is it important that we have the supports there if they do fall there? I think it is a mix of both and I was keen to see your impression on it, but I think I have got that from your testimony, so I thank you for that. I know my colleague the Hon. Trevor Khan has a couple of questions, so I will pass to him. I am assuming he is on.

The CHAIR: The Hon. Trevor Khan.

The Hon. TREVOR KHAN: Good afternoon. I think I will address my questions to Ms O'Hara, but please do not take it that I am simply only speaking to Ms O'Hara. Ms O'Hara, I am interested in your insights into the opportunities for access and, indeed, the accessing of preventative health services by the Aboriginal community. I am thinking of such services as breast screening and whether that is appropriately provided to the Aboriginal community.

Ms O'HARA: Preventative is always better than the other options, is it not? Breast screening is accessed by a lot of Aboriginal women, but again it goes back to the same thing that Mr Packer was talking about. If we see more black faces in these jobs, you would see more Aboriginal people accessing these services. It is all women's health, all women's business, which has probably got that little bit of a shame factor, which we have been working on over the years to try and encourage Aboriginal women to access services. Prevention is better than a cure in the long run. It is a hard one. We have done a few campaigns over the years where we have done peer support stuff. We have had some local women who had their pictures put on posters and brochures and we did some training with those women so other women in the community could then go and speak to these locals because they have done some training and they have done a bit of background on how quickly lumps can be detected through breast screening. It works but it is just that getting over the shame that some Aboriginal women feel.

The Hon. TREVOR KHAN: Do you think there is anything more that we could recommend that could be done—and we will deal purely with breast screening—to make the breast screening more accessible to Aboriginal women, particularly in rural and regional areas?

Ms O'HARA: I am not quite sure how far they go out into the more remote communities. I do not know whether they travel out to, say, Hillston, which is 100 kilometres north of Griffith. But there used to be the BreastScreen van that was fully equipped and it would go out to the more remote communities and set up for a couple of weeks at a time, and it would give women the opportunity then to access those services rather than having to drive 100 kilometres or 200 kilometres to access a service, and you could probably double that so it is a total women's health clinic, so it not only dealt with breast screening but it dealt with all the women's health issues.

The Hon. TREVOR KHAN: Chair, there is a lot more I could ask, but I am alive to the time frame, so I think I will leave it there at this stage. I think Mr Packer wants to say something.

Mr PACKER: It is Greg, sorry. I just think that there is always a nursing shortage. Stacey and I go back in health for 30-odd years. We were sitting around the table 30 years ago talking about exactly the same stuff we are talking about now and I just think it is tragic that we are still doing it. Even if we cannot get Aboriginal people in those centres, we need to make those centres culturally appropriate that Aboriginal people can actually walk in the door. It could be Aboriginal paintings in the corridor, just to make them more culturally appropriate for Aboriginal people to walk into doors. I know in a new hospital we engage a lot of Aboriginal artists to do some stuff around the walls—paintings and all that. I just think we need to come up with some way—and it is not only for Aboriginal people; it is for all nurses.

If you are talking about nurses right across the board, we need to look at some sort of package that is going to give people incentives to want to be a nurse. Maybe we could waive all their fees and all that sort of stuff and say, "Okay, we'll waive your fees but we want you to stay in that remote area. When you graduate we want you to stay in that remote area for five years after your employment and then you can move on", and we just keep turning them over, because we are paying a lot of money for overseas nurses and all that and we just do not seem to be doing any good. We are paying out more money and recruiting from overseas, where we should be recruiting

from our own people here in Australia. That is the way that I reckon it should go. I remember 25 years ago I sat down at a State meeting and they said that 75 per cent of the nursing staff throughout New South Wales was close to 65 years of age and they were all going to retire. What do you do then? I just think we need to start thinking strategically on how we can have a better working system for everybody across the board.

The CHAIR: On that note, I thank you all very much for making yourselves available today. As I indicated at the start, the submission that was made provided a platform with much information and it has been much expanded, I think, over the course of the questioning. Can I particularly express our gratitude to the very specific examples that have been given as well. We would otherwise would have liked to have travelled and been able to meet with you face to face, but with COVID and other restrictions that has not been possible to do. But the firsthand examples you have all been able to give have given us some very good insights into the issues confronted by our Indigenous brothers and sisters. We are looking forward to taking that information into account when we develop our report and recommendations. Once again, on behalf of the Committee, thank you very much.

(The witnesses withdrew.)

GEOFFREY PRITCHARD, Private Individual, sworn and examined

PAUL MARA, Private Individual, sworn and examined

The CHAIR: Thank you for joining us. We look forward to evidence from two people who are very experienced in matters that are before this inquiry. I acknowledge your submission, Dr Pritchard. It has been made, received and processed by the Committee secretariat and stands as submission No. 586. That is thus evidence to the inquiry. What we would like to do, if you are both agreeable, is to invite you to make an opening statement. Keep it relatively brief if you could please and then that will give us maximum time for questions and exchanges between Committee members and yourselves. Are you okay if we proceed that way?

Dr PRITCHARD: Fine, thank you.

The CHAIR: Thank you, doctors. Dr Pritchard, I invite you to make an opening statement.

Dr PRITCHARD: I am a retired specialist surgeon. I worked mostly in three major hospitals in Sydney, particularly at Prince Henry Hospital. When that was being wound down I moved out to Tumut, where I had been as a kid, and practised for the south west slopes area here, which is at Tumut hospital which really was a regional hospital for Gundagai through to Tumbarumba. I did that for about 13 years and then retired and worked for two years as the Director of Medical Administration for the Greater Southern Area Health Service. My submission is basically what I have got to say, except that the Snowy Valleys is now booming, partly because of the COVID virus, but we have major industries like the Visy mill and the timber industry and mountain recreation and so forth. We are a growing area, and that is all I will say at the moment I think.

The CHAIR: I am sure that sets it up nicely. I am sure the Committee members will have some particular questions given your depth of experience in previous roles you have had, so that is fine. Dr Mara, I invite you to make an opening statement.

Dr MARA: Thank you very much. Thank you to the Committee for allowing me to make a presentation and to answer questions. I have forwarded my introductory comments to the Committee secretariat, and I am not sure if people have those available. If they do, I can truncate my comments a little bit. Firstly, I pay my respects to the traditional custodians of the land and to Elders past and present. I have been a rural doctor in Gundagai, practising with my wife, Virginia Wrice, for almost 39 years. For two decades plus I also worked in Tumut providing anaesthetics and obstetrics services. I was a founder and president of the Rural Doctors Association and I have undertaken consultancies and published widely on rural medical workforce. By way of background, I have also attached a citation made to me by the then president of the Australian Medical Association when I was made a fellow of the Australian Medical Association.

There is no doubt that there is a rural medical workforce and service meltdown across the Riverina and other small towns across New South Wales and Australia. Yet both the Commonwealth and the State have spent hundreds of millions, or even billions of dollars, of taxpayers' money over many years on policies that have failed and organisations that have not been accountable for outcomes. All small towns across the country should be asking the question, "Where has the money gone?" It seems that with the money spent we could have sent a person to the moon but not a doctor to Hay. There has been a 30-year failure of policy and policy that has supported failure. Yet the problem, I believe, is not intractable and not unsolvable. It is time to call it out.

Rural general practice training providers have failed to deliver. Practices across rural and remote Australia have dedicated time and energy into training and supporting a revolving door of doctors who simply head back to the city on completion of their training. People in the bush are paying taxes to train doctors to feed large corporate medical businesses in cities and major centres. Workforce agencies, for all the money and sometimes their personal efforts, have failed to deliver on their fundamental remit. The College of GPs itself does not accept that rural practice is not simply general practice in a rural area. There is a fundamental lack of understanding of the nature of the medical workforce problem.

In rural areas the medical workforce deficit relates to workforce capacity to provide comprehensive and continuing services across a range of settings, including after-hours, emergency- and hospital-based services. In metropolitan areas the perception of not enough doctors is driven by the number of practices, not medical need. Too many practices creates hyper-competition for doctors to service business needs of practices and not the medical needs of patients. Anyone can set up a medical practice. An open ended Medicare scheme, current methods of engagement and ways in which we pay doctors have created a perfect medical workforce storm. Medicine is no longer about service models. We have moved even beyond the built-for-profit model. Investors are now being funded by the taxpayer through Medicare to establish built-to-sell models in medical practice.

Rural practice is a unique and demanding discipline that requires specific training, flexible practice models, innovation, investment and real incentives. For some years I have been promoting a new model of medical workforce support, employment, training and service delivery in the Murrumbidgee. This solution has been enthusiastically taken up by the current CEO of the Murrumbidgee Local Health District, Jill Ludford, and her team. It involves the MLHD taking on responsibility for employing trainees for a two-plus-four-year specialist rural doctor training program. It is supported by the New South Wales ministry and Government. The program is providing more flexibility and higher quality training in both major hospitals and rural practices. It is using available resources and has raised considerable interest among medical students and junior doctors. It will change the churn culture and provide more certainty for communities, and it could deliver 10 new doctors into the district next year and more every subsequent year. This provides a medium-term sustainable solution.

So what is the problem? The Commonwealth Department of Health, while perhaps recognising the elegance of the solution, and in spite of the fact that similar employment arrangements apply in Queensland and other jurisdictions, says the program is against health funding arrangements and agreements and have thrown out the tyre spikes, limiting the number of entrants in to the program. The model has the status of a pilot only. Meanwhile the MLHD is having to spend millions on locums, ambulance transfers and propping up failed rural practice services, which rightly are the responsibility of the Commonwealth, to solve access problems for people living in rural and remote towns across the Riverina.

Management and bureaucracy are about doing things right; leadership is about doing the right thing. If we want a different outcome we need to do the right things differently. Practices and communities need action now to build confidence in rural medicine. If we want to find out why many small towns across the Riverina, State and country do not have well-trained doctors available to service their comprehensive healthcare needs, we need to look to Canberra and follow the money. There are incentives now in the system that mean that we should be continuing this workforce crisis. The crisis in rural medical workforce is a crisis in policy, not doctor numbers.

To resolve the problem we need to stop rewarding failure and make policy and organisations accountable to outcomes; let rural doctors and practices determine the viability, quality and effectiveness of the so-called sole employer model of rural generalist training in the Murrumbidgee and not bureaucrats in Canberra; mandate that every doctor, regardless of preferred specialty, work in a rural community—Modified Monash Model level 4 and above—for at least six months prior to entry into their preferred vocational training as part of a mandatory three-year residency post-graduation; and restrict the growth of new practices, particularly in metropolitan areas, by introducing a licensing system that takes into account local health needs and demonstrated capacity of the proposed practices to deliver on these needs. Thank you.

The CHAIR: That was a very comprehensive opening statement which ranged over a number of issues, which I am sure will come up in the questioning, so thank you very much. We will commence with the Opposition—the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you, doctors, for your evidence and your opening statements. Dr Mara, I do understand that much of your introductory statement related to GPs, which in fact come under mostly Federal. Because we are a State inquiry and a lot of the evidence that we had presented to us related to concerns about small country hospitals, MPSs, district hospitals and the inability to retain or attract doctors to those facilities, what advice and experience do you have that we could recommend to the State Government on getting doctors, especially coverage particularly on weekends? What advice or recommendations could you suggest in that regard?

Dr MARA: Some years ago I undertook consultancy looking at what constituted a viable or sustainable model of practice in a rural and remote area. On rural practices, as I said in my introductory comments, cuts [audio malfunction] divide into a secondary level system of care, and this is where we have problems at the moment. There are three pillars, if you like, that ensure a sustainable medical practice in a country town that provides those viable services. The first pillar relates to the structural areas around practice. I alluded to some of those in my introductory comments, but if you do not have a proper structure and proper infrastructure in which to practise in, then you will not attract a doctor there. The second pillar relates to the professional components, and they include such things as on-call time and workforce in the area. There is no doubt that doctors beget doctors, and if you have capacity [audio malfunction] the amount of after-hours and the workload is reduced and that has a big impact on the capacity to draw doctors into the system. The third area relates to remuneration [audio malfunction] and there is too much emphasis placed on improving rebates or improving payment for doctors. I think the money is there. It is just [audio malfunction].

If you do not have appropriate systems in all those areas, you do not have a sustainable practice in that town, and what we have seen then is that we cannot just segregate out the towns and say, "There is a problem here." We have to look at the system, and what I have tried to look at was show that where you have got the State

looking after the hospitals and the Commonwealth looking after the general practice, there has not been a link between those two areas and system faults in both areas are creating the problem. It is for that reason that I believe that the solution lies [audio malfunction] proposals that I put forward. The Murrumbidgee rural generalist training program [audio malfunction] at the Commonwealth level because allowing more doctors to come into that—and frankly if it had not had been for the delays implemented by the Commonwealth, we could have had 15 or 20 new doctors coming through that program, working in rural and regional areas and getting adequate training rather than the current five that we have at the moment.

The Hon. WALT SECORD: Dr Pritchard, do you have anything to add to Dr Mara's comments?

Dr PRITCHARD: Yes. We have got plenty of GPs in our town, believe me. Because of the business structure that they have, they do not want to go to the hospital particularly. I think there should be some compulsion for the doctors to spend some time in the rural areas, as Dr Mara said, before they get full registration or are let loose. One of the problems is that the area health service is letting us down a bit because we have got a new hospital at Tumut which drains a big set of New South Wales, yet we do not have a resident anaesthetist, which for emergencies is essential. There is not one between here and Wagga. We do not have a resident GP surgeon.

We have one GP obstetrician who is limited because he has not got an anaesthetic backup and he can only do extremely simple deliveries. The deliveries in the last few years have dropped from 150 per year to 50 per year. People are not coming to our area because they do not think we have got an adequate health service. In fact, people of my age are leaving the area to go somewhere—not that they are going to have babies of course—where they have easy health service. Overall the health service is fantastic.

The other area of concern is that we cannot get GP proceduralists to come to our area if the hospital is blocking them. The Tumut area health service [inaudible] they talk about 16 acute care beds, four medical, four day surgery beds, four maternity beds and one palliative care. But saying that day surgery is being promoted says to them that they cannot do anything more than day surgery. No anaesthetist is going to come to town if there is only day surgery. Presently, the day surgery is done by a specialist doctor from Wagga and an anaesthetist coming into our town, doing the operation and going back over 100 kilometres through irregular terrain. They are not there overnight; they are not there to do emergencies. That is Third World practice and it has been promoted by the area health service.

We have got a new hospital and there is still an operating theatre. They have got down here a day surgery procedure unit. In other words, if a doctor is thinking of coming here and he looks up the paperwork from the area health service, he will say, "There is no place for me to come." There is only day surgery. No anaesthetist can keep up his skills with that. No surgeon will come here. The obstetrician will be burnt out and frustrated somewhat because he cannot do a caesarean section. As area health services are phasing out these hospitals—

The Hon. WALT SECORD: Dr Pritchard, I am not criticising you, but you have just painted a picture of a problem that you cannot really solve.

Dr PRITCHARD: We can solve it. I think—

The Hon. WALT SECORD: Okay, so what would you recommend that we do then?

Dr PRITCHARD: We have a shortage of labourers picking blueberries, but the Government gets people from overseas and puts them there on their visa. There are plenty of Australian-trained, English-speaking doctors in the South-East Asian area and I have trained a lot of them and they are top quality people. All we have to do is offer what the Federal Government is offering for the fruit pickers, and that is give them a provisional visa if they stay in an area for five years and then they can bring their family and dog and whatever they like with them to stay there. It is a simple solution and it is one that would be effective.

The Hon. WALT SECORD: Dr Mara, do you agree with that?

Dr MARA: I think what Dr Pritchard has elaborated on is the problem, and the fact that we have not addressed these problems systemically has meant that we have got this decline which may [audio malfunction] out of that situation. The reality is that if you look at the proposals that I put forward—having the training program, requiring the Commonwealth Government to put more people into that training program—we could put doctors into Tumut next year [audio malfunction] the list of approved areas under that Commonwealth training program. That is a fundamental problem that we have. The Murrumbidgee Rural Generalist Training Pathway would be oversubscribed at the present time. We would have the doctors there.

The other point that I would make is that the importation of doctors from overseas has been going on for years. We have brought thousands of doctors in from overseas, and yet we still have not solved our workforce problem. Simply putting more doctors from overseas or more doctors through our medical schools is not going to change this situation. We have to look very carefully at the structure. When I did medicine and when I became a

rural doctor, 30-odd per cent of the people who I graduated with became rural doctors. Now there is 15 per cent of medical graduates that want to do general practice. There is a fundamental structural problem in the way in which we do that. Where have all the rural doctors gone? They have all gone to become emergency medicine specialists because it is contained, it offers flexibility, it offers employment and industrial options.

What the Murrumbidgee Rural Generalist Training Pathway does is it starts to create a new paradigm of service delivery, employment, industrial relations and flexibility. If we can get that up and running properly, that will create that focus. But we have to move in that direction by looking again systemically at the stupid notion that we can allow any doctor, any failed doctor, any hairdresser, any plumber or any pharmacist to open up a medical practice anywhere, anytime, because it is that increasing number of practices across the country which is sucking up the medical workforce to serve their own business models and not the health-need models of the communities. This is what happens [audio malfunction] the bush. Then those doctors go back to these places where they are employed and engaged by these new practice models. There is hyper-competition for doctors in the metropolitan city areas in particular.

We have to address both of those areas. The way in which I am proposing we address that is to look at a proper licensing system for practices that ensures that if a practice is to be set up then they have to demonstrate a medical need, they have to demonstrate a capacity and a reliability in terms of what they want to achieve. You cannot just take one item. This is the point that I am trying to make: Unless you have an understanding of the workforce problems or the workforce determinant in rural areas vis-a-vis the workforce determinant in the metropolitan areas, then we will never solve this problem. You have to take it at two levels.

The Hon. WALT SECORD: Dr Pritchard, did you want to add something to that?

Dr PRITCHARD: It is just that when I was a boy, 80 per cent of the students were male and they usually married a nurse who often came from the bush. That is what propped up the service. But nowadays there are more females than males doing medicine and they often marry one another or some other professional and they do not want to relocate to the country areas. I think there has to be some degree of compulsion somewhere to get them to come to the country areas. But they will not come to our country area when they are only allowed to do day surgery. We do not have an anaesthetist on call on the weekends, and so all the stuff with broken arms and dislocated shoulders and deep and serious lacerations cannot be treated here. They have to be sent across to Wagga, which is over 100 kilometres away. During the bushfires we had trouble transporting people. We have to have a GP anaesthetist or two in Tumut hospital to service from Gundagai through to Tumbarumba and beyond. We have had the COVID thing. They often go onto respirators and you need a skilled anaesthetist with anaesthesia to put a tube in and put them on a ventilator. It is serious stuff. For a big area, if we are going to grow, we have to have that anaesthetic service.

The CHAIR: Thank you, the Hon. Walt Secord, and thank you, doctors. We will move now to the next set of questions coming from the crossbench members. I invite the Deputy Chair, the Hon. Emma Hurst.

The Hon. EMMA HURST: Thank you, doctors, for coming in today and speaking with us. Dr Pritchard, I have just got a couple of questions following on from the Hon. Walt Secord and a couple of comments that you made. I know in your submission you talked about Tumut getting a new hospital, but it would only undertake that day surgery that you were talking about.

Dr PRITCHARD: Yes.

The Hon. EMMA HURST: Is that a downgrading from the current services that are available?

Dr PRITCHARD: Absolutely. Absolutely downgrading. When I was at practice and Dr Mara used to come and give anaesthetics, we would service the whole region. But when you are publicising that this is a day surgery hospital, that means it is not a normal hospital. It is a definite downgrade.

The Hon. EMMA HURST: I think in your submission as well you said that by changing it to a day surgery hospital it would be even harder to retain staff. Can you explain what the issues there are? We have heard so much in this inquiry about how hard it is to recruit staff already in certain areas and to retain them. How will this make it even more difficult?

Dr PRITCHARD: When I trained I went down to Tasmania at one stage to be able to do hands-on surgery. I followed the jobs around to get my experience. To restrict somebody just to do day surgery—that is stuff I used to do in the rooms mostly, and it is a complete downgrade. It is Third World to have a surgeon and an anaesthetist come from 100 kilometres away and go back that night. If there is any complication that night, what do you do? Pray. There is a critical care advisory service which is available to the hospitals, but that closes at 11.00 p.m. and does not open until 7.00 a.m. the next morning. The nurses at the hospital when they [inaudible] a doctor on call have no backup at all. For this area, we need to have a balanced health service.

The CHAIR: Dr Pritchard, can I just ask what document you were quoting from there, just for clarity's sake?

Dr PRITCHARD: I beg your pardon.

The CHAIR: The document you were just referring to. Just for clarity's sake, was that a particular document you were referring to?

Dr PRITCHARD: Yes, the Tumut health service. All I know is it is the area health service. It is a document I got from the area health service.

The CHAIR: Okay, thank you. I just wanted to clarify that.

Dr PRITCHARD: That applies to all the hospitals. This critical care advisory service is at all the hospitals in the Riverina. It is very good, but it closes at 11 o'clock at night. The nurses are just abandoned basically and so they call for the ambulance and send the patients all the way across to Wagga for treatment which a doctor could fix up in no time.

The Hon. EMMA HURST: What is it like currently at Tumut hospital? Is it currently adequately staffed and resourced, or is there something that also needs to happen there in the interim, even while we are waiting to build this new hospital?

Dr PRITCHARD: The new hospital is just about built, but they are pulling down the old hospital so there is no area for accommodation for visiting doctors or students and things like that. I think it is adequately staffed, except we do not have the visiting [inaudible] and we need more GP proceduralists, and the Government has to address that problem. Dr Mara knows all about it as well. When I was a medical student, they offered you free holidays in the country areas. Then you would go up there and stay at the nurses home and the doctors would take you out for dinner and show you around the area and try and marry you off to one of the locals. There has been a doctor shortage in rural areas, for instance, since I was a young medical student, and that is a long time ago. We need to have some compulsion to get the distribution of the doctors correct.

The Hon. EMMA HURST: I just want to ask a question. There was something else in your submission that caught my attention. You said that medical practice has changed in recent years and it is hard to get emergency coverage at the hospital.

Dr PRITCHARD: Yes.

The Hon. EMMA HURST: Can you expand on that and how it is changed and why it is harder to get that emergency coverage?

Dr PRITCHARD: As Dr Mara was saying, a lot of these medical practices are now groups of doctors as a business and they have got high overheads and receptionists; it is like a real business. For them to take a doctor out of that area to the hospital to spend half the day resuscitating someone or doing an operation, it ruins their business overheads. In the past we had no trouble with the manning of doctors; it just was automatic. You reported to a hospital and you just did the on-call work. You were hungry for work to get the experience so you could do your job properly. I cannot understand why the doctors will not presently do it, apart from the commercial pressures that Dr Mara alluded to.

The Hon. EMMA HURST: What would you like to see from this inquiry as far as a recommendation, particularly in regard to some of the concerns that we have talked about in regard to Tumut and the day surgery? What are some of the key recommendations that you think will really support the area?

Dr PRITCHARD: Tumut hospital should be recognised as a sub-regional hospital. Wagga is obviously the main hospital, but that is a long way away. We even used to get patients back from the Wagga waiting list across here—they would want to come and get it done in Tumut—and people from Cooma coming all that distance to be done in Tumut, whereas we can give them an instant service and if there is a problem, we are here. To advertise itself as a day surgery hospital means they are saying, "We don't want proceduralists here." It is as simple as that, and it is repeated throughout their literature.

The Hon. EMMA HURST: Dr Mara, do you have anything to add to that?

Dr MARA: Again, I think what we are looking at is the problems rather than moving ahead to the solutions. In the Tumut environment, there are far more doctors there than when Dr Pritchard and I were working together doing the anaesthetics and surgery. Those surgical lists at that time—Dr Pritchard is right. I would be giving an anaesthetic for a breast cancer mastectomy, a fundoplication, varicose veins and a number of other things all in the space of one day. The capacity is [audio malfunction] do it but the doctors are not there.

The point that I am making is that because of this interaction between the Commonwealth and State you do not have a system—except for what we are trying to do with the Murrumbidgee training program—to allow the doctors to work in their private practice and also work in the hospital setting. If the Commonwealth said tomorrow, "Yes, we will allow Tumut to be part of this so-called pilot," then we could have two procedural trainees in Tumut as soon as that is done. The demand from the students is there.

This has been hampered by bureaucracy and by organisations that are being funded with hundreds of millions of dollars to solve this problem. They have been part of the problem; they have not been part of the solution. When we put this proposal up to the Commonwealth, the major regional training GP provider in New South Wales actively sought to undermine it at the Commonwealth level. To me, it is a scandal that these groups and organisations are being paid millions of dollars to solve the problem yet in reality the incentive is there that they keep this problem going [audio malfunction] amongst that.

The CHAIR: I invite Cate Faehrmann.

Ms CATE FAEHRMANN: I have only got one question. I was almost going to pass because most of my questions have been asked and time is running out and it is all wonderful in terms of your evidence. I will just ask you a question on what you just said, Dr Mara, in terms of the organisations that are actively blocking the work that you do, if you like. You just indicated a statewide training organisation did it because they were incentivised to do it. I will allow you a bit more time to expand on that, please.

Dr MARA: Okay. The way to get training [audio malfunction]. Currently, the main way is through the regional training organisations. The regional training organisations were established in regional areas with the remit to train people equipped and capable of working and providing workforce solutions in those regional areas. Over 20 years they have clearly been a failure because we do not have the doctors that Dr Pritchard described with the skills and training to stay in those places. When we implemented this new system, there were representations made and behind-the-back undermining of the Murrumbidgee rural training [audio malfunction]. This was active; it was not passive. It was active undermining of the scheme.

The problem is that this scheme at the Murrumbidgee involves a relationship between the doctor, the practice and the Murrumbidgee Local Health District. There is no need to have third-party involvement in that. The market itself will say that [audio malfunction] down into the future. We have got these layers of bureaucracy that have hampered and not supported or taken responsibility for the workforce in these smaller towns. For example, if you look right across the Murrumbidgee Local Health District, you have got a number of small communities out there that were never going to get the benefits of this scheme because they were not accredited to become part of the training program. They were never going to get that workforce support at that level.

The solution that I have proposed would see that all doctors would have to do a turn at an appropriate level and appropriately supervised in a rural area prior to them doing their vocational specialist training. That would provide an immediate bang for buck across [audio malfunction] graduates in medicine each year, I understand, and so you are putting a huge arithmetic number of doctors into those smaller country towns at an appropriate level of their training for a certain period of time. If you couple that with a rural training program and couple that then with attempts to limit the number of practice [audio malfunction] you turn the whole system around.

The CHAIR: Do you have any further questions, Cate? Thanks very much, Cate. We will now move to Government members. Will it be the Hon. Wes Fang or the Hon. Trevor Khan?

The Hon. WES FANG: The Hon. Trevor Khan is indicating, so I will let the Hon. Trevor Khan go first.

The Hon. TREVOR KHAN: Thanks, Wes. I will not take up all the time. I am going to direct my question to Dr Mara, but I think Dr Pritchard may have some comment as well. Can I just indicate to you that I come at this on the basis that my father was a GP literally for 50 years in Wollongong. My perception was that in the time that he practised, the nature of general practice changed. I think it picks up on some of what Dr Mara said. A lot of the small surgical work that he used to do in the surgery is no longer done by GPs. Indeed, they seem to shy away from that small procedural work. I am asking you is that as a result of the people who are being selected to do medicine or is it caused by some other element, whether it is the remuneration scheme or the like, that has changed the nature of most GPs from being essentially GP proceduralists to what seem to be "refer us to specialists" and the like?

Dr MARA: I think that is a question that has a lot of insight into the real problem that we are facing here. There is only 15 per cent of graduates from Australian medical schools now that want to become GPs. The work of a general practitioner in a metropolitan area I think is highly demanding, but the work of a rural doctor [audio malfunction] practice as well as those other elements. The reality is [audio malfunction] doctors in recent years to do both of those elements, and that is why you get the situation that Dr Pritchard is describing in Tumut

where a number of the doctors there simply refuse to go on the roster, or pack up and go to Sydney for the weekend, leaving the hospital frankly in the lurch. Gundagai is probably one of the only towns across the Riverina that guarantees to the Murrumbidgee Local Health District [audio malfunction] coverage of the hospital area.

The point I am trying to make here is that rural practice is not general practice; general practice forms a large part of it [audio malfunction] specialty. Until we see it as a unique discipline which requires unique training and different flexibilities and different remuneration models, then we are really working behind the scenes to counteract people getting into these areas. We should not be talking about GPs in the bush, although [audio malfunction] and that is great and we need them. We should be talking about rural doctors, and the concept of the rural [audio malfunction] the primary care area but also the secondary care areas I think is a very important component. It is only when we start to differentiate that we are going to start to see people wanting to move down that direction because of the different benefits and advantages that they may see in terms of that career pathway.

If we look at the Queensland rural generalist training program, it was essentially designed by the Queensland department of health to fulfil their small hospital requirements for doctors working in those areas. Surveys of those doctors said that if they did not become a rural generalist, they would not have become a metropolitan GP; they would have become an anaesthetist or an obstetrician or an ED specialist. I think if you ask most of the rural doctors in New South Wales now who are still doing the procedural work or still doing the after-hours, they would say the same thing. I would have become [audio malfunction] myself and not a GP working in the city. Part of that reason is because the city GPs unfortunately—and it is not their fault entirely—have abandoned a lot of that extended care that they used to provide. GPs in the city used to deliver babies et cetera. That does not mean that general practice in the cities cannot be a worthwhile proposition; it is. There is huge scope to provide adequacy of services but it is different, and unless we recognise that difference then we are not going to solve this problem in the rural workforce area.

Dr PRITCHARD: Just to answer Trevor's question, Mr Chair, it is more difficult to do these minor surgeries in your office nowadays because of the accreditation and so forth, but nevertheless it can be overcome. But it takes time and the GPs that train nowadays just churn through the patients. They cannot do a minor operation. It takes a fair while, particularly as I charged them all Medicare rebates and I did not charge them anything out of their pockets. That has changed enormously. Now if they want something excised, they get sent to a specialist at Wagga who books in to a day surgery centre and there is the cost of all that, particularly for people who have to come from out of town and stay overnight. We are not doing this stuff locally and we will not get the GP surgeons into our area if we can only allow them to do day surgery in the hospital. Half of that stuff should be done in your rooms and it costs nothing. I mean it costs a fair bit, but it does not cost the patient anything.

The Hon. WES FANG: Thank you both for appearing today. Obviously I come from the region that you both live in. I very much appreciate the insights you have provided on providing healthcare in the Riverina area in particular. Leading on from the Hon. Trevor Khan's question, how much do you think the issue that we have seen with attracting doctors to regional areas is attributable to the continual reliance on the goodwill of doctors of the past where they go to a rural-regional area and they are just continued to be asked to do more or cover this on call, do another hour here, see another patient, and it is just that continual build-up of burden on them that I guess other people then see the lifestyle that has been lived by doctors in rural-regional areas in the past and decide that it is too hard for them? How do you see that being a GP versus a rural doctor is different? What can we do about those rural doctors to make sure that they have a life outside of medicine when they do come to rural-regional areas?

Dr PRITCHARD: The reason I came to Tumut was because during the war my father led the family down there for safekeeping and my mother got an abscess around her tonsil and got what they call a quinsy, and 50 per cent of them died in those days. The two doctors came to our house and did the operation in the house and she obviously survived. I do not know what day of the week it is half the time. You are doing your medical practice and I have been on the council for years and getting involved with community activities. It is a wonderful life and I am sorry I cannot continue it at this stage. I am not short of answers, but I think you have to do as Dr Mara says and get some degree of compulsion for everyone to serve some time in the country areas. I think that is the solution, but it has to be compulsory.

Dr MARA: Can I just [audio malfunction] understanding of the true value of rural communities in Australian society. Part of this I think really comes through if you look at some of the shows on the ABC such as the *Back Roads* show. They really come to the heart of what rural country is all about. Each year, before the COVID pandemic, for five years I took medical students from the University of New South Wales up to Hamilton Island and Airlie Beach for the sailing race week. There were 16 students who went up there. The whole aim of that was to show them that you did not have to be confined or trapped as a rural doctor; you could do other things. I am talking off the hat here about my personal life, but I have flown a plane three quarters of the way around the world. I have owned a racing yacht and sailed around the world. I have been mountaineering in Antarctica and

New Zealand. Being a rural doctor does not mean that you are inhibited. If anything, I think it has got more advantages around it. We need to be selling that sort of thing to the people who want to do it.

There are three parts to the Murrumbidgee training program. It is not just about teaching people how to do anaesthetics or obstetrics. It is about identifying the long-term continuous service needs in each of the communities and how you are going to best address that. It is about the training itself and what that training should look like to address the needs of those communities. When the doctors are out there, it is about supporting them, and doctors beget doctors. We have to turn these smaller towns where you have got one burnt out and buggered doctor into a three- or four- or five-doctor town so that they can continue to provide that continuity of services. If we provide good training, flexible employment arrangements and support from the major hubs, then we can turn this whole issue around. But it has to be linked in with Commonwealth agendas and initiatives as well.

The answers really are there; it is just a matter of goodwill to actually take it. Frankly, I cannot stress enough that when I first talked to the Commonwealth about this program and we had wide enthusiasm from the [audio malfunction] confronted by these problems every single day, we had acknowledgement from the politicians that this was the way to go, yet it was held up in bureaucracy for two years and then limited to five people in the system. We could have put 15 in the system in the first year. We cannot continue to work where people with a spreadsheet on the fifth floor of the Sirius Building in Canberra make policy on this matter. We cannot continue to work for organisations that are being funded with millions and millions of dollars to solve this problem and that have negated their responsibility and accountability for outcomes. Why do we [audio malfunction] that do not fill up the hole? It is as simple as that. We have got to stop doing that and start demanding accountability and demanding outcomes and results for communities on the ground.

The Hon. WES FANG: Thank you very much for both providing your insights today. I really do appreciate it. I think it has been valuable for us, and taking the time out to speak to us has been particularly rewarding for me.

The CHAIR: I echo the Hon. Wes Fang's thanks to you both for very thoughtful contributions today. They have taken us very deeply into some key areas, which we will need to give consideration to with respect to the development of a report and recommendations. It has been wonderful to have two doctors of such enormous experience being able to reflect over not just some years but decades of professional life and inject that into what is our current inquiry. Whilst I am here, can I just acknowledge the combined service. I do not know, but if one adds the two doctors' services together, I expect it is probably in excess of 80 years of service to communities in New South Wales. You do not get the opportunity to thank professionals like yourselves very often. That is an enormous contribution you two gentlemen made with your professional medical service to the citizens of this State. I would like to take the opportunity to thank you both for doing that and serving the people so well in your respective communities.

Dr PRITCHARD: Thanks for asking us.

The CHAIR: Thank you very much to everyone who has joined us today. That brings us to the conclusion of today's hearing. On behalf of the Committee, thank you all for participating today. *Hansard* for today and yesterday is being prepared and will then be placed on the Committee's website. That will probably take a small number of days. All the content of the very valuable evidence of the two days will be available pretty quickly for people to review. Once again, thank you very much.

(The witnesses withdrew.)

The Committee adjourned at 14:54.