REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

CORRECTED

At Jubilee Room, Parliament House, Sydney on Thursday, 2 December 2021

The Committee met at 9:15 am

PRESENT

The Hon. Greg Donnelly (Chair)

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

PRESENT VIA VIDEOCONFERENCE

Ms Cate Faehrmann

The CHAIR: Good morning and welcome to the twelfth hearing of Portfolio Committee No. 2 – Health into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. The inquiry is examining health outcomes, access to services, patient experience, planning and capital expenditure in rural, regional and remote New South Wales. Before I commence I acknowledge the Gadigal people, who are the traditional custodians of the land on which this Parliament sits. I also pay respect to Elders past, present and emerging of the Eora nation and extend that respect to Aboriginal people who may be viewing the broadcast today, wherever they may be. Today's hearing is being conducted virtually. I ask for everyone's patience through any technical difficulties that we may encounter. 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 hear from a number of important stakeholders based in and around Walgett, Broken Hill and surrounding areas, including local councils, private organisations, nurses, private individuals, Aboriginal health services and the Far West Local Health District. I thank everyone for making the time to give evidence to this important inquiry. I acknowledge that our plan had always been, in these last few hearings, to visit those important places around New South Wales, like in the north-west and Broken Hill. However, because of the COVID emergency and the need to adjust to the requirements relating to that, some weeks ago we had to make a judgement that we would have to either participate in a remote fashion and collect our evidence that way or potentially run the risk of running into the end of the year and early into the New Year, and potentially even miss that opportunity of getting to our important witnesses in the more remote parts of the State.

Regarding Walgett and Broken Hill, and the important evidence from Indigenous health services in particular, I acknowledge that it was not our first preference to be doing these last couple of hearings in this way. Nevertheless, with what has been before us, we have had to be considered in our judgement about how we go about collecting evidence. As I said, whilst this is not our first preference, it is quite adequate and suitable. Indeed, over the course of the year we have collected evidence remotely in some instances. All the evidence will come in uninterfered with and, obviously, will be used by us in conjunction with your submissions that will contribute to the development of the report and the recommendations.

Before we commence I will make some brief comments about procedures. Today's hearing is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcasting guidelines, media representatives are reminded that they must take responsibility for what they publish about the Committee's proceedings. While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the virtual hearing. Therefore, I urge witnesses to be careful about comments you may make to the media or to others after you complete your evidence.

Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard, it is important that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily. Of course, 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 answer only if they had more time or with certain documents to hand. In those circumstances witnesses are advised that they can take that question on notice and provide an answer within 21 days.

Finally, I make a few comments on the hearing etiquette to minimise disruptions and assist others, including the Hansard reporters. I ask Committee members to clearly identify who questions are directed to. I ask everyone to please state their name when they begin speaking. Could everyone please mute their microphones when they are not speaking and remember to turn their microphones back on when getting ready to speak. If you start speaking whilst muted, please start your question or answer again so it can be recorded for the purposes of the transcript. That is important for Hansard. Members and witnesses should avoid speaking over each other so we can all be heard clearly. To assist Hansard, I remind members and witnesses to speak directly into your microphones and avoid making comments when your head may be turned away from them.

IAN WOODCOCK, Mayor, Walgett Shire Council, before the Committee via videoconference, sworn and examined

MICHAEL URQUHART, General Manager, Walgett Shire Council, before the Committee via videoconference, sworn and examined

DARRIEA TURLEY, Mayor, Broken Hill City Council, before the Committee via videoconference, affirmed and examined

The CHAIR: We will provide an opportunity for opening statements. I acknowledge that we have received the submission of Walgett Shire Council to this inquiry, thank you. It is noted as submission No. 341. It has been processed, stands as evidence to the inquiry and has been uploaded onto the inquiry's web page. Mayor Turley, thank you for the Broken Hill City Council's submission, which stands as submission No. 398 to the inquiry. Likewise, it has been processed, stands a submission to the inquiry and has been uploaded to the web page. We will proceed in the order in front of me by starting with Mayor Woodcock. Mayor, will you be making the opening statement?

Mr WOODCOCK: I would ask our general manager to do that, thank you.

The CHAIR: Mr Urquhart?

Mr URQUHART: Firstly, I would like to thank the New South Wales Government for affording Walgett Shire Council this opportunity to provide further information to the inquiry into health outcomes and access to services in rural, regional and remote New South Wales. Walgett shire has a population of 6,100 people, dispersed across 22,000 square kilometres in far north-west New South Wales, with an Aboriginal population in the order of 2,500. Council's primary concern with the health services to the region is the replacement of face-to-face primary care with the telehealth platform. Councillors and community believe telehealth has its place in the health system as a tool to assist general practitioners [inaudible] of specialist services or assessment of minor illnesses by nurse practitioners, but it should not be seen as a replacement for face-to-face primary care by a general practitioner.

It is a known fact that people living in remote New South Wales do not enjoy the same health care as their city cousins living in more densely populated and serviced metropolitan areas of New South Wales. Our remote shire experiences poorer health, higher chronic disease, an aging population and a lower life expectancy. Quality medical services in rural and remote towns are an essential element for every individual's quality of life and the ongoing economic sustainability of our communities. A reduction in basic face-to-face medical services is a retrograde step, one that increases isolation and remoteness for residents and a widening of the gap between the haves and the have-nots.

For residents living in the shire it is a terrifying situation when one becomes seriously ill, knowing that face-to-face primary care is limited and emergency specialist services are three hours away in Dubbo. In summary, the community asks that they be properly consulted with any future changes to health services in Walgett shire and that the New South Wales Government design and implement a new GP recruitment and training program for rural and remote communities, increase the funding for rural and remote health services, and increase primary health care general practitioners in rural and remote areas. Once again, I thank you for this opportunity.

The CHAIR: Thank you, Mr Urquhart. That was a very good opening statement which lays out a lot of important groundwork that I am sure is going to lead to questions of both you and Mayor Woodcock. I move now to Mayor Turley. I invite you to make your opening statement.

Ms TURLEY: Thank you for the opportunity. I would like to acknowledge that I am on the land of the Wilyakali people of the Barkindji nation. I pay my respects to Elders and acknowledge the ancient wisdom that they share. I would also like to acknowledge all of the doctors, nurses, allied health workers, cleaners, administrators and gardeners who support the delivery of health in the Far West. Broken Hill City Council welcomes the opportunity to be able to be part of this inquiry. We think Broken Hill is a key centre for residents in the whole Far West, and it provides services that cover over 196 square kilometres. I am going to go straight to the point and say that the issue for us is always around recruitment and retention for our workers and how we care for and look after those workers when they do come and work in outback towns. The other part that really concerns us at the moment is the cross-border referrals. We are so challenged under COVID about accessing health services that I cannot predict what the impact on health will be for our community.

The stories that have been told to me about delayed services are beyond my capability at the moment. Every day someone gives me examples of melanomas not being removed, or they are about to see a cardiologist but there is no service and they cannot go to Adelaide because of the cross-border community issue. We are

recommending a memorandum of understanding [MOU] with South Australia so that nobody is disadvantaged. I have to repeat this: We will not know the impact of COVID until about three or four years down the track, or more, and I am beyond thinking about what is being delayed. Particularly I acknowledge a young mum who is trying to get an assessment for her child for autism. For people living in Sydney, if you cannot get an assessment you will go to your next key stakeholder or non-government organisation in the next suburb.

This person has been waiting over 12 months. This is 12 months delay. Even the Far West health service cannot help them. We need an immediate review of what is happening for the delivery of health in the Far West. I also want to acknowledge the delay in specialist care. I was told about one incident where a person had a referral. I think their referral was in 2019. They were told by the specialist clinic that they would be moved down the list because priorities come in, so it may not be until 2023 that this person is seen. I want to say: Is this acceptable under our health service?

The Hon. TREVOR KHAN: No, it is not.

Ms TURLEY: I keep hearing that the further out you are, the more challenges you have in the delivery of health. I want to acknowledge Walgett and all they are undertaking, because telehealth is supposed to supplement. But, for us, we want to make sure that we start to seriously look at the delivery. I also add that we believe we should be recommending a drug rehab centre for Broken Hill. To access drug rehab services—and it is in our submission—is challenging beyond compare. Again, if you are in the city it would be easier to access a drug and alcohol health service. The other part that we would like to share, and I will say it in the opening statement, is that our community deserves to know the data that reflects our service delivery.

We deserve to know what is actually being delivered, how it is being delivered and what health improvements there are. I would have to say that the annual report recommended by the New South Wales Government, that the local health districts would present an annual report, the way it is presented during the day, you cannot attend if you are working. The data is not easily accessible to the everyday citizen. I can tell you that there are many people that would like to know the good things that we deliver and the challenging things. I particularly want to acknowledge Mrs Cools, who is probably watching this today, and say that we need to deliver care for all. Thank you for the opportunity.

The CHAIR: Thank you, Mayor Turley. Before I open up to questions, on behalf of the Committee I express my thanks and gratitude to our local government representatives, particularly our mayors, councillors, general managers and other staff who have been involved in providing material as submissions to this inquiry, particularly for the oral evidence they have given at our public hearings. Some of the most clearly articulated and detailed evidence we have received through both submissions and oral testimony has been from local government. In some sense more than anyone or any group, as an organisation it has provided such clarity into so many of the challenging issues regarding the provision, delivery and outcomes of health with respect to regional and rural New South Wales.

I want to put that on the record because our inquiry would be much impoverished but for the provision of that most valuable evidence from our local government representatives, particularly the mayors, general managers and their staff. We will open up for questioning now. It will be roughly eight to nine minutes for each of the groupings around the table, which is the Opposition, the crossbench and the Government. We will commence with the Opposition and the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you. I would like to start with Councillor Turley. Thank you for making a submission and making yourself available today. Councillor Turley, what is the current status of preparedness for COVID in Broken Hill? Sydney is now grappling with the South African strain. What is happening in Broken Hill at the moment?

Ms TURLEY: I have not been briefed by the chief executive about their preparedness, but can I just acknowledge that Dr David Lyle and our public health unit have been doing an incredible job during COVID. I am very concerned about anybody understanding the data around vaccinations with the Delta strain. I was very concerned that there was not a lot of planning and very concerned that there were not resources put into the area health across the whole district, but particularly the Far West, back when we were seeing the strain develop in Sydney. I have been very vocal about that.

When I was asking what the vaccination rates were, nobody knew. Everybody was willing to pass the buck onto someone else. My thing is that data is gold. You should understand the data; it took a while for people to get that. I should acknowledge that I worked in Health for 41 years and I have a little bit of understanding about the delivery of health services for the area. I covered, at times, Oberon to Broken Hill. But I was shocked and angry to understand that at that time, for Delta, there was no understanding of vaccination rates. I am challenged at the moment. I have not been contacted by the chief executive, to date—I hope that will happen—to tell us their

preparedness around this new strain. Certainly, the public health unit—we have got some absolute stars there that are working 24/7. But I think at times communication needs to improve.

The Hon. WALT SECORD: What are the vaccination rates in Broken Hill at the moment? Are people getting boosters?

Ms TURLEY: Yes. Boosters are just starting. Our vaccination rates—once people got the understanding, it is priority, our vaccination rates are incredibly high. My challenge is the—we were targeted by Clive Palmer, by his groups, to try and get people to stop vaccinations. Misinformation that he was lending—he actually sent flyers to our communities, I think, three times, maybe four. So we still have some hesitancy in some elements of our community. That is a concern.

The Hon. WALT SECORD: Clive Palmer's group targeted Broken Hill with an anti-vaccination message.

Ms TURLEY: Yes, and misinformation. And he changed the image of the flyer. At first it was yellow and black, in their party colours. Then he changed it to looking like a medical flyer. It was white, blue and red. I was just outraged. I just thought, "This is just unacceptable."

The Hon. WALT SECORD: How did you feel as a health professional when you saw that?

Ms TURLEY: I was shocked. Do they understand the consequences? What is the intent of sending a flyer to the most vulnerable community? This is a community that has 12 per cent Aboriginal living in the whole district. What is the intent of sending that flyer? It is just outrage. My thoughts were not only for those community people that would read it and think it is a medical flyer but for our staff in the ICUs and emergency department. There is potentially such a risk.

The Hon. WALT SECORD: Thank you. Ms Turley, if time permits, I will come back to you. I would just like to speak to the gentlemen from Walgett. Gentlemen, correct me if I am wrong. Your health facility in Walgett—is it a multipurpose service [MPS]?

Mr WOODCOCK: Yes, it is.

The Hon. WALT SECORD: It is. You used the word in your opening statement. I think the general manager, Mr Urquhart, mentioned that it was terrifying. If there is a problem and you cannot receive medical care at the MPS, where is the nearest major health facility? Dubbo?

Mr URQUHART: Dubbo.

Mr WOODCOCK: Yes, that is right.

The Hon. WALT SECORD: We have heard evidence to this inquiry, that there have been other MPSs, district hospitals in western New South Wales and southern New South Wales, where there was a lack of a medical doctor at facilities. Do you have a medical doctor at your MPS, 24/7?

Mr WOODCOCK: No, not 24/7. They are on call if they are available.

The Hon. WALT SECORD: Can you explore this a little bit for us? When you say "if they are available", what do you mean?

Mr WOODCOCK: There may be times when there is no doctor here.

The Hon. WALT SECORD: When you say "here", you mean in the town or in the hospital or in the region?

Mr WOODCOCK: In the hospital.

The Hon. WALT SECORD: What happens when there is no doctor? You are quite a big—you have 6,100 people in your area. No doctor for an area like that. What kind of presentations would occur at the Walgett MPS?

Mr WOODCOCK: We have a hospital. We also have the Walgett Aboriginal Medical Service, which is a very good service and supplies medical services to the town itself. Quite often times they may have a doctor available, which somehow or other they borrow to the MPS if there is no-one up there. It happens there. It happens at Lightning Ridge, exactly the same thing. Ochre now are contracted to look after the MPS. They have fly-in fly-out doctors all the time. They are here for a week or a fortnight at a time, and they are gone. Rural and Remote Medical Services [RARMS] had a service in Lightning Ridge. They lost the contract for the visiting medical officer [VMO] rights, because Ochre took that over. I think we are down to only one doctor there at the moment, who services the town. They are available, but they do not go to the hospital.

The Hon. WALT SECORD: What do patients do? They have to rely on a nurse and telehealth?

Mr WOODCOCK: They do. A lot of people do not seem to like that idea because they do not feel as if they are getting a proper consultation, because sometimes the line might drop out. Signals are not really bright at times. There is a lot of confusion about it. I know one of our councillors had to go down to—I think it was Coonamble—last week. Think it was Coonamble. He had to go. No-one was here in Lightning Ridge. He had to go and have a telehealth thing done. He said it was disgusting. He is a medical man himself. He said it does not work. People do not feel as if they are getting the proper treatment. If the doctor is there to have a look at you and say "Have a look at this" or whatever they need to do, sometimes it does not work if you are looking at it on screen.

The Hon. WALT SECORD: Do you find that people in the community, because they have to resort to telehealth, simply do not get medical treatment?

Mr WOODCOCK: It appears that way, yes. They do not like it. They do not want to have anything to do with it.

The Hon. WALT SECORD: Gentlemen from Walgett, the general manager, Mr Urquhart, mentioned in his opening statement that it was a desire from Walgett Shire Council, to be consulted. Can we explore that a little bit. What were you talking about? What were you referring to? I would assume that the local council would be consulted by New South Wales Government and Health. What were you referring to?

Mr URQUHART: When the tender for the health services at the MPS went out, we were not consulted as to what was going to happen. At Collarenebri, which is another small town in the LGA, it was being cut back by, I think, one day per week to have medical services available. Lightning Ridge was being cut back to three days a week. I am not sure, cannot remember what it was for Walgett. But I think it may have been five days a week instead of seven. We were not consulted with any of this. It was just by chance. One of our counterparts was able to get hold of the tender and to find out actually what was being promoted by the western area health and the reduction in face-to-face primary care services.

The Hon. WALT SECORD: This was just dropped on you. There was no communication? You just found out that health services were being cut.

Mr WOODCOCK: We found out by accident.

The Hon. WALT SECORD: Thank you, gentlemen. Hopefully, I can return if time permits.

The Hon. EMMA HURST: Just following on from the Hon. Walt Secord's questions about the services being cut. I know that in your submission you mentioned that you were concerned there was going to be a 53 per cent reduction in primary care services in the area. But I also note that that submission was written almost a year ago now. Can you give us an update on what has happened in the past year? Have there been any changes? Has anything happened since you wrote that submission about the 53 per cent reduction?

Mr URQUHART: We have been very fortunate that RARMS have stayed in all three centres. They had no doctor here for a while in Walgett. In Lightning Ridge, I believe, it is [inaudible] down to only one doctor from RARMS. Ochre also have their doctors there. So we are probably about the same as what we were before. But it certainly was not a drop of 53 per cent that was the final outcome.

The Hon. EMMA HURST: Are the concerns going forward that there might be more drops or more reduction?

Mr URQUHART: The concerns going forward are that we would like to be consulted if there is to be a change in the health services for Walgett shire. In fact, those three statements that I made there, with the designing and implementing new GP recruitment for rural and remote and increasing the primary health care.

The Hon. EMMA HURST: So you are concerned that there might just be a sudden reduction in primary healthcare services to the area and that it will just be announced after it has been done.

Mr URQUHART: Yes. That is what we are frightened of. It does happen. You might have two doctors this week and next week you will have none.

The Hon. EMMA HURST: In your submission you also note that there are six children in the shire with serious heart conditions. Do you know how they are able to manage these conditions despite the lack of specialists and access to care generally?

Mr URQUHART: I know one child here from Walgett. That little girl had to go to Sydney here a while back. So there are no services, I do not believe, locally for them but they actually go away to Sydney for specialist care.

The Hon. EMMA HURST: So most of them are having to travel to Sydney for any kind of attention?

Mr URQUHART: Yes. And in the interim, if needed, they would have to be flown to Dubbo. That is the biggest concern. If anything happens to anybody out here—they do not like to touch people. They just assess them and then they fly them out to Dubbo. That is quite frequent.

The Hon. EMMA HURST: Is that causing a lot of stress for these families, obviously, with having young children that have heart issues?

Mr URQUHART: It certainly is.

The Hon. EMMA HURST: I have a question for Mayor Turley. Mayor, you mentioned in your opening statement that you were wanting to have a memorandum of understanding with South Australia. I was wondering if that is progressing in any way or if that is something that you are looking for assistance with.

Ms TURLEY: That is something we are looking for assistance with. In the last two years, under COVID, it is beyond a challenge. But it is something the New South Wales Government will have to be the lead for that. Every day our access to South Australia changes. We have had people turned back at the border at five or six o'clock at night, which means—the border crossing is not actually on the border. It is three hours from Broken Hill, so you travel into South Australia. You are travelling there and you arrive around six o'clock to go through the border check and all of a sudden borders close.

You are travelling back in the dark to Broken Hill. But also you have lost all your motel accommodation and your doctor's appointments, which is what the critical part of it is. We really need the New South Wales Government to have a greater understanding. At this stage my understanding is that the Cross-Border Commissioner is not even informed by the South Australian Government when they close the border to Broken Hill. The New South Wales Government is not informed, let alone the mayor of Broken Hill. It is creating risk. It is reducing access to health services. For all of us the stress to our community is unmeasurable.

The CHAIR: Cate Faehrmann? Cate, you might be on mute.

Ms CATE FAEHRMANN: Yes, sorry. It kept re-muting. That is very strange. Thanks for joining us. I wanted to echo the Chair's comment about councils and how much during this inquiry you have really stood up for your communities and shed a light on what is happening because of the lack of health resources, particularly in remote New South Wales. I wanted to thank you for your advocacy there. I will go straight to you, Mayor Turley. You mentioned in your submission and in your opening statement the need for a drug rehabilitation centre in Broken Hill. What has been the impact of not having drug rehab services in Broken Hill for so long despite—I know there has been advocacy for this—the impact to individuals, families and the broader community?

Ms TURLEY: Could I just acknowledge the great counsellors we have at our mental health unit. But when you are looking at your referrals for drug and alcohol rehab, people have to travel a long way. What often happens—one story I heard is putting your young teenager on a bus to get to a drug rehab centre. You do not even know if they will arrive. But it is the fact that it actually delays care. It can actually interfere with the holistic approach to caring for that person and their family. Because drug rehab is not just about the person; it is the family dynamics. For all of that, what really happens, simply, is people do not have that access.

They do not have the intervention. They certainly do not have an early intervention so they are crippled by the impact of their addiction. Addiction is a medical condition that NSW Health needs to understand does not just happen in Sydney. It happens in these rural communities. I am reminded, talking about this, of the ice inquiry when someone asked me, "Would a drug and alcohol rehab centre help if there is one in Dubbo?" And I thought, well, would it help you in Sydney? Because you live closer to Dubbo than I do. We are a long way away, yet we are an important part of the population and our community deserves to access care and services.

Ms CATE FAEHRMANN: What has been the response from the Government? Where is that up to? I know there have been several years of advocacy to get that treatment centre in Dubbo. So what has the response been? Is there any hope that something is going to happen sooner rather than later, or at all?

Ms TURLEY: We are about 800 and something kilometres from Dubbo. Our care factor really is about Broken Hill. I do not know what is happening in Dubbo. We do not get Dubbo news. What we want—and we have got a great team that are leading this. Joanie Sanderson—you know, community members that understand partnerships are important. They are working with the primary health unit in the Western NSW Primary Health Network [PHN]. They are working with them to try to get funding now. I hope they do. I think it is an important issue. I cannot imagine someone in Sydney sending their family members over 1,000 kilometres away for treatment. I just think that, when you are looking at addiction, it needs a holistic approach and it certainly needs support, not isolation.

Ms CATE FAEHRMANN: What is the level of demand, Councillor Turley. Do you know?

Ms TURLEY: I do not know. I do know that we have a low socio-economic community—

The Hon. TREVOR KHAN: But I know Walt wants some extra time.

Ms TURLEY: Sorry?

The Hon. TREVOR KHAN: Sorry. My fault.

The CHAIR: Sorry about that interruption.

Ms TURLEY: Do you want me to continue?

The CHAIR: Yes. I apologise.

Ms TURLEY: That is fine. I do not have the data in front of me. Again, we would have to find it from Health. But anecdotally we are an outback community. We are isolated and we do not have that early intervention. If you are waiting potentially three years for a referral to a specialist, then imagine what you would be waiting to get early intervention for addiction. I think that we have a great team and they help with a great job but with very limited resources.

The Hon. WALT SECORD: Ms Turley, I would like to go back to the Clive Palmer anti-vaccination stuff. Did it in fact impact on the community? Did it increase the number of people who were vaccine hesitant in Broken Hill?

Ms TURLEY: My understanding is that there are still people that have vaccine hesitancy. We are very lucky. We have a higher rate overall. But if you broke down and looked at the target groups—I would imagine there are specific target groups there that have hesitancy. I have not got any data to say that this flyer influenced it. But if you receive a flyer that looked like medical information, you would be thinking that this is real, to keep it simple, and thinking these messages that were in the flyer were recommended by health professionals rather than for whatever reason they targeted our community.

The Hon. WALT SECORD: Councillor Turley, what do you think the purpose was? From memory it looked like a bit of medical advice and it was put in with Aldi material. Is that correct?

Ms TURLEY: Absolutely. I wonder if we were being targeted to trial one of their treatments. Like, first let us get some low vaccination rates and then let us trial this crazy—I did not mean to say crazy treatment—this untested, proven-not-to-work treatment. I just do not understand why they would target a community of the most vulnerable with such misinformation. It is a shame that they were able to circulate that information. It is a shame that nobody has ever legally taken them to task. I have to wonder why that has not happened.

The Hon. TREVOR KHAN: Councillor Turley, I return to the issue of the drug and alcohol facility or the lack thereof. Do you know what programs exist under the merit scheme, say, in the Local Court in Broken Hill?

Ms TURLEY: Very good question because I actually developed the merit scheme for Broken Hill.

The Hon. TREVOR KHAN: Well, there we go.

Ms TURLEY: Where it does exist it has been in place I think since 2004. It is pretty hard to refer people to drug and alcohol services but also there is a difference between rehab services, in a lot of ways, and detoxing. Again, I do not have the data but it does exist. Certainly, it is a good intervention program. I know that one of the stories that was told to me is about—and I have used this story before—a 14- or 15-year-old started to use drugs, the parent wanted to get early intervention and could not even get a paediatrician to see the child. So it is very hard in the outback but it should not be. We should have those services. We cannot keep saying it is too hard. This is a great opportunity to progress it.

The Hon. TREVOR KHAN: Councillor Turley, just before I go on to the next question, you have got me absolutely on side. I have to say, with clients of mine out of Tamworth where we were we were having to send them to facilities on the coast, regrettably sometimes we would lose our client somewhere on the way to the facility and then we were back at square one. So I understand the point that you are making—that you need a facility close by in order to do it. Do you know what sort of manpower footprint would be required to operate such a facility and the like?

Ms TURLEY: I do not. The group that locally is developing a case study at the moment—and I think that is one of the issues about what would the services be. It has to be reflective of our whole community. We have a very important Aboriginal community near Broken Hill as well, in the Far West. But at the moment a case study is being developed.

The Hon. TREVOR KHAN: If we could just go to this issue of the cross-border problem that you have got. The Cross-Border Commissioner, and I suppose you could say Health generally, were fairly successful—and I will put the caveat of fairly successful—at setting up models on the Victorian border and also the Queensland border to allow movement of patients and the like across the border. Again, how successful that has been has varied over time. Are you telling us that in Broken Hill that level of both communication and cooperation that existed just has not taken place for you?

Ms TURLEY: It took some time and we finally got what was a buffer. I wrote to the Premier and everybody on a Friday—my love letters to South Australia, I called them. We finally got a buffer but they pull this so-called buffer constantly. So people travelling, I am just trying to work out the day, at the beginning of this week—we thought that the borders were open and we could cross over. All of a sudden I got a call on the weekend from a mum who was taking her child for a cardiac paediatric assessment. Imagine this—if you are in Sydney, you could probably go to a suburb, but you have to travel over 550 kilometres for a paediatric cardiac assessment. I got a call from this mother saying, "I don't know what is happening with the border at the moment." So I found out thank you to the public health unit—a great champion there Kathy Seward. Even though it is clear as mud when South Australia changes their public health order, it was very hard to understand. It may not be you need to have a COVID test, you still have to apply for a border pass but what we had to resolve was that everybody should just get a COVID test to go over for an assessment and it looked like the child should as well.

It is just terrible that we do not get up-to-date information about borders and how quickly it could change within a week or within a day. But nothing is ever sent to Broken Hill—to the Far West Local Health District—that I am aware of but particularly even to our media, so we can say, "Don't drive to Adelaide unless you get a COVID test. Don't drive to Adelaide—the border is closed. You are going to be caught on the road for six hours if you do this." But more importantly is the delay in accessing health care. One lady was flown out to Adelaide so she could go to Adelaide. She had to have a stent put in for a stone, came back to Broken Hill and was supposed to go back to Adelaide to have the stent removed. That is not an emergency, so she cannot go back. This was in the first outbreak of COVID. She could not go back. What this means now because she could not have the stent removed, the operation is bigger—much bigger. She was delayed and it just has such impact. I have a thousand stories but ones that heartbreak me are around children and accessing care.

The Hon. TREVOR KHAN: I think it will be my final question, Councillor. In the Broken Hill community do I take it from your evidence that the primary source of specialist consultation is Adelaide as opposed to Sydney? And the second part of that question is: What is the source or the home location of the specialists coming into Broken Hill? Is the source or the home location for those specialists Adelaide or Sydney?

Ms TURLEY: Primarily they are from Adelaide. Again, because of COVID, once COVID hits they cannot travel because we have cases where the border closed. If they did come to Broken Hill and went back to Adelaide, they would have to go into two weeks' isolation and so they were not prepared and everybody understands this. But what that means is their caseload—all those appointments—were pushed back and, again, our community did not have that intervention of care. This is a constant story. And I would say, if you are looking at anything, reviewing the specialist clinic in Broken Hill, they need our support but certainly, as I have said, delays of appointments could be up to three years.

The Hon. TREVOR KHAN: Thank you. I would like to ask more but I have run out of time.

The CHAIR: I have a couple of questions before I close this session. These can be taken on notice but I will just explain the thrust of my two questions. The first question to both councils is with respect to your annual budgets for your councils. Do you contain within them a line item for expenditure on what I will describe as health and medical services? In other words, because this has become such an issue over the years, the council specifically is including within its budget consideration expenditure for health and medical services. I am saying this is beyond what historically may have been done and considered normal for councils and shires.

Secondly, with respect to that, I would be keen to find out—I am sure the Committee would be as well—if we look at the 2019-20 financial year and the 2020-21 financial year, what have been those health and medical costs? And I am thinking in line with ideas like what could be subsidies that are paid for perhaps housing for doctors and nurses. It could include also matters like the advertising costs that the councils go to to advertise themselves for nurses, doctors and allied health workers. It could provide also incentives in money or kind—those types of items which can be aggregated as expenditure essentially now being devoted by the councils on health and medical matters.

I will let you take that on notice and prepare for that but that information will be very valuable to inform our deliberations. Thank you very much. On that basis on behalf of the Committee I thank both mayors and the general manager. It has been great to see you. Once again, it would have been our first preference to come out and spend some time with you and perhaps even meet some of the citizens in your area in your towns and locales, to

talk with you explicitly about these matters but that has been denied us. But once again I can assure you that your evidence has been quality evidence and will be most usefully used by the inquiry. So thank you very much and all the best for this afternoon.

(The witnesses withdrew.)

MARK BURDACK, Chief Executive Officer, Rural and Remote Medical Services Ltd, before the Committee via videoconference, affirmed and examined

RICHARD ANICICH, AM, Chair, Rural and Remote Medical Services Ltd, before the Committee via videoconference, sworn and examined

The CHAIR: Welcome to our next witnesses to our public hearing this morning. We appreciate you made your time available to be able to participate to provide helpful oral evidence in addition to the valuable evidence that has been provided in your submission. My name is Greg Donnelly, and I am the Chair of the Committee. As I have said, with respect to your submission, thank you for that. It has been received, processed and stands as submission No. 705 to this inquiry and has been uploaded to the inquiry's webpage. I invite you to make an opening statement. I am not sure whether one of you or both of you will participate in that respect. Has someone been delegated to or has a decision been made about who will do the opening statement, or would you both like to make an opening statement?

Mr ANICICH: Chair, thank you for that opportunity. I have been delegated at least to work through the opening statement, which we have submitted to the inquiry in the last day or so as well. Can I say initially thank you for the opportunity to address what we see is a very critical and important inquiry on rural and remote health. I open, firstly, by paying our respects to the Gadigal people on whose lands you are sitting in Parliament today but also to the Gamilaraay, the Wiradjuri, the Wailwan and the Yuin people on whose lands our company works every day to address the gaps in rural health care in New South Wales. For our part today, we are giving evidence virtually from the lands of the Awabakal and the Wiradjuri peoples, respectively.

We would like to acknowledge the more than 20,000 people who entrust us with their daily lives, with daily care, 25 per cent of whom are Aboriginal and Torres Strait Islander people and upon whose wisdom and knowledge we rely every day to understand how better to deliver healthcare sustainability in rural and remote communities. Rural and Remote Medical Services Ltd [RARMS] has worked as a charity for about 20 years now, delivering better access to health care in New South Wales rural and remote towns. The organisation was established in 2001 by a group of dedicated rural general practitioners, with the support from the Rural Doctors Network NSW. Initially, we addressed the lack of GPs in towns like Collarenebri and Lightning Ridge. Our service locations and operations have evolved and adapted over that period of time to meet community demands and expectations.

In doing so, we have proven that it is possible to deliver sustainable health care that reflects the priorities of individual rural and remote towns if we have the will to do so, supported by the right policy settings and well-directed public funding. You have received over 700 submissions to this inquiry and taken evidence from a large number of witnesses over 11 days of hearing so far, with more to come before the inquiry is concluded in the new year. There have been some distressing stories relayed to the inquiry, but it is not our intention today to comment on specific examples but rather to speak on what we see are some systemic issues and our thoughts on how they might be addressed. Across rural and remote New South Wales we have community and clinical consultative committees working diligently to address the health needs of local communities. The question, therefore, is not whether we have consultation mechanisms but are they working. In 2019 the New South Wales Auditor-General observed:

> Despite the importance of community and consumer engagement … it is difficult for LHD boards or the Ministry to know with confidence that community and consumer engagement is being done effectively.. If devolution was intended to bring the management of health services closer to local communities, then there is little way to know whether this is being achieved.

The 700-plus submissions you have received in this inquiry painted a clear picture that rural and remote people do not feel that their needs are being met or that their voices are being heard in decisions about their local health services. The problem was illustrated to this inquiry when it was advised that NSW Health is "moving away from the GP VMO model" on which rural and remote towns rely to sustain their primary health and hospital systems. As far as we are aware, this was the first time people in our communities were told that the Government is making, or plans to make, a radical change to the way health care is being delivered in our communities for over 50 years—and this was at an inquiry in Sydney to find out what is wrong with our rural health system, not at community meetings involving rural and remote people in the bush.

We will only get to solutions that work if there is a genuine collaboration with rural and remote communities in the design of local health systems to address their specific needs and opportunities, which are very different from metropolitan and larger regional locations. In October this year the Commonwealth Department of Health released a consultation draft document, *Primary Health Care 10 Year Plan 2022-2032*, and that notes:

> People living in rural and remote areas have more limited access to health care services and poorer health outcomes than people living in metropolitan areas.

We cannot go on imposing a one-size-fits-all solution on the diverse needs of rural and remote communities. This inquiry has also heard from NSW Health that:

> … primary health care and GPs are the absolute backbone in keeping people healthy and avoiding unnecessary hospitalisations, and the care and supports that they provide improve health outcomes.

To us, this begs the question: If primary health care is so important to the future of rural and remote health in New South Wales, why do we not have a New South Wales primary healthcare strategy, a rural health plan that sets out measurable health outcomes against which governments will be held accountable, or clear and accessible framework that tells rural and remote people exactly what services they can expect in their local hospital and the minimum workforce it will receive? Sustainable primary health care is the key to the future of rural health, and this can only be delivered if there is a clear strategic and accountability framework, and the resourcing, to support primary healthcare-led service delivery in rural and remote communities.

This requires some frank and honest discussions about culture, development and the structures that support rural and remote health. In its evidence before this inquiry, NSW Health seems to be saying that the problem of rural and remote health comes down to a simple "workforce problem"—the lack of GPs willing to live and work in these towns. Workforce shortages, however, do not explain why in some rural and remote towns there are GPs who simply refuse to work at the local hospital, and why in other places there are local rural GPs who are qualified but not accredited to work at the local hospital. In November this year *The Daily Telegraph* published a report on a study of junior doctor perceptions of our hospital system. It was not very pleasant reading. It used words like, to describe the system, "toxic", "poisonous" and "dangerous". It would strain credulity to suggest that the sort of cultural problems that affect our hospitals in Sydney do not also exist in the bush.

We need to acknowledge the impact of culture and working conditions in rural hospitals as a factor in the willingness of GPs to live and work in rural and remote towns. Every year, as a community and government, we spend a lot of time and money training enthusiastic young doctors to work in rural and remote towns [audio malfunction] out to communities that lack adequate services, where hospitals and healthcare services are overstretched to operate in primary healthcare facilities that would not be out of place in some towns from the 1960s. We spend millions of dollars building new rural hospitals in the hope of attracting doctors without recognising, though, that GPs spend 90 per cent of their time in general practice, not at the hospital—and then we wonder why GPs do not work in rural and remote towns.

One of the most important reasons we have failed to solve these problems is because we have treated the problem as exclusively a "health workforce" problem, rather than a community development issue. We need a broader development approach that involves a bottom-up, joined-up, whole-of-government effort that is co-designed with local communities, not for them. This is not inconsistent with a comment in the Commonwealth's draft *10 Year Primary Health Care Plan* that I referred to earlier, which notes:

> PHNs and LHDs are best placed to understand the needs of regional and local populations, to drive bottom-up planning and to collaboratively commission services to integrate the health system locally and regionally.

Whilst this plan supports the need for "bottom-up" planning, we say, though, that the primary health networks [PHNs] and the LHDs are not best placed to do this unless that planning includes genuine consultation with and input from local communities in that planning. Hospitals treat disease and emergencies, and they do that very well. To achieve this, they deploy a model of care which requires centralisation of staffing and services and are heavily reliant on ever-increasing levels of specialisation. Primary health care, on the other hand, is about keeping people healthy and out of hospital. It is built around continuity of care by clinicians who live in a community for which they care and who are trained to understand social determinants that drive health outcomes. GPs work to build a continuous and trusting therapeutic relationship with the patient and the community. For 75 per cent of Australians, primary health and hospital care are two completely separate systems: They do very different things and their models of care are not interchangeable. This is not the case in rural and remote areas. Rural and remote practices have historically relied on State VMO funding to be sustainable.

In the past, New South Wales understood that supporting primary health care in rural and remote communities not only helped to reduce preventable illness and avoidable hospitalisation but also meant there was always a GP available to treat patients who turn up in the rural emergency department. This shared care approach made it more financially attractive for GPs who work in rural and remote towns, and recognised GPs as clinical leaders in community care. This collaborative approach has given way over the last few years to a more managerial approach, as health budgets tighten and demand increases. Rural GPs are no longer, in some cases, treated with respect as clinical leaders and VMO funding is too often viewed as the New South Wales Government paying for a Commonwealth responsibility. This has eroded a once-collaborative and positive approach to leveraging available resources to achieve better health outcomes for rural communities. In this context, we also note the evidence from NSW Health where it was said:

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

I could come back to that in the Q and A session if you want, but in my other [audio malfunction] roles, I see that problem every day as well.

The CHAIR: Mr Anicich, sorry to cut you off. We have your statement with us, and I think that is what you are reading from if I understand correctly.

Mr ANICICH: I am. Correct.

The CHAIR: If we have that fully incorporated into *Hansard*, that will enable us to move to the questioning straight away without actually having you to—

Mr ANICICH: [Inaudible].

The CHAIR: Is that okay with you? It will just open up more time for the questioning.

Mr ANICICH: Yes, it is. It absolutely is. Assuming all the Committee members now have that statement and have the opportunity to read it, that is fine.

The CHAIR: Yes. It will just enable more questioning and it will be reflected in the *Hansard*. I am not meaning to cut you off, but it is just so we can open up the question time. Your statement will stand as evidence to the commencement of this session. The remaining statement is as follows:

> We don't refer to this evidence in a critical way. But, it is a clear statement of what we see as core to the issues in rural and remote health services.
>
> In the past the State actively sought opportunities to help support a strong and sustainable general practice sector at the heart of rural and remote health ecosystems.
>
> The fact is that the health of rural and remote Australians is not a NSW or a Commonwealth responsibility – it is everyone's responsibility.
>
> The fact is that the Commonwealth funds primary care, it does not deliver it. It also funds more than 50% of the State's hospitals, but we do not hear anyone saying that we should absent ourselves from any role in our hospital system.
>
> The fact is that primary health care is delivered by thousands of small to medium businesses registered and operating in the NSW economy. The more support these businesses get from the NSW Government, the more money the Commonwealth pays into the NSW economy.
>
> The National Rural Health Alliance estimates that the lack of available primary health care in rural and remote Australia saves the Commonwealth billions of dollars a year in Medicare and PBS rebates. It begs the question, why is NSW not proactively supporting rural and remote primary health care to leverage our ability to increase revenue, reduce the rate of mortality and morbidity among its own citizens and getting more doctors for the bush?
>
> Towards Solutions
>
> NSW needs a primary health care plan like other States and Territories to define the role of primary health care in our human services system, and as a driver of economic growth and rural development.
>
> There needs to be a more integrated and coordinated place-based approach between primary health care, human services and regional development in NSW to address the social determinants, reduce preventable illness and to improve access to services in small towns.
>
> The biggest gains that can be made in improving health care access and outcomes in rural and remote towns are through the integration of primary health, human services and regional development.
>
> In this context, the Commonwealth Department of Health's draft National Preventative Health Strategy 2021-30 notes:
>
> "… it is widely recognised that there are broad contextual factors that play an integral role in determining the health of society many of which lie outside of both the health system and the control of individuals. These broad contextual factors include the social, environmental, structural, economic, cultural, biomedical and commercial environments in which we live, work and play".
>
> The Committee must reject the advice that the problem of rural and remote health is solely about workforce shortages and that the GP/VMO system is not working. There is strong evidence to show that the GP/VMO role is central to quality healthcare in our rural and remote communities.
>
> We are not aware of any evidence presented to this Inquiry that suggests we should 'move away from the GP/VMO' model because it will be better for the health of rural and remote people. The problem is not the GP/VMO model, but that we have inverted this model to become a VMO/GP model which is not fit for purpose – we need to return to the old shared care approach and reinvigorate the GP/VMO role.
>
> As we have said, we cannot solve workforce issues through a health workforce lens - we need a development lens.
>
> It is time in our view for rural and remote health to be managed by an independent body in NSW. We need to design a new and accountable system for community and clinician involvement in decision-making in rural and remote health care.

> We need a Minister for Rural and Remote Health supported by an independent and well-funded Rural and Remote Health and Development Commission that brings together all the resources of government at a State and Commonwealth level, not just health, into a coordinated approach to address the reasons people get sick (social determinants), the provision of social and health support to small towns, the training of doctors and nurses for rural and remote practice, and which supports rural and remote communities to be attractive places for doctors, nurses, teachers, social worker, accountants, lawyers, police officers and other workers to live and work.

The Hon. WALT SECORD: I would like to ask Mr Burdack a question. You are on the record as saying that there is too much focusing on attracting GPs and doctors to country areas, and you believe the shift should be to retaining them. What do you mean by that and what are you proposing? What do you think we should recommend in that area?

Mr BURDACK: The issue in rural towns, whether it is doctors, teachers, police officers, social workers or accountants, is how you get people to the towns but how you sustain them within those communities. The challenge we see is one where we are putting a lot of money into training doctors to come to rural towns but very little investment in actually making those towns places that people want to set up life and a family. We have got a disconnection. We have literally spent billions of dollars over the last 20 years. We have rural graduates coming out to these towns but they are confronted with a situation where services have been withdrawn, there are not jobs for spouses, there is not appropriate infrastructure, and so they leave very quickly thereafter. If we want to create effective solutions, we have got to simultaneously build a workforce but also look at what the dynamics of those communities are and how to invest in those communities to make them more attractive places to remain as well.

The Hon. WALT SECORD: When you have prominent GPs or community leaders who decide to leave communities, do you do what the corporate sector calls "exit interviews"? Do you ask them or research and find out? What is the number one reason for leaving those communities?

Mr BURDACK: I think it is because there is not a career pathway in those communities. There is not opportunities for their children, for example, to attend the sorts of schools necessarily that they would like to be attending. We have got fantastic schools in rural towns, but often the children of doctors or children's parents are looking for a type of education that is not necessarily accessible locally. That is a major reason. We often see doctors leave around about that year 7 mark where their kids are moving into high school. Spousal employment is another really significant issue. If you have a doctor, you may well have the husband or wife who is an accountant or a doctor themselves, and so what you need to be able to do is have a sustainable career for that person within that community.

For a lot of these things, it is not actually a big challenge to address many of those problems, and part of what we see is that we know that 80 per cent of our health is determined by where we are born and where we grow. We know things like high unemployment is very strongly related to poor health. We know that low education or attendance is associated with high unemployment and poor health. But we also know those factors make it more difficult to attract doctors into the town because of economic decline.

As we are doing regional development in these towns, we need to think more holistically about how we create environments that people want to remain in by creating active economies. That requires us to link up planning in a much more effective way than we are doing. We cannot treat health as though it is in a silo from everything else. It needs to be part of an overall strategy. I was speaking with a fantastic group of people yesterday, the Warren Health Action Group, who have really taken this bull by the horns. They have got some really serious trouble and were saying to me, "What do we need to do?" I said, "There are about 100 things we need to do, and it is getting all those ducks lined up and making sure we can make our towns as attractive as possible to keep doctors here for the longer term."

The Hon. WALT SECORD: Mr Anicich, I would like to turn to something you raised in your opening statement. You talked about concern about the communicating of NSW Health changing the VMO model. Can you take us to that, what occurred there, what the deficiencies were and how it unfolded?

Mr ANICICH: I was referring to some evidence given. I think it was on the first day of the hearing of this inquiry, and that is the evidence from some of the senior health ministry officials for this inquiry. That is what I was referring to. Whether that statement is a reflection of current Government policy or not, I am not sure, but the point that I think they are making is that for the 20 years that RARMS has been operating in these towns, it is the VMO GP model which has been underpinning the sustainability of the practices and it provides the resources for a GP, whether it be someone who is permanently residing in the town or on a regular locum basis. But they are not just working in a hospital setting; they are working also in our practices and providing that community-led health care to the patients and dealing with these management plans, dealing with the issue of diabetes and things like that. It is not just the acute care which might lead to a presentation in a local emergency department. From the management of the health budget point of view, I am sure that we should be trying to keep people out of the hospitals and being dealt with by GP and allied health-led care in the community.

The Hon. WALT SECORD: Either one of you can answer this. In the opening statement there was reference to doctors refusing to work in local hospitals. What would be a blockage or what would make a doctor refuse to work in a local hospital if there are very few doctors in that town? What is the blockage or what is the reason? Why would you be reluctant to work in the hospital? Is it long hours? Is it insurance? Is it pressure? What is the reason? Why would you refuse to work in a local hospital?

Mr BURDACK: I am happy to answer that question, if you would like.

The Hon. WALT SECORD: Please, thank you.

Mr BURDACK: There are various factors, I think. We have very good, dedicated staff working in rural hospitals across the board but there are examples of hospitals where the culture of not supporting having general practitioners in those communities in the hospital itself. We see in some towns where you might have six or seven doctors and they will not want to work in the hospital because they do not feel that they are well supported or that their clinical skills are properly recognised, or the culture of the hospital is such that it is not a pleasant place to work. We have seen that across the board in hospitals in Sydney and in the bush. It is not something that is unique, but it is a real challenge. If 95 per cent of the job of a doctor is general practice then 5 per cent is up at the hospital, but if that is a really unpleasant environment, it causes problems. We certainly have experiences of hospitals that are not conducive to supporting doctors working in that environment, and so we have had doctors say, "We cannot work there."

The Hon. WALT SECORD: So you have a toxic atmosphere in a hospital where a doctor does not want to work there, and you said you had a town of up to seven doctors but none of them are working in the hospital.

Mr BURDACK: Yes.

The Hon. WALT SECORD: Wouldn't alarm bells go off in NSW Health? We have seven doctors in the community and none of them want to work in the hospital. I cannot get my mind around that. You have no doctors in the hospital but you have seven in the town and they will not work at the hospital.

Mr BURDACK: Yes.

The Hon. WALT SECORD: Can you educate me on this?

Mr BURDACK: Yes. I think it is a complex beast. In rural communities one of the challenges is we do not necessarily have a full suite of skills available in health services management and practice management, so there is a very strong reliance when you get to these capabilities to run a hospital, which is a very complex job—it is about managing budgets, managing facilities, managing clinical governance standards, and recruiting doctors and nurses. So there is a trade-off that occurs between having those skills in the town and the culture that is created within that town. You have situations where you have leadership in some of the hospitals—and this is a very small number, I do not want to give the impression that this is across the board.

I think in our submission we talked a little bit about that we have to have hospitals operating at the top of their game in the same way that the community embraces the local GP and makes them feel welcome in the town. That can all be undone in two seconds flat if they are not getting that level of support in the local hospital. The solution, I think, sits around having clear performance indicators on hospital management that say—if you have seven doctors in a town and none of them want to work in the hospital, that is actually your performance indicator.

You are obviously not creating the environment, the remunerative structure, the working conditions or making these doctors feel as though they are welcome and clinically respected in the role they perform in that hospital, and you will be performance managed on that. We do not have any such structure in place in New South Wales to put accountability expectations. I would say some hospitals have got fantastic health services managers who do a wonderful job and really work for their community and other towns do not, and it shows. If you ran a list through those towns where the local GPs do not want to work, you will find the hospitals where there are cultural challenges potentially.

The Hon. WALT SECORD: What community were you referring to where there were seven doctors who did not want to work in the hospital?

Mr BURDACK: I think the challenge for me is I do not want to—rural communities have it tough enough as it is. What I would prefer to see is a focus on what the systemic problems are. If I go round naming towns then that creates a problem for recruiting to those towns, if you understand what I mean.

The Hon. WALT SECORD: Okay, I take that—

The CHAIR: Mr Burdack, you can take that question on notice and come back with a considered, broader response as opposed to feeling that you have to name the town, if that is what you would prefer.

The Hon. EMMA HURST: I will follow on from some of the questions from the Hon. Walt Secord with regard to attracting doctors to rural and remote areas. We have heard a lot in this inquiry about how difficult it can be to attract doctors into rural areas, but in your submission you point out that a lot of other States and Territories are doing a better job than New South Wales. I want to get a feel for what you felt those States were doing and getting right that we should be implementing in New South Wales.

Mr BURDACK: I think there is a range of things. I should start out by saying that I do not think anyone does it perfectly, but there are "good" practices and "less good" practices, and New South Wales perhaps falls into the category of "less good" across most of the indicators. Remuneration is certainly one of those things, but I do not want to focus too much on that because it is not, I think, the overall determinative factor. We have doctors working who have worked with us for many years because they are committed to the local community and because we support them really well in general practice, and we put a lot of work into that. Where you see those differences in those different States is around the culture of respect for general practitioners and primary health care in those States. I would say that is the defining issue.

In reality, we do not run hospitals in rural and remote communities. It is sort of a misnomer. At best, if you are in Lightning Ridge or at Walgett, a patient will be brought into emergency. If they are a serious triage category one, two or high three, they will be transported to a referral hospital where the traditional functions of a hospital are performed. In the States that are affected I think they have respect for the fact that they are supporting good primary care and excellent emergency interventions for transport. They are not trying to run hospitals. In New South Wales I think there is a very hospitalist culture and an attempt to impose lots of very different forms of medical care and an operational framework onto rural hospitals that are essentially primary care and aged-care facilities. I think the biggest issue is we are running a hospitalist model in rural areas that is based on fragmented episodic care for acute patients when what our hospitals need in those communities is exceptionally advanced primary care that requires respect for GPs, primary care nurses and primary care allied health. I do not think that is built into the way we operate hospitals in our rural and remote towns.

The Hon. EMMA HURST: One of your recommendations is that the New South Wales Government establish a community service obligation payment to recognise the broader community service role played by rural and remote GPs. Could you expand on this and on what some of the community service work is, and if that kind of payment exists in any other States?

Mr BURDACK: There are various models for this, and I think we are flexible. If you look at the average day of a GP in a rural or remote town, you might have somebody come in for typical aches and pains but you will have other people coming in because in most of these towns, the doctor is the most trusted person in the town. They build up a therapeutic relationship and you tell them all sorts of personal, private issues. So that trust relationship is so critical. What we find is people will come in and talk about their legal problem and how it is causing them stress. So the doctor becomes the facilitator of access to local services, either directly or they get the practice staff to do that. Somebody comes in, they have got a chronic asthma condition and it does not seem to be a biological cause.

The doctor starts talking about the house and it is found that the roof is leaking and there is fungal growth in bedrooms producing fungal spores, so we get on to talking to the department of housing saying, "Can we get that leak fixed?" So the healthcare solution is not always about health, and that function that rural doctors play—because remember most of those services do not exist in our towns anymore. They are delivered remotely from Dubbo or Orange or even from Sydney. So the doctor ends up having to play this facilitation role or coordinating role to get people to the services that they may not know exist. If they do not feel confident being able to demand that the hole in the roof is fixed with the Department of Housing, we can provide support there. None of that is funded and it is not something that metropolitan practices are required to do.

On the question of is it done elsewhere, it is, in different ways. In Queensland you have the navigator model where you have nursing staff work in practices to help people to navigate various social services that might be available. It is called, in substance, "social prescribing", and it comes from work in the UK. The UK has a very extensive network of social prescribers who recognise that medication is not the solution to every problem. In Victoria you have care coordinators who work with primary care to link people to the appropriate services. So there are a couple of models out there, and there is really good emerging evidence to say that because 80 per cent of our health is determined by things that are not medical in nature, having that role supported in rural and remote communities not only makes general practice more financially sustainable but gets patients to the services that they need and helps government agencies to make sure that they are getting the services to where they need to get them.

Ms CATE FAEHRMANN: Thank you both for appearing today and for your extensive submission. It is an excellent submission. It is really hard to know where to start in asking you some questions on it because it contains so much excellent information, which I am sure will be very useful in the final report. I might go straight to waiting times. In your submission, you said:

> Waiting times are one example of how we use process measures, rather than community health outcome measures, that are designed to drive health system efficiency and performance.

You give the example of telehealth—if telehealth was measured in that performance. Can you expand for the Committee why that focus on waiting times has led to, I suppose, poorer health outcomes? I am not too sure who to direct that question to.

Mr BURDACK: Mr Anicich, would you like me to address that?

Mr ANICICH: You take that, Mr Burdack.

Mr BURDACK: I think we are very good at measuring a lot of things in health. I come from outside health so it has been a bit of a baptism of fire for me, looking at the way—so, for me, you need to have clarity about the strategy. You need to know what you are doing. For us, that is about improving health in rural and remote communities. We do not seem to measure that. If you look in the rural health plan in New South Wales, it is largely about the hospitals. It is not about health. It is about how hospitals are organised, not about how we are going to reduce pre-diabetes in Aboriginal communities in rural and remote areas. It is not about how we are going to intervene in early years to build up an understanding and health literacy around respiratory diseases so that kids do not end up smoking and end up with chronic obstructive pulmonary disorder. So none of those things really jump out.

We work on waiting times, we work on triage categories, but they do not tell us anything about the health of communities. It only tells us about how our hospital system is run. That is the issue I think that we have identified in New South Wales. We have no primary healthcare plan. We do not have a rural health plan that is actually about rural health; it is about the rural health system. We do not have measures, for example, to say we are going to close the gap in diabetics' outcomes between rural communities and cities in the next 20 years. Those sorts of things, if we start driving it to those directions, mean we have to make different types of decisions. But if the outcome indicator is "we have built a new hospital", then when you build a new hospital you have met the outcome, without necessarily actually achieving any improvement in health. Therein lies the problem if you like.

In terms of telehealth, it is a complex issue. We just noted the anomaly, rather than being able to testify as to what caused the problem. But we will have better wait times in terms of wait times in hospitals that have no doctors than we had in towns with doctors. So you get this sort of distorted picture that hospitals with doctors are less efficient than a hospital that perhaps is operating on a telehealth service. There are other issues and other integrity issues then that can give us the wrong answer about what is working and what is not because if you do not define what good health is and what the system is there to do then you are going to end up with some rather distorted answers.

Ms CATE FAEHRMANN: Thank you. I did want to try to jump in with another question before my time runs out. I was fascinated by the Easy Entry, Gracious Exit model, where you talk about the different recruitment that differs from previous recruitment models, emphasising this continuity of practice as opposed to continuity of the doctor. There are a couple of elements to this question. Firstly, if it is so successful, which it sounds like it is, why is it limited to just the RARMS model? How come the New South Wales Government has not adopted this more broadly, if you like? Because it does sound extremely successful. Why is your organisation not rolling out more of this across New South Wales? What are the blockages there? Because it does sound fantastic.

Mr BURDACK: It is a model that has been researched quite extensively, and there is a number of published papers that look at its sustainability and its effectiveness. You can put it in combination with the Aboriginal Medical Service model. That is a community-controlled model in a slightly different way, but the methodology of how it would work is very similar. Why has it not been adopted? Two reasons: I think, partly, we have a bit of a tendency to stick to our knitting, and we stuck to the places that we knew and we were not running around looking for new opportunities in the way in which you might otherwise expect. So there was a bit of an internal issue, and we would be taking that on the chin, but I think also that there has been a growing sense in New South Wales in particular—I have certainly heard this amongst senior officers of the Department of Health—that our model is seen as NSW Health obtaining from the Federal Government funding responsibility because we drive things through a primary healthcare lens.

I think this is becoming increasingly a more acute blockage for models like this to be rolled out into other communities, because if it is seen as VMO funding being necessary to make this work, and if that is seen as a

cross-subsidisation of primary care, you end up with a situation where New South Wales says, "That's not our funding responsibility. We're getting out of that game." That is very much what has happened over the last two to three years—is a very strong message that VMO money is no longer to be used to cross-fund primary care. The reality is I do not care whether you call it VMO money or whatever—give it a better name. The State has always supported primary care because it is actually designed to keep people out of hospitals and reduces the total cost to the State whilst keeping people healthy.

I think it was the Mayor of Leeton yesterday who said that no-one in rural Australia gives a damn whose responsibility it is—fix it. Bang some heads together and say, "Fix it." In effect, that is what we did with the old greater western area health service. It was much more community based. The board was community. They knew what these communities were about. The Royal Flying Doctor Service, the Walgett Aboriginal Medical Service, the NSW Rural Doctors Network all got together and said, "We can't get doctors into these towns. What are we going to do?" We came up with this model, put it in place, made it work. Everyone put some money on the table to make it happen, and we came up with the solution that we were very successful with for 20 years.

Now we are being told that, as you are moving away from the VMO model—we do not know what replaces that. We have certainly seen telehealth replace that. We think that retreat away from VMO, because it is a cross-subsidisation of Commonwealth responsibilities, simply makes rural people a sort of pawn. Their lives are going to be damaged because a couple of people cannot get their heads together and work out how to pool those resources across State, Federal and local government to make it work for our communities. If they did, we would have medical services in most of these towns.

The CHAIR: Thank you very much. We move now to Government questioning and the Hon. Natasha Maclaren-Jones.

The Hon. NATASHA MACLAREN-JONES: Thank you very much, and thank you for your submission. I am looking at the recommendations, particularly recommendation 15, point 3, where you have suggested establishing a trial of social prescribing. Could you outline what you mean by social prescribing and how that would operate in an Australian or a New South Wales environment?

Mr BURDACK: Once again, Mr Anicich, I will jump in there, if you do not mind. Social prescribing, as I think we talked about, is recognising that 80 per cent of people's health is determined by factors that sit outside—you can't get it out of a bottle of medicine. It is about addressing why asthma is being caused because of the housing conditions. It is addressing people's employment and how that impacts upon their ability to access the health care that they need. There is a whole range of stuff that human services departments in New South Wales address, but there is not a connector between the hospital system and those services in rural and remote communities. What we end up with is lots and lots of resources coming into those communities, often from very far away—they are delivered from Dubbo or sometimes from Melbourne into Lightning Ridge—but we do not connect up those services.

I was talking to some community transport folk the other day and said, "Can we train up your bus drivers to take oximeter readings on elderly Aboriginal patients as they go on transport and then let us know if their oximeter readings are off? It might give some indication of respiratory problems." There are all these resources out there, but we are not actually pulling them together in those communities. We have police providing domestic violence support services. We have social planning and community services doing communities and justice. They all come in different directions, and then we try to coordinate that through a stakeholder coordination group. We do not do that with the community. A lot of the work I do is, when people come to me and say—as they often do— "Can you get us a doctor?" I say, "Is that what we need? Let's have a look at the problems." A lot of the stuff can be addressed just by better coordination of those services.

What we mean by social prescribing is having somebody in these towns, which creates jobs in rural areas and creates capacity, whose job it is to essentially navigate with the client. The doctor says, "I'm going to give you some analgesics, and I am going to prescribe you a consultation with our social prescriber, who is going to sort out your housing needs." And so, rather than government services hovering around towns, you actually have somebody in the town going, "Can you help with this problem? We need to have a roof patched. This person really needs to get a certificate III. How can we make that happen so they can get a job, because there is a vacancy at the local butcher?" We can do a lot more because we have the infrastructure in the town; what we do not have is the connecting resources to make that infrastructure as effective as it could be.

Mr ANICICH: Could I just briefly add to that? There has been a fair bit of evidence before, in our submission and in some other submissions, around the concept of the social determinants of health. We need to be thinking more broadly than just prescribing pills and potions from the GP. I refer you, in particular, to the submission to the inquiry from the member for Barwon, which goes into that in some detail. Mr Burdack, it might also be worth briefly mentioning to the inquiry what we are doing in Collarenebri at the moment. It is a small

town with less than 1,000 people in population; a large proportion are Aboriginal and Torres Strait Islanders. It is one of the towns that we stayed in after we were unsuccessful in the VMO contract at the Western NSW LHD because the community wanted us to stay there.

We have been successful in obtaining funding from the Commonwealth in the Murray-Darling grants round to enable us to acquire a property in the town to not just rebuild our GP practice but build it in connection with a community centre, where we will house, for example, the local library, and where we will have facilities for young kids to come after school and have access to the wi-fi so that they can do their homework. They would not be doing it in their own home environment. We are providing far more than just a local GP. We are providing a community service, if you like, to try and foster some encouragement to the community to improve their lives, improve their lifestyle, improve their dietary habits and all of those sorts of things. It is all part of social prescribing and the social determinants of health to improve their health and wellbeing, keep them out of the hospitals and save the State health budget money by keeping people out of hospital while improving the lives of the people in the community. I think that is one very live example which we are currently getting off the ground at the moment.

The Hon. WALT SECORD: In response, earlier we had the Mayor of Broken Hill give evidence about Clive Palmer's movement distributing anti-vaccination material. I believe that was irresponsible, reckless and a downright act of bastardry. How do you guys feel about the anti-vaccination movement targeting rural and regional areas, especially the Clive Palmer movement targeting Broken Hill?

Mr BURDACK: We perhaps do not have a comment specifically on that particular matter, but we are certainly doing a lot of work to communicate with our communities about the safety of vaccination. I was on radio in Queensland this week to talk to Aboriginal communities about why it is safe to take vaccines and why it is really, really important to do it. We are focusing, I suppose, on the evidence. In our practice towns—this is a good opportunity to use this as an example—almost 100 per cent of our patients are single or double vaccinated. That is where we have populations that are 50 or 60 per cent Aboriginal people. That is because we have a trusting relationship with our communities, because we are there and we have been there for a long time.

It is not just the doctors; it is the managers, the practice reception and the nurses. You build up that relationship and whoever is saying, "You shouldn't take a vaccine," no-one is going to listen to them. They are going to listen to their local GP because they trust them. That is why we desperately need to continue to maintain and support the growth of primary care in our communities, because we are going to face other pandemics and other challenges as we go along. We need those trusted people in the community who help communities to understand. That is certainly what we have seen across our patch.

The CHAIR: Gentleman, on behalf of the Committee, I thank you very much. As Ms Cate Faehrmann said, your contribution via the submission was most substantial. I have to say that the oral evidence today from both of you has been of a particularly high standard in terms of what you have been able to communicate to us. It was not just thoughts and ideas about dealing with the matters before this inquiry; most significantly, it was particular suggestions and proposals about dealing with the matters before us. So much of the evidence before this Committee has been articulation of the problems, and there has been a lot less than I would have liked in terms of thoughtful ideas for initiatives, programs and solutions for looking at things differently than we have done in the past. I think that is going to be necessary to confront and deal with the issues before us, because of the size and magnitude of them. That contribution by yourselves and the organisation is most appreciated. Thank you both very much.

Mr ANICICH: Whilst Mr Burdack and I have not been with the organisation for the 20 years of its history, the organisation has been on the ground in these communities for that period of time. I think we do have a good understanding of the problems, as you say, but our focus is on how to solve them. What is the future? What is the future for the benefit of the communities we serve? So, thanks. We have put a fair bit of it into our submission.

The CHAIR: It is much appreciated. I can assure you that it will be very much front of mind for us when we look at developing our report and recommendations. Thank you.

(The witnesses withdrew.)

GREG SAM, Chief Executive Officer, Royal Flying Doctor Service of Australia (South Eastern Section), before the Committee via videoconference, affirmed and examined

JENNY BEACH, General Manager, Health Service Development, Royal Flying Doctor Service of Australia (South Eastern Section), before the Committee via videoconference, affirmed and examined

The CHAIR: Joining us now are representatives from the Royal Flying Doctor Service of Australia [RFDS] (South Eastern Section)—a well-known organisation to the people of New South Wales and beyond. We are particularly grateful for the outstanding work that the RFDS does for and on behalf of our citizens outside the major metropolitan areas. We invite you to make an opening statement. Would either one of you like to make an opening statement?

Mr SAM: I will provide the opening statement.

The CHAIR: Thank you, Mr Sam. Please proceed.

Mr SAM: Thank you. Health and wellness continues to be disparate for those living in rural and remote communities in New South Wales. The associated poor health outcomes and access to health care is both well evidenced and well documented. Despite these challenges to improving a disparity, it remains unacceptable to us that geographic location continues to determine the quality of life and health outcomes. The impact of care delivery within existing health systems declines with increasing rurality and remoteness, as the underlying components of effective health systems become more variable, fragmented and less available. Reduced access is further compounded by underlying socio-economic and demographic differences. In short, the provision of rural health is not on a level playing field with urban, metropolitan or supra-regional populations. There is a place and a need to continue to increase investment in secondary and tertiary healthcare systems, so as to assure service quality and outcomes, as the vast majority of care received, once accessed, is at a desired standard.

The more challenging problem, however, relates to the significant geographic and temporal gap between wellness and the need for managed care, arising due to the factors that limit or complicate access to the right care, importantly, at the right time. Poor access is composite of extensive distance, lack of transport availability, low income, low affordability, lower health literacy, fewer choices and attitudinal barriers to the priorities of rural health delivery. The continuing decline in permanent, small town, general practice presents two fundamental problems: the direct loss of community-based primary care medical services and the loss of the primary access relationship between communities and the broader health service and system. We assert the value of this relationship is essential in improving access.

The RFDS operates comprehensive, 24-hour emergency, pre-hospital and extensive preventative and primary health care in communities with limited or no service access. In response to the widening access gap and to the limits of our resourcing, we have sustained our emergency and aeromedical services, whilst expanding general and specialist primary care, including mental health, dental health, child health and chronic disease management. We hold and have held for a long time a unique health relationship between communities, our services and the broader health system. We understand and work within a complex State and national health system. However, we consider that improvements to health and wellness disparity for rural communities are achievable and sustainable through supporting locally designed and managed care models by organisations funded for that specific purpose.

We therefore recommend a sustained investment in primary and community-based care models administered by community-connected and -engaged non-government organisations that can establish a formal service relationship, can offer services within communities, governed locally, and established by a co-design for minimum thresholds of care, which recognises the dislocation from established health and social infrastructure, that this be supported by a broad-based, fixed and variable funding model to enable required service, workforce and technology planning over time and to respond to local need and, finally, that these models support multidisciplinary models of care to optimize limited and available workforce. We believe this approach fills the important gap of declining GP and community-based services and provides direct healthcare outcomes. Importantly, it also assures a local health service relationship and improved engagement with the broader health system, connecting people into appropriate primary, secondary and tertiary care as quickly as possible. Thank you.

The CHAIR: Thank you very much. If it is agreeable to you both, we will move to questioning from Committee members. Before doing so, I acknowledge and thank you for the submission made by the organisation. It has been received and processed and stands as submission No. 677 to this inquiry. It has been uploaded onto the inquiry's webpage. That will help inform us in our deliberations with the preparation of the report and its recommendations. We will move to questions now. The Hon. Walt Secord.

The Hon. WALT SECORD: Thank you, Mr Chair. I will take you to the emergency retrieval team and the work that they do. That would be the clearest and most graphic illustration of the lack of rural and regional health services. That would be at the very front end, would it not?

Mr SAM: I think any emergency service, particularly from our perspective, suits two fundamental responses. One is that we provide the direct emergency response in areas where there is poor or little proximity to acute services. In other words, we become the emergency provider. Our retrieval service is the retrieval service for those communities. In addition, we work with the Ambulance Service of NSW and the LHDs to be part of the retrieval system across New South Wales. We provide both those functions. Yes, the nature of that is that it responds to both acute emergencies arising from trauma or injury, accident, as well as the need to move critically ill patients or severely ill patients between community and facility or between facilities.

The Hon. WALT SECORD: How much of that activity would be the result of what you describe as avoidable situations or preventable situations if medical care had been provided earlier?

Mr SAM: It is difficult to be accurate in quantifying that. It is fair to say, though, that increasingly the long-term impact of chronic disease and the poorer access to ongoing management of chronic disease is featuring more in the nature of patients we need to move around. I think, again, that reflects both a lack of access to service but this compounding problem of fundamentally a sicker population.

The Hon. WALT SECORD: How do you respond to incidents or mental health needs through the Royal Flying Doctor Service? What are the challenges that you have in that area and how do you respond to them?

Mr SAM: I defer to my colleague on this one, thank you.

Ms BEACH: Certainly. We have in more recent years expanded our mental health and alcohol and other drug services quite significantly. We respond to those across the spectrum really in place. There are a few times when we will have an emergency retrieval service, where we go out when somebody is in a crisis. Then we have a team that works with them at the lower end of the spectrum throughout life. In the areas that we are working with at that end of the spectrum, we aim to work with people and manage their mental health issues so that we either stop them exacerbating or we recognise them very early in that exacerbation and we can improve the outcomes.

The Hon. WALT SECORD: Can I take you to dental treatment and dental patients? What kind medical services are being conducted or carried out in regard to your service? Is it simply extraction? How do you provide dental services through the Royal Flying Doctor Service?

Ms BEACH: I will start to answer that question. We provide it in a number of ways. Our focus is, again, very much around rural and remote people. We have services that we provide through a number of different avenues, and sometimes partnerships and contracts. We go into remote communities and there is a range of services that are provided. It is not just extractions. There are a lot of—we have dental assistants. We have dentists. We have a range of staff that work out there, so they are working, again, on prevention and on treatment. We have people that go into some of those communities. They work sometimes out of the Aboriginal medical services or the local health districts. In addition to that, they will go to remote clinics, where they take everything they need, including the chair. People will come into those remote places. Then they go into clinics that are RFDS operated, such as Tilpa, Louth, Innamincka—places like that. Again, we have a dental van that visits various remote locations around the State.

The Hon. WALT SECORD: Can I ask a question about medical doctors and dentists that work for the service? Is there a high turnover? Do they go through the service quickly or do they stay for a while? What is the average stay at the Royal Flying Doctor Service in south-eastern New South Wales?

Ms BEACH: I can answer that one. We did some stats on that not very long ago. The average, I would say, is two years but it is a varying mix. We have some people that have been with the service for a long time and we also have a large locum workforce as well. That is one of the things in rural and remote areas that most of us are facing.

The Hon. WALT SECORD: I asked a question earlier about exit interviews. Someone staying for two years is quite a short period of time. What is the reason? Is it because they find themselves only doing emergency work and that reduces their skill set? What is the reason for such a short period of time?

Mr SAM: I might—a general and a specific. Our service really is impacted by the same market forces that most rural health services are currently. We have traditionally relied on a mix of both Australian-trained graduates and Australian training pathways to provide our workforce, as well as overseas-trained graduates. That has started to change obviously through the impact of COVID more recently. We know that the shifting dynamic of rural careers is almost universal—certainly nationally and certainly across the State. What we have moved to

do more of is offer professional experience throughout your training and development and your career, rather than an endpoint that says, "We want you to come work with us for 20 years and buy a house in Broken Hill and stay." That model is very much now becoming the minority of our workforce.

It is about trying to find a model of care that works for community, so that there is consistency in both the provision of the care and the care providers, as well as the opportunity for us to be able to accommodate this rather shorter turnover. The other expansion for us is traditionally we only really employed staff who were, in effect, able to work at the top of their accreditation or qualification—in other words, shovel-ready staff. We are now very much participating in different pathways of training and development so that we can take on registrars, internships et cetera that still provide some level of service but also support the broader rural health workforce.

It is fair to say the other trend particularly is that, increasingly, we have to meet rising compliance and accreditation needs. In other words, the concept of a generalist flying doctor from 20 years ago is very different now. We are required to have accredited, vocationally registered staff, whether that is emergency positions or general practitioners. You will be aware of the emergence of sort of rural generalist pathways that aim to give quality procedural skills and enable more workforce to be able to practise a broader scope. They are the same challenges that most health services have. I think it is fair to say our brand—in terms of our remote work, our fly-in fly-out services and our relationships with remote communities—is a point of attraction. Keeping people more than two years now is a challenge.

The Hon. WALT SECORD: I take you back to your comments about the Royal Flying Doctor Service brand. Even though you have a turnover of doctors, as you said, at an average of two years, does your brand make it easier for you to recruit doctors and get doctors?

Mr SAM: I think it is easier to attract among a pool of staff that want to go and work rural and remotely, so we do have a point of difference. I think for us, given where we sit in New South Wales predominantly, we are seeing the impact of that decentralised regionalisation where it does provide us greater access to the sort of specialist workforce. To some degree that has two dynamics: One is that it still allows people to come in with us without being a remote-based clinician, so it enables us to sort of share across the service, if you will; but, equally, we do have staff who only specifically want to work remotely under a more traditional model. The other phenomenon—

The Hon. WALT SECORD: I am mindful of my time. I would like to ask just one last question. Is the demand on your services increasing or decreasing over time? Do you find that you are called upon to do more or less activity? What has been the trend?

Mr SAM: The trend in our emergency service is that it is reasonably stable in terms of the overall activity of emergency work and that reflects the broader impact of health services. Where there has been a rapid increase and greater demand is in the primary care pre-hospital. It is step-down type care and that has been associated with largely the decline of small town general practice and that traditional model of local GP, permanent GP, and the relationship between those roles and small hospitals: So that traditional view that small communities had a GP and a small hospital, they could do some procedures. That has changed and continues to change and that is adding to the demand on our service.

The Hon. EMMA HURST: Thank you again both for coming here today. The Hon. Walt Secord asked you some questions about the dental services. I just have a couple of further questions about that because we have had other submissions raise concern about the lack of dental services in remote areas and many people are relying on the Royal Flying Doctor Service to deliver these services. Are you seeing an increased demand specifically for dental services? I might ask Ms Beach.

Ms BEACH: That is quite a difficult one to answer over the last two years. It has been a particularly challenging time for business due to many of the restrictions in the last two years. I think that the demand for the service is probably growing but we also have to put it in the context of the way we have been operating for the last two years. Preventative dental care is particularly important and I think there is a great need for that in young people, particularly in schools. In terms of treatment, there are waiting lists. Basically, I would suggest the demand is there. There are increasing numbers of people who are needing treatment as well as preventative care.

The Hon. EMMA HURST: You mentioned waiting lists. Do you have any idea of how long some of those waiting lists might be? I am sorry: How long people on that waiting list would be waiting for?

Ms BEACH: It is quite—I am not trained to be a dental service but there is a triage system so that people who need to be seen urgently are seen within days. Obviously, for people who are considered less urgent, there is a longer time period. I do not have the specifics on that, but sometimes it can stretch into weeks.

The Hon. EMMA HURST: Okay. Thank you. In your submission you say that the focus of local health districts is often on reducing transport cost to the detriment of the patient journey. I throw this to either one of you but I was wondering if there are any examples of this and what are some of the decisions that have been made to save costs.

Mr SAM: I might respond. I think in terms of the decisions to save costs, I cannot comment about that. What we see is that a large part of our business and service outside of providing direct care is providing transport for patients largely who require flying around the State, and particularly between facilities, and we have also seen that that has broadened in terms of the demand for moving lower levels of emergency or acuity. There is quite a distinct structured patient flow system in New South Wales that relies on different scales of acuity of moving patients around. The comments around the price signals and the use of that largely relates to lower acuity or non-emergency patients so there is no restriction or indeed limitation if we are tasked to move someone who requires urgent care or emergency care or are classified at a certain level.

There is another category of non-urgent patient that basically can run more on a schedule or requires managing in terms of when and how those patients may be moved around. Clearly, using the air appliance is expensive and at times there are marginal decisions on whether somebody living within a particular distance could be moved safely with a vehicle or could be moved safely with an aircraft. Those decisions at times can be subject to financial pressures just in terms of how the system can cope with it.

The Hon. EMMA HURST: Thank you. You also raised concern in your submission that a lot of the funding for rural and remote health is short term, making it quite difficult to plan long-term services and recruitment. One of your recommendations was that a service planning and funding is extended to a five to 10-year time frame. Could you expand on what some of the benefits are that you think that that would bring?

Mr SAM: I think there are several but the key ones are back to the concept of in communities, if there is not sufficient resident medical care, that that community basically has to respond episodically. In other words, when there is a care need or when there is a service provided, that is the focus for how that care is managed and provided. In other words, it is very reactive and responsive. A lot of funding is based on episodic care so I guess it addresses the issue of occasions of service. But from our perspective what we would like to see is that the benefit of longer-term funding enables us and other organisations to establish a relationship with a community to be able to both plan and prioritise across a continuum of care needs rather than episodic care based on, "I really am sick and I need care now", or which particular service is available in the community at any particular time. That is part of the challenge currently.

So longer term planning that then we can align our service delivery to so it makes it more efficient in how we use resources, even down to how we schedule and roster and rotate our fly-in or drive-in or in-community services, for example. To support that, increasingly we have access to technologies that support either remote or supplement remote care so we can provide more care, provided that infrastructure is there. That infrastructure requires investment and that investment is better justified with a return that can look at it over a five- to 10-year period. So it makes the ability for us as an organisation and indeed other funders to invest in communities if there is some assurance that that service will be continued for a length of time.

Finally, we do know that part of the issue with workforce attraction is that there is some ongoing relationship that rather than looking at that episodic occasion of care model and locum model we are able to actually bring workforce in, establish them in a relationship that enables them to be part of that planning process, part of that multi-disciplinary team, and ultimately get a sense that they are contributing longer term to the health of that community rather than simply providing episodic care.

Ms CATE FAEHRMANN: Your submission and your statements just now talked about the changing nature of the services provided by the Royal Flying Doctor Service, particularly over the last decade of primary health care. I suppose it is a bit of a political question but was a deliberate decision made at the time—say, a decade ago—in conversation with governments that this is where they would like to see the Royal Flying Doctor Service moved to fill these gaps because they were potentially withdrawing some services and funding themselves, or did you see the need and choose as an organisation to fill those gaps?

Mr SAM: I think both is the answer. Over time we certainly have shifted from the idea that we were fundamentally an emergency service and, whilst we were not providing emergency services into remote locations, we could optimise our resources by providing other forms of care. I think we initiated broadening our capacity and capability. That led to us being able to work with other services around planning services into those communities. And I think we do have a relationship with other parts of the health sector, particularly the LHDs and primary care centre, around a role for the RFDS into communities. But we are also reading and responding to the broader change to the way that health services are structured across the State. And we are seeing gaps emerge

that we will, again, under self-direction determine are a need and we will make a commitment to service provision there.

If I may, just quickly—there has been a traditional view around the non-government sector and how organisations like the RFDS actually develop any role. And I think, in my experience, historically it was always relying on funders—governments and other donors—to basically carry a lot of that financial commitment ahead of the decision to move a service in, or fear that that funding may not be sustained. We have adopted a very different approach which fundamentally says that, if we are able to identify a need and we are able to provide a quality service, ultimately someone will want to fund it. And it is against a background of increased demand, but importantly against a background of the difficulty of being able to supply services, that the role for an NGO like RFDS actually has evolved to the issues you have outlined.

Ms CATE FAEHRMANN: Thank you. I was going to ask about funding very quickly as well, so you have just touched on that. What is the percentage of your funding that is through the private sector versus government?

Mr SAM: We receive, of our total budget, approximately 30 per cent from the Commonwealth Government, approximately 30 per cent from the State Government and the rest is through donor and fundraising, which would be about another 30 per cent, and 10 per cent we undertake other forms of commercial or social enterprise activity to supplement it.

Ms CATE FAEHRMANN: Is it a bit of a shift then from government responsibility for primary health care to having to do the kinds of raffles and fundraising—I know you do much more than raffles. It certainly sounds like that from speaking to a few witnesses.

Mr SAM: I think the issue of primary care is a combination of the difficulty of the population you have got to serve and the difficulty in the provision of care, and hence many players have a finger in that pie. The clear delineation of who has sole, singular responsibility for that I guess can be argued and debated. We see our role as fundamentally trying to represent the interests of the communities and to that end being able to both provide a service where we can track funding, making a case to government at State and Commonwealth level for the value of that, as well as making direct appeals to donors who see the value in us being able to move quickly to actually respond to emerging needs.

To pick some examples of that, all levels of government and funders wanted to respond historically to drought, they certainly wanted to respond to COVID and they will want to respond to a number of other impacts in rural communities that lead to health outcomes or health challenges. The value of organisations like ours is that we can move very quickly with and ahead of those responses. I think back to the earlier question on the long-term funding—maintaining that relationship with community that has the service and thinking longer term of the community need, in addition to the longer term planning and mapping of the way that the health systems are evolving, is probably where the gap is currently.

The Hon. WES FANG: Thank you both for appearing today. It is really great to have your experience and thoughts presented to the Committee today. I wanted to start where Ms Faehrmann finished off, that was around the issue of funding. I used to work for a retrieval service, which was an NGO, and I know that fundamentally our service would have been different had we been, say, a corporate entity as opposed to an NGO. The culture would have been different and the provision of service and that sort of dedication to community would been different as well. Mr Sam, could you provide some insights as to how being an NGO operator—in partnership with NSW Health and, like you said, the Federal Government—provides you that link to community?

Mr SAM: Thank you. It has a direct link in that we see the community fundamentally as our shareholder. We are in effect governed through a structure that puts our governance back into community membership. To that end we are accountable to the community for our purpose and our mission fundamentally. That gives us three levels of advantage. Firstly, we are very quickly attuned to what communities need but, importantly, expect from an organisation like ours. So that accountability is far more clear and present. Secondly, I think governments of all levels—local, State and Federal—see the value of the third sector in that role, in other words, holding a responsibility to represent the interest of communities and equally holding a responsibility to be able to respond and be part of a response to that community—so being complementary to the overall provision of service or at least the plan to provide services. Finally, from an employer's perspective, we see that there are a number of professionals, and particularly in emergency care and health care generally, who have an underlying sense of value and values to our mission and see that that is a point of difference—in other words, that working with the RFDS you sign on to the fact that we have a very firm view of what our priorities are in terms of the [inaudible] and how we manage our services but also how we behave as an organisation.

The Hon. WES FANG: I guess it is also that rich history that you have got with serving Australia and the rural and regional communities that comes with that as well. With regard to the retrievable component that you do for the New South Wales Government, that is certainly contracted and funded, is it not, through that contract?

Mr SAM: That is correct. We are contracted by the New South Wales Government through the ambulance service for the provision of inter-hospital transfers as well as other forms of retrieval as part of the broader statewide retrieval system. That is a partnership in as much as we are a subcontractor for the provision of fixed- wing care but also we provide that ambulance safety in very remote areas. Secondly, we are also contracted to the New South Wales Government through HealthShare to provide those non-emergency transport and patient services that I referred to earlier. Finally, we also have direct relationships with the local health districts in terms of where we might provide particular services into particular communities.

The Hon. WES FANG: Thank you. I do not know if you have been following this inquiry closely, but during the inquiry we have been presented with some disparate views around telehealth. I know certainly in my time it was emerging, but the ability to be in transit, say, over a regional part of New South Wales and actually have the tertiary consultant online providing feedback to the team was available in my time, albeit probably not as advanced as it is now. Are you able to provide some insights as to the positive benefits that the telehealth initiatives of the Government have been able to advance patient care?

Mr SAM: Perhaps I will comment on the broader acute systems and then I will defer to Ms Beach to speak about primary care. In terms of the use of remote-based technologies, it has enhanced the quality of service. To your point, the ability for us now to have both audio and visual contact through a retrievable—through our aircraft or through our vehicles or through place-based technologies, does improve the quality of care. It also improves, I guess, the clinician experience as well. In that context, it is very much complementary and, increasingly, it is supplementary. From our experience, we have limited numbers of aircraft and limited numbers of staff, and if those assets are being engaged, having access to telehealth and remote technologies actually adds another dimension to the provision of our services. I might ask Ms Beach to comment on the primary care.

Ms BEACH: Certainly. We have seen an increase in the use of telehealth over the last couple of years. Our philosophy has been, ever since we started to use it, that it will meet our on-the-ground services—so in addition to. We have not removed services in place of telehealth. I think that what it has really helped significantly with is our ability for continuity of care to look after that [inaudible] throughout life, to make sure that we have very regular catch-ups with those people. In primary health, if we have [inaudible] one day and then they are not back for a month, we are actually able to have those appointments in between. That has been a big advantage to us; it has helped a lot. Throughout the last considerable amounts of time, for the last two years we have done a great deal in terms of mental health, and the teams back on the ground and the communities that they are dealing with have spoken about the success of that. The uptake has been very positive and we have continued with their treatment sort of programs via telehealth. So that is where I can see great success in terms of primary health.

The Hon. WES FANG: Thank you. Would it be fair to say then that, given that you have both presented, I guess, a positive view of some of the services within telehealth, any attempt to demonise the service would be detrimental to the confidence that patients might have in the ability of telehealth services to be able to make a difference in their lives?

The CHAIR: I think we need to explain what "demonise" means.

The Hon. WES FANG: I would have thought it would be self-explanatory, but I can rephrase the question: Do you think that it is potentially going to create confidence issues with those in rural and remote communities when we continually see attacks on the name "telehealth" when it actually is quite a wide-ranging and very beneficial service for the community?

Mr SAM: Perhaps the way I will respond to that is our experience—and certainly reflecting our introduction of telehealth and our view of seeing the introduction of telehealth across our service footprint—is that there is a lot of concern expressed by community and by clinicians that the introduction of these models of care is replacing or displacing other forms of face-to-face or personal-based care. From our experience, we have had to spend a significant amount of time engaging with community and explaining the rationale behind it, both in terms of the benefits that it affords but it is more so addressing the underlining concern that says that the majority of people would prefer to see or at least have a relationship with a clinician or a provider or a service, and that transition, I think, has been challenging for us but we have been able to have those conversations.

At scale, it is seen as the only, I guess, focus for the provision of health service, and in the absence of any other discussion about the inability for particularly rural-based services to find a workforce or a service model, at times it is the only service that is at hand. Communities rightly say, "But we still want an organisation like the

RFDS or any other health service to do absolutely everything they can to improve proximity to access to clinicians and to clinical services." In summary, I would say often what gets lost is the broader discussion on why traditional models of services are declining and why it is very difficult to sustain them. As with many other structural issues of where health services are available and how patients access them, telemedicine at times can be absolutely complementary and, as I said, supplementary. The debate seems to be heading more around it, in and of itself, as the only available care model.

The Hon. WES FANG: Thank you. I note the time. There is the buzzer. I say thank you very much to both of you for providing those insights today. It was really valued.

The CHAIR: Thank you. I have a question about the funding—to the extent you can deal with it now or take it on notice—that the Royal Flying Doctor Service may receive, broadly the organisation but specifically the South Eastern Section, from shires and councils in New South Wales. In other words, whether or not reflected in your accounts, through a form of donations or other forms, support given to the Royal Flying Doctor Service by shires and councils in New South Wales. On that note, on behalf of the Committee, once again I want to acknowledge and thank the Royal Flying Doctor Service for what it does for and on behalf of the citizens who reside in rural, regional and remote New South Wales and, indeed, right across Australia. Your service is quite literally world-leading and cutting-edge and it has been for a long period of time, and that is something you can be most soundly proud of and we are of the work you do.

The Hon. WES FANG: Hear, hear!

The CHAIR: We are all very grateful to the Royal Flying Doctor Service for its outstanding work and service in the past, in the present and in the future. Once again, we thank you very much for all the wonderful work you do. Thank you.

Mr SAM: Thank you.

The CHAIR: That brings us to the end of this particular session. We will now break for lunch and return at 12.40.

(The witnesses withdrew.)

(Luncheon adjournment)

BETTY KENNEDY WILLIAMS, Enrolled Nurse, New South Wales Nurses and Midwives' Association, before the Committee via videoconference, affirmed and examined

The CHAIR: I thank both Ms Kennedy Williams and her support person, Katrina, for joining us this afternoon. With respect to the formalities this afternoon, can I confirm whether it will just be Ms Kennedy Williams speaking?

Ms KENNEDY WILLIAMS: Yes.

The CHAIR: Thank you. For the record, I just say that your submission and its subsequent follow-up parts have all been received and processed by the Committee secretariat. They stand as submission Nos 258, 258a, 258b and 258c and are all consolidated as what is essentially your submission, although it is in four parts. They stand as evidence to this inquiry and have been uploaded to the inquiry's website, and this afternoon is the opportunity to provide some oral evidence. I invite you to make, if you wish to do so, an opening statement, which will be followed by, if you are agreeable, questions from the various Committee members. Are you okay with that?

Ms KENNEDY WILLIAMS: Yes, I am okay with that.

The CHAIR: Let us proceed, then, with your opening statement.

Ms KENNEDY WILLIAMS: Hi, my name is Elizabeth Kennedy Williams of Walgett. I am a member of the local branch in my workplace. I have been a member for over 30 years. I trained through the hospital system. I grew up in a tin shack on the banks of the Namoi River, where it was harder as an Aboriginal nurse starting out. I had to endure discrimination and travelling away from family to do the training in Dubbo. As an Aboriginal nurse, knowing how hard it is to be in Dubbo with no family and no support, it was a lonely experience, but I stood strong and knowing I did it for my community. As a member of our local branch, I experienced a lot of changes in regards to nursing staff.

When I was first trained we had just the right amount of staff for each patient, but these days the staffing is critical for patient care. As the years went on, there was a decrease in nursing staff. There is not enough staff to assist with mental health, which is a high number of cases in our town. This is due to the number of drug and alcohol-related issues and the COVID pandemic. Staff are not able or available to give them one-on-one care. There is violence around mental health clients but not enough staffing, including nursing and security. Due to our past history, we need to move on but not go backwards.

Following our staff review and a staff meeting with a representative from our local health district, the nursing staff was promised that we would have security 24 hours a day. To achieve this, the nursing staff was reduced to allow for more security staff. These positions have not been filled to capacity and this had never been more evident than the recent months, when at times this hospital did not have any security on evening shifts and night-duty shifts. This impact on our staff to be able to provide quality nursing care—the shortage of nursing staff. We have not got community health nurses, palliative care nurses or mental health staff. We need to have more Aboriginal health workers for our community. These positions are important to our community due to the high volume of deaths within our communities.

We need a solution for our hospitals for more staff for the community. Everybody deserves to be nursed and treated as an individual, and not having enough staff will impact on that. We need to give our community opportunity to do training in nursing on country at our local TAFE centre, supporting them through each pathway. This will allow interim people to kickstart a career in nursing without having to leave country. Indigenous people will communicate and relate more efficiently with training on country in their communities, where all the support is. Never has it been more vital to look at local solutions to our health issues. During the COVID pandemic period, when we had the COVID-19 outbreak there was additional support to trace, test, vaccinate and help educate our community, but this quickly disappeared once the outbreak was over. Thank you.

The CHAIR: Thank you very much. Once again, that contributes very nicely. The other submissions are under the umbrella of the NSW Nurses and Midwives' Association, of which you are a proud member.

Ms KENNEDY WILLIAMS: Yes, I am.

The CHAIR: Obviously we are now filling that out with specific evidence from nurses to provide some, dare I say, "flesh on the bone" with some real-life examples of what has been going on. Once again, thank you—and thank you, Katrina, for joining us this afternoon with Betty. It is really appreciated. We will now begin questioning with the Hon. Walt Secord.

The Hon. WALT SECORD: Ms Kennedy Williams, thank you for your time. I am Walt Secord and I represent the Labor Party. How many years have you been a nurse?

Ms KENNEDY WILLIAMS: I started by training in 1978 and finished in 1979. I have been nursing since then.

The Hon. WALT SECORD: How long have you been at Walgett District Hospital?

Ms KENNEDY WILLIAMS: I have been here all the way through.

The Hon. WALT SECORD: All the time?

Ms KENNEDY WILLIAMS: On and off. I have left to have babies but I always return back to Walgett hospital.

The Hon. WALT SECORD: Fair enough! Has nursing at Walgett District Hospital, which I understand is now an MPS, got tougher?

Ms KENNEDY WILLIAMS: It has got tougher, mainly because there is hardly any staff. They are all doing double shifts and everything here.

The Hon. WALT SECORD: I was going to say, what is a typical work week like for you?

Ms KENNEDY WILLIAMS: Most of us are doing 12-hour shifts here at the moment.

The Hon. WALT SECORD: That is five days a week.

Ms KENNEDY WILLIAMS: Yes, maybe every day when everybody is doing doubles to catch up to try and do our workload here.

The Hon. WALT SECORD: That would be, on average, a 60-hour work week.

Ms KENNEDY WILLIAMS: Yes.

The Hon. WALT SECORD: We have had evidence of hospitals that are unable to locate doctors or have no doctors on duty in their hospital. Do you have a situation like that at Walgett?

Ms KENNEDY WILLIAMS: No, we are pretty covered with doctors with the Ochre Medical Centre. They have taken over from RARMS.

The Hon. WALT SECORD: Ochre—is that the Indigenous service?

Ms KENNEDY WILLIAMS: No, they took over the lease for the doctor's remote area.

The CHAIR: Just before you go on, in terms of consistency for Hansard reporters to record your testimony, Ms Kennedy Williams you said they took over from RARS. What does that stand for?

Ms KENNEDY WILLIAMS: RARMS.

The CHAIR: That is okay. What are the initials?

The Hon. TREVOR KHAN: It is Rural and Remote Medical Services.

Ms KENNEDY WILLIAMS: Yes.

The CHAIR: Thank you very much, the Hon. Trevor Khan. That was just for the record.

The Hon. WALT SECORD: Can I take you back to what you said. You said it has gotten tougher, with fewer staff and resources and that. What about maternity services at your hospital? If someone goes into labour, can they give birth at your hospital?

Ms KENNEDY WILLIAMS: No, they need to go to Dubbo, but because of the isolation out this way the mothers tend to stay until the last minute to birth on country because there is no accommodation over at Dubbo or finance for them. Being away, if they have got a big family, they think about the other family that is left behind. Who is going to look after them? They tend to stay here and try and birth here before they go over.

The Hon. WALT SECORD: Does that make for complicated births having to occur at Walgett?

Ms KENNEDY WILLIAMS: Yes.

The Hon. WALT SECORD: How does that impact on the community, the babies and the mums?

Ms KENNEDY WILLIAMS: It impacts because we have not got a midwife here. We have not got any staff for the midwife.

The Hon. WALT SECORD: What happens then?

Ms KENNEDY WILLIAMS: The normal registered nurses [RNs] deliver the babies and then the air ambulance comes and picks them up.

The Hon. WALT SECORD: How often does this occur?

Ms KENNEDY WILLIAMS: It occurs regularly.

The Hon. WALT SECORD: You are a person with more than 30 or 40 years' experience.

Ms KENNEDY WILLIAMS: Yes.

The Hon. WALT SECORD: Have you seen preventable mistakes or preventable deaths occur?

Ms KENNEDY WILLIAMS: No, not in my time.

The Hon. WALT SECORD: But have you seen close calls with complicated births and things like that?

Ms KENNEDY WILLIAMS: Yes, but I think the girls that do the delivery here are pretty experienced, even though they are not midwives. Because we get an influx of deliveries here, they tend to escalate it up. They ring up to Dubbo and get some information from them.

The Hon. WALT SECORD: You have heard a bit about telehealth. Do you have telehealth at Walgett?

Ms KENNEDY WILLIAMS: Yes, we have it.

The Hon. WALT SECORD: Do you deliver babies via telehealth?

Ms KENNEDY WILLIAMS: I think they do if one comes in, but the staff find it really hard sometimes because it does not link up very good out this way because of the remoteness and also just trying to explain things to the guy on the other end of the video link-up about the patient.

The Hon. WALT SECORD: Do telehealth baby deliveries happen very often?

Ms KENNEDY WILLIAMS: Not really, no. They tend to deliver really quick when they do come so they have not got time to link up.

The Hon. WALT SECORD: You talk about RNs delivering the babies. Where are the doctors while this is occurring?

Ms KENNEDY WILLIAMS: They come over and they are on call 24/7. As soon as [inaudible] they are a phone call away so they come over.

The Hon. WALT SECORD: What about other things like mental health treatment services and things like that at Walgett? What are the services like there?

Ms KENNEDY WILLIAMS: It is very poor because our mental health is at the Ridge, and they only service us once a week, maybe every fortnight, and so all our clients are missing out on all that service. We used to have mental health on site but they retracted it to the Ridge.

The Hon. WALT SECORD: When you say "the Ridge", do you mean Lightning Ridge?

Ms KENNEDY WILLIAMS: Yes, sorry, Lightning Ridge. They have a full team out there.

The Hon. WALT SECORD: Is there a long waiting list for mental health services in Walgett?

Ms KENNEDY WILLIAMS: Yes.

The Hon. WALT SECORD: How long would a person wait to see—

Ms KENNEDY WILLIAMS: They wait—to see somebody?

The Hon. WALT SECORD: Yes.

Ms KENNEDY WILLIAMS: Over two weeks, sometimes not even that. Sometimes they have to wait at least three weeks because the mental health worker might be off or they have not got a counsellor there.

The Hon. WALT SECORD: As part of this inquiry, we make recommendations to the Government. What would you like to see improve? How could you better serve the community out there? What could Government do to assist you and other nurses?

Ms KENNEDY WILLIAMS: To have a mental health worker on site would really help our community because we have got heaps of mental health clients in town.

The Hon. WALT SECORD: When you say "mental health", without revealing people's identities, what kind of challenges would they be facing? What would they be worried about? What would they be experiencing?

Ms KENNEDY WILLIAMS: The clients or us?

The Hon. WALT SECORD: The clients.

Ms KENNEDY WILLIAMS: Mainly counselling. A lot of them like face-to-face talking. They do not like the video links that link up or phone calls.

The Hon. WALT SECORD: As a First Nations person, do you find that you have to encourage or prod other people along to get mental health treatment and medical treatment in the community up there?

Ms KENNEDY WILLIAMS: Yes. We tend to go out in the community and talk to them because most of the people in Walgett I am mainly related to anyway. I have got a big family. I tend to go out and talk to them and they relate to me so I bring them in.

The Hon. WALT SECORD: I am just mindful of my time. I will ask you one last question. What about drug abuse—ice and others? Does Walgett have a problem in the area?

Ms KENNEDY WILLIAMS: Heaps. We have got heaps of sellers in town who bring it in all the time. We get heaps in the hospital. We had one the other day. He had heaps of drugs on him and nothing happened. Because we have got no security guards, there is nothing for the nurses so they lock themselves in the nurses station.

The Hon. WALT SECORD: You have no security guards. What do the nurses on night duty do at night?

Ms KENNEDY WILLIAMS: They just sit. That's it. We do not have any security at night.

The Hon. WALT SECORD: So what occurs? You said that they lock themselves into the nurses station.

Ms KENNEDY WILLIAMS: There is not much they can do if that person goes off.

The Hon. WALT SECORD: What about local police?

Ms KENNEDY WILLIAMS: It takes them a while to get up here, to call them on the night shift.

The Hon. WALT SECORD: Can I ask you a really direct question?

Ms KENNEDY WILLIAMS: Yes.

The Hon. WALT SECORD: How do you continue to work facing all these challenges?

Ms KENNEDY WILLIAMS: Because I love the job, I love the community and I love my mob. I do it to keep them safe.

The Hon. WALT SECORD: Thank you.

The Hon. EMMA HURST: Thank you both for coming here today and speaking with us. We know that obviously the understaffing of nurses in rural and remote hospitals has been raised as a major issue within this inquiry. I just wanted to hear a bit about what your experience has been and how understaffing has potentially impacted your work.

Ms KENNEDY WILLIAMS: It impacts mainly on the patient that we look after. They could be sitting in the bed and if we got a trauma or something else, that patient is left in the bed because we have not got enough staff to nurse them.

The Hon. EMMA HURST: We spoke to nurses about the stress when someone is sick or if someone had to take time off for something. Is that something you are experiencing there as well?

Ms KENNEDY WILLIAMS: Yes. That means more people working overtime than before. There are not enough staff to call in on our casual list. The nursing staff that are here have to pick it up.

The Hon. EMMA HURST: Just to give us an understanding, what could that mean? If somebody had to pick up extra shifts, how many hours could they potentially be doing in a week if there was some kind of an emergency with other staff?

Ms KENNEDY WILLIAMS: They could do up to three or four overtime shifts a week.

The Hon. EMMA HURST: That would be three or four extra eight-hour shifts beyond the average five days a week.

Ms KENNEDY WILLIAMS: Yes. When we had the pandemic, the girls were doing overtime over the weekend just to do the swabbing and that. They was working 24/7 on that for days.

The Hon. EMMA HURST: That is many extra hours. Obviously that is going to lead to a lot of burnout for people. Have you seen staff burning out? What has their experience been?

Ms KENNEDY WILLIAMS: I have known one nurse that cannot take time off because she is needed at the hospital. She cannot take her holidays that she is due—she is overdue, actually. So she has to stick around.

The Hon. EMMA HURST: I know the Hon. Walt Secord asked what sort of recommendations you would like to see from this inquiry, but I just wanted to hone in specifically on this situation. What do you think we need to do to address this situation? Is it a matter of having minimum staffing ratios or is it much more than that?

Ms KENNEDY WILLIAMS: I reckon we should start training people, training more staff.

The Hon. EMMA HURST: Do you think that there needs to be more funding generally or do you think we need to have funding specifically for more staff and training more staff?

Ms KENNEDY WILLIAMS: We need funding for training more staff in rural and remote areas, like through TAFE. We have a good TAFE here that can run courses and sustain more local people here in the towns who know the community. But, yes, that is what we need. We need funding for those sorts of things. If we can do it on country, people do not have to go away to do the training. They have got all the support here in Walgett with their families if they have to do the training, and they do not have to worry about finance or anything when they go away. At the moment they has to go to Dubbo to do the course, which is three hours away or more, and be isolated and away from the family.

The Hon. EMMA HURST: Do you find that people are resistant to going to do the training because it is so far away? Is that acting as a disincentive?

Ms KENNEDY WILLIAMS: Yes. It is the isolation plus the finance of staying somewhere while they are over there doing the training. Plus, what about your family at home—like your small kids—while you do the training?

The Hon. EMMA HURST: Do you think that we need more incentives for nurses to also move into the area? If so, what do you think that would look like?

Ms KENNEDY WILLIAMS: I know there were incentives before with nurses.

The Hon. EMMA HURST: Do you recall if that worked? Did it help the situation at the time?

Ms KENNEDY WILLIAMS: It did work for a little while, but I find that if you did do that you have to have some sort of thing on it where they stay around for so many years, not come here for that long and then up and go.

The Hon. EMMA HURST: In regards to training, I am just wondering if you have any idea about additional training and continuing education. I know we talked about training more nurses up, but we have had a lot of evidence given to the inquiry that a lot of the nurses that are already nurses are not provided access to further training that other metro colleagues are often given. I am wondering if you think that is something that is also missing, and what you would like to see there.

Ms KENNEDY WILLIAMS: I would like to see the training be on country, really. Most Aboriginal people love their country, and going outside their country, it just breaks them down, going off country. If you need training in TAFE, get them in to TAFE and do the training that is done in Dubbo three hours away here in Walgett. Maybe that would be a way to train them all up to grow our own local staff.

Ms CATE FAEHRMANN: Thank you both very much for agreeing to appear today and for the very important work you do in Walgett. My first question is about the alcohol and other drugs rehabilitation services and support issue. In Walgett at the moment what is available to people who need treatment? Say if they go and talk to somebody like a doctor or in the health centre, are there any services or any alcohol and other drug specialised health workers at all?

Ms KENNEDY WILLIAMS: We have got one at the Aboriginal Medical Service [AMS], but she only just came. She is fantastic in her job and loves her job, but she is not sticking around, she said. Once she is gone, we have got no-one. The rehabilitation centres are all in Orange and Dubbo. They send us all down that way. We have got two not far away, in Brewarrina and Moree, but I find that as soon as they go there, they come straight back and they are straight into it again. I find if they go down to Dubbo or Bathurst, they are so much better. They get the counselling and people that understand them.

Ms CATE FAEHRMANN: Getting to Dubbo and Bathurst then, it is good to know that that can be effective for a start, but then they come back. So they need the support in Walgett. You said there is one woman who has started just recently and is specifically trained in this—

Ms KENNEDY WILLIAMS: Yes,

Ms CATE FAEHRMANN: —but she is unfortunately not sticking around.

Ms KENNEDY WILLIAMS: No.

Ms CATE FAEHRMANN: Do you think that is just because it is too hard, the overall support?

Ms KENNEDY WILLIAMS: No, it is not hard for her. It is because she wants to move closer to her family. She is fantastic. She is Indigenous and knows the community. But we are losing her so we have got no-one after she goes. And it is a big population of drug and alcohol now.

Ms CATE FAEHRMANN: Yes. The AMS obviously recognises that need. Will there be a vacancy that is a funded position that will need to be refilled? Is that your understanding? Do you know?

Ms KENNEDY WILLIAMS: I think they will. I think they will try and sell it but it is just trying to get the staff out this way.

Ms CATE FAEHRMANN: In terms of beds and other things, having the counselling—the staff is one thing, so it is great that there has been this woman in that position for a little bit, but if they need treatment in terms of getting into a rehab bed, there is nothing. Is that right in Walgett, it is just the worker that they see and then for any other service they need to go elsewhere?

Ms KENNEDY WILLIAMS: It is the registered worker they see and then they go.

Ms CATE FAEHRMANN: And they come back with that, okay. The mental health worker who you mentioned in response to a question by the Hon. Walt Secord, you said that they had relocated them. Was that a conscious decision to get rid of the position of a mental health worker in Walgett and move them somewhere else?

Ms KENNEDY WILLIAMS: I will have to find that out. All of a sudden they were there and the next minute they were gone. We did have a drug and alcohol worker for a while at the hospital, and they have gone too.

Ms CATE FAEHRMANN: Over the past, say, 10 years or so, do you think the situation is getting worse in Walgett in terms of the health services? It has probably always been pretty shocking. I was trying to think of a word without swearing—pretty shocking.

Ms KENNEDY WILLIAMS: It is getting worse. I found out the other day that we have got no nursing staff for February so the hospital will have to shut down.

Ms CATE FAEHRMANN: What?

Ms KENNEDY WILLIAMS: Yes. That is how bad it is, because we cannot get any staffing in to cover these shifts.

Ms CATE FAEHRMANN: Hang on, wait. So shutting down, what are you saying?

Ms KENNEDY WILLIAMS: The services here. There are not enough staff to cover shifts.

Ms CATE FAEHRMANN: So you shut down the—

Ms KENNEDY WILLIAMS: We shut the beds down and they have to relocate. We send them on to Dubbo or wherever.

Ms CATE FAEHRMANN: Have you shut down before for a month?

Ms KENNEDY WILLIAMS: We have shut beds because of the staffing here.

Ms CATE FAEHRMANN: When you say "shut down in February", do you mean shut down all the beds?

Ms KENNEDY WILLIAMS: No. Just partly, not all the beds.

Ms CATE FAEHRMANN: When you have shut down before, does that mean that people who need critical health support and services have to—from experience, have you seen bad outcomes as a result of that, as in people not being able to get the medical services that they need at the time?

Ms KENNEDY WILLIAMS: They will get the service for a short time and then they will have to go out to Dubbo. Once they are in Dubbo they have got to find their own way back home. That is another issue.

Ms CATE FAEHRMANN: That is another big issue, isn't it, the transport? We have heard that issue a lot. Did you want to tell the Committee what that is?

Ms KENNEDY WILLIAMS: That means when they get to Dubbo, they have been transported out of here by air ambulance or by road transport. Once they get to Dubbo they are put out of the hospital once they get well and then they find their own way back to Walgett. So most people object to going there; they will sign themselves out.

The Hon. EMMA HURST: I will move to Government questions.

The Hon. TREVOR KHAN: Can I get some context in terms of Walgett? I am interested in the issue of training on country and whether that is feasible. Am I right that Walgett has about 2,500 people in it?

Ms KENNEDY WILLIAMS: Yes.

The Hon. TREVOR KHAN: I am not asking for precise numbers but that is, as I recall it, the sort of size of the town.

Ms KENNEDY WILLIAMS: Yes.

The Hon. TREVOR KHAN: In terms of Walgett shire, that is 6,000 or 7,000 people?

Ms KENNEDY WILLIAMS: Yes, because most of the region probably comes into it.

The Hon. TREVOR KHAN: You, like me, have been around for a while.

Ms KENNEDY WILLIAMS: Yes.

The Hon. TREVOR KHAN: What has the population of Walgett been like since, say, the 1980s? Has it gone up, gone down or stagnated? What has the position been?

Ms KENNEDY WILLIAMS: I reckon it has gone down a bit. Most people go away but they come back. When they get sick they come back to Walgett.

The Hon. TREVOR KHAN: Do I take it that, in a sense, what you have is a young population and an old population and the middle is hollowed out a bit?

Ms KENNEDY WILLIAMS: Yes.

The Hon. TREVOR KHAN: To that extent, you have problems with chronic disease in the elderly. Would that be right?

Ms KENNEDY WILLIAMS: Yes, we have.

The Hon. TREVOR KHAN: And you have the paediatric issues, both in terms of births and problems with childhood illnesses and the like. Is that what you are confronting in terms of your work?

Ms KENNEDY WILLIAMS: Yes, that and palliative care.

The Hon. TREVOR KHAN: Yes. We have not really talked much about palliative care with you.

Ms KENNEDY WILLIAMS: Sorry.

The Hon. TREVOR KHAN: No, that is not your fault. We just have not got there yet. Let me go to the training exercise. Tell me something about the size of the TAFE that you have got there.

Ms KENNEDY WILLIAMS: It is fairly big, the TAFE. I do not know how many staff they have on board.

The Hon. TREVOR KHAN: What trades and the like and what courses are taught there?

Ms KENNEDY WILLIAMS: I do not know but I will get back to you. Not nursing. I know it is not nursing.

The Hon. TREVOR KHAN: When you talk about training on country and it being done at the TAFE, are you talking about courses for registered nurses or enrolled nurses [ENs]?

Ms KENNEDY WILLIAMS: Let's say if you do training from an assistant in nursing, maybe start doing the AIN and then into an EN and maybe an RN. Maybe they all go right for the RN. But get them involved in the first bit, the first enrolment, to get them up to that level.

The Hon. TREVOR KHAN: I am not being critical but my guesstimate was that you were not going to be able to train RNs there simply because of the skill levels that are involved.

Ms KENNEDY WILLIAMS: No, you have got to go over to [inaudible]. But if they do the AIN then the EN, they would be able to do it.

The Hon. TREVOR KHAN: That would be feasible.

Ms KENNEDY WILLIAMS: Yes.

The Hon. TREVOR KHAN: I will break it down into its component parts. In terms of your place of work, the MPS, how many RNs are employed there?

Ms KENNEDY WILLIAMS: I do not know. I will have to get back to you because it changes. We have got new ones who are just starting.

The Hon. TREVOR KHAN: And ENs, do you have any idea on that front? It is alright, you can get back to us. That is fine.

Ms KENNEDY WILLIAMS: I will get back to you. Sorry about that.

The Hon. TREVOR KHAN: To be honest, I am interested in the MPS model, having seen it in other areas. I do not think I ever visited it in Walgett. Essentially, do I take it that you have an ambulance facility, the hospital facility and an aged-care facility all rolled into one? Is that what you have there?

Ms KENNEDY WILLIAMS: And also we have got a renal dialysis unit.

The Hon. TREVOR KHAN: I was going to ask that. How many chairs have you got?

Ms KENNEDY WILLIAMS: We have got four chairs. It is run six days a week and there are seven times.

The Hon. TREVOR KHAN: Is it one of the RNs who essentially supervises the dialysis chairs?

Ms KENNEDY WILLIAMS: Yes, and that one is via Dubbo.

The Hon. TREVOR KHAN: Samples and the like all go back to Dubbo.

Ms KENNEDY WILLIAMS: Yes.

The Hon. TREVOR KHAN: You are essentially a spoke out of Dubbo. That is right, is it not?

Ms KENNEDY WILLIAMS: Yes, that is it.

The Hon. TREVOR KHAN: So if somebody has got severe renal failure, they will be shipped off, one way or the other, to Dubbo.

Ms KENNEDY WILLIAMS: Yes, by ambulance.

The Hon. TREVOR KHAN: Do I take it that even though I think by distance you are closer to, for instance, Narrabri, there is really no communication along that line?

Ms KENNEDY WILLIAMS: No, only Dubbo.

The Hon. TREVOR KHAN: Similarly, Moree is not a line of essential communication or provision of services?

Ms KENNEDY WILLIAMS: No, that is outside our boundary.

The Hon. TREVOR KHAN: If we then go back to the issue of training, if you are going to get nurses into your MPS, the likely route is through Dubbo—training in Dubbo and then out to Walgett. Would that be right?

Ms KENNEDY WILLIAMS: Yes.

The Hon. TREVOR KHAN: Are your RNs First Nations?

Ms KENNEDY WILLIAMS: No.

The Hon. TREVOR KHAN: Any? None?

Ms KENNEDY WILLIAMS: None. There is only me.

The Hon. TREVOR KHAN: Only you, right, fair enough. You are doing a good job. I take it that those RNs who come there are relatively young when they arrive, are they?

Ms KENNEDY WILLIAMS: Yes.

The Hon. TREVOR KHAN: I am not trying to put words in your mouth.

Ms KENNEDY WILLIAMS: You're right.

The Hon. TREVOR KHAN: Do they stay there, do some additional training and then head out again? Is that a problem that you are confronting in terms of holding staff or am I wrong in that regard?

Ms KENNEDY WILLIAMS: Yeah-no, they come and go, yes.

The Hon. TREVOR KHAN: Are they with family there or are they single?

Ms KENNEDY WILLIAMS: They are single, but some of them hook up with some of the locals and stay.

The Hon. TREVOR KHAN: That is good.

Ms KENNEDY WILLIAMS: Yes, but there are not many of them.

The Hon. TREVOR KHAN: If they hook up with locals, they are likely to stay.

Ms KENNEDY WILLIAMS: [Disorder].

The Hon. TREVOR KHAN: Being single in a small country town, the problem is you are likely to lose them again after a period of time.

Ms KENNEDY WILLIAMS: Yes, that is right.

The Hon. TREVOR KHAN: In terms of the doctors that service the MPS, are they in a similar category—they are from Dubbo, stay there for a while and go—or are they more long-termers? Or are they locums?

Ms KENNEDY WILLIAMS: No, they come and go. They stay for a few months, a couple of months or a month and then they go again and they switch over.

The Hon. TREVOR KHAN: Let me just go back to the MPS model for a while. How long has the MPS been there?

Ms KENNEDY WILLIAMS: It was there in 2016.

The Hon. TREVOR KHAN: It is a relatively new one of the model.

Ms KENNEDY WILLIAMS: Yes.

The Hon. TREVOR KHAN: Before that, how was aged care provided in Walgett?

Ms KENNEDY WILLIAMS: How was it?

The Hon. TREVOR KHAN: Yes. Was there a separate aged care facility there?

Ms KENNEDY WILLIAMS: Yes, it was a different building to the nursing acute ward. So there were two nurses over there at all times. I am pretty sure we had three or four over the other side in the acute ward because we had the babies—baby ward—and the acute ward and men's ward and female ward.

The Hon. TREVOR KHAN: Do I take it that the consolidation of the services into an MPS has allowed the available staff to cover, essentially, all the aspects of care from birth through to, dare I say, death in the one facility?

Ms KENNEDY WILLIAMS: Yes.

The Hon. WES FANG: I will ask a few questions if you do not mind.

Ms KENNEDY WILLIAMS: Yes, you're right.

The Hon. WES FANG: I want to say, firstly, thank you for appearing today. I think it is fantastic to be able to get some insights from you directly, with your on-the-ground experience. I am very keen to hear about your thoughts on training more First Nations people locally to be part of the health process, whether it be ENs or the like. Do you have some thoughts around how we can encourage greater consideration by First Nations people, not only in regional centres but in those remote centres as well—to let them know that it is an option for them. How do we get through to the younger generation that that is something they can aspire to?

Ms KENNEDY WILLIAMS: Most of the ones I have seen have seen me working here at the MPS for all them years, and I think a couple of them went through nursing because of me, because of what I have done. So they all know that I work here and have been here forever. To me, the encouragement would be really good. I will encourage a lot of young people.

The Hon. WES FANG: So can I suggest then a scheme of mentoring would be a good way to actually do that?

Ms KENNEDY WILLIAMS: Yes.

The Hon. WES FANG: Thank you again very much for coming today.

The CHAIR: Before we go, the Hon. Walt Secord has a matter of clarification on a matter that has been raised.

The Hon. WALT SECORD: Ms Kennedy, you talked about the hospital having to close down in February.

Ms KENNEDY WILLIAMS: Yes, it is only the beds. It will be the beds.

The Hon. WALT SECORD: It is the beds, so it means you will not be taking patients in the hospital in February because you will not have enough staff?

Ms KENNEDY WILLIAMS: Yes, we will not have any staff, but the patients—

The Hon. WALT SECORD: Where will the patients go?

Ms KENNEDY WILLIAMS: The ones who are critical will go to Dubbo.

The Hon. WALT SECORD: And the less critical ones? What will happen to them?

Ms KENNEDY WILLIAMS: The less critical ones, they will manage around who is there with the staffing. There is a shortage of staff so they will manage with whatever they have got, but if there is anything major that comes in, they will just ship out.

The Hon. WALT SECORD: What will the hospital be doing? What will be happening in the hospital at the time?

Ms KENNEDY WILLIAMS: The hospital, there will be staff there but they would be looking after the aged care and they would be looking after dialysis. We cannot stop dialysis because—

The Hon. TREVOR KHAN: No, you sure can't.

The Hon. WALT SECORD: No, you cannot stop dialysis.

Ms KENNEDY WILLIAMS: No.

The Hon. WALT SECORD: Thank you, Ms Kennedy Williams.

Ms KENNEDY WILLIAMS: Thank you.

The CHAIR: Thank you both for being available this afternoon. I did want to mention that our plan had been, earlier in the year, to come to Walgett and that part of the State—

Ms KENNEDY WILLIAMS: Did you?

The CHAIR: —to actually be on the ground, so to speak. I know Ms Cate Faehrmann, in particular, has an interest in Indigenous health and wanted to be up there and to be able to talk to people on the ground. But for reasons that we all know of, that has not been available.

Ms KENNEDY WILLIAMS: [Disorder] out this way.

The CHAIR: I have to say it is our second-best option, doing it remotely.

The Hon. TREVOR KHAN: Third-best.

The CHAIR: But it is a way of doing it and we appreciate it.

Ms KENNEDY WILLIAMS: No, that is okay.

The CHAIR: We know what the telehealth experience is like. We are getting a real feel of what telehealth was like. Once again, on behalf of the Committee, thank you very much. Thank you also for the wonderful work you do up there in the community.

Ms KENNEDY WILLIAMS: Thank you. Goodbye.

(The witness withdrew.)

AUNTY MONICA KERWIN, Community spokesperson, Wilcannia, before the Committee via videoconference, sworn and examined

MICHAEL KENNEDY, Private citizen, before the Committee via videoconference, sworn and examined

The CHAIR: Thank you for making yourselves available this afternoon. What we will do now—and this is what we normally do—is invite both of you to make an opening statement and say a few words to set things up before we ask questions. You would have been informed about that. We will start with Aunty Monica. Would you like to make an opening statement, Aunty Monica?

Aunty MONICA KERWIN: Yes, I would. How long have I got?

The CHAIR: Listen, keep it between three and five minutes. That would be great, because there will be lots of questions that arise from that. Three to five minutes is fine.

Aunty MONICA KERWIN: Can I have three minutes? I feel like I'm in a game show here.

The CHAIR: Everyone's a winner at our inquiry, Aunty Monica. Take your time; three minutes is fine.

Aunty MONICA KERWIN: For the last minute, can I please have that as a minute's silence [inaudible]?

The CHAIR: You certainly can.

Aunty MONICA KERWIN: I don't know what to call you. Sir? Your Honour?

The CHAIR: No, just "Greg" will be fine.

Aunty MONICA KERWIN: Greg?

The CHAIR: Yes.

Aunty MONICA KERWIN: [Inaudible]. I will have the last minute of my statement be a minute's silence, if that's alright with everyone.

The CHAIR: It certainly is.

Aunty MONICA KERWIN: Thank you. Basically, about me, I was born and raised in Wilcannia. I grew up there, lived there all my life and never moved away. I have seen our Aboriginal people at the highest times of their lives and seen them in their lowest times. I basically know everybody in my community. I love where I live. Standing up for our Aboriginal [audio malfunction]. It was something I woke up one day and decided to do, to stand up for a lot of Aboriginal issues in our community. Health is one of them. I love my community and I love my people, and I want to see them being treated right and fairly by a government that we all vote for. Just to see better outcomes for our people and our community [inaudible]. I just recently lost a son to suicide, so today is emotional, but I still want to do this. Mental health plays a big [inaudible]. Something I want to see, particularly for our men, is mental health. We need more out there for the fellas, you know? [Inaudible]. I wanted to speak today. I wanted to [inaudible].

The CHAIR: We very much appreciate you doing that.

Aunty MONICA KERWIN: If I can spend the last of my time as a minute of silence, in memory of the tragic losses in the past 12 months [inaudible]. I don't know where I am in my five minutes. [Inaudible].

The CHAIR: Shall we honour your son with a minute's silence, Aunty Monica?

Aunty MONICA KERWIN: Yes, thank you.

The CHAIR: We would like to do that by standing up and showing him the respect and honour he deserves. We will all stand for a minute's silence.

Committee members and officers stood as a mark of respect.

The CHAIR: Thank you. Can you still hear us, Aunty Monica?

Aunty MONICA KERWIN: Yes.

The CHAIR: May I ask, Aunty Monica, what was your son's name?

Aunty MONICA KERWIN: Mark.

The CHAIR: Mark. That must be a tragic loss.

Aunty MONICA KERWIN: It was. I can't believe it, but I've got to do this, you know? [Inaudible].

The CHAIR: Yes. May his soul rest in peace. We are very saddened to hear what has happened to your son Mark, and by the loss of all lives to suicide, particularly amongst our Indigenous brothers and sisters in communities all around the State. I appreciate you being very strong, Aunty Monica, and agreeing to come along today and share. It must be a very difficult time for you. We thank you for that. Mr Kennedy, would you like to make an opening statement?

Mr KENNEDY: Yes, just to follow on from Monica. I am the same. I am born and raised in Wilcannia. One of the main concerns that we have in our community is suicide, but it is right across the board. Like suicide, it is our health conditions here in Wilcannia. What frustrates me the most is, we have got three different health organisations running our community and we are going backwards. Our people die. On average, a male in Wilcannia only lives to 37 years of age; a female, 41, 42 years of age. It is quite alarming that we have three health organisations in Wilcannia and in the year 2021 this is our statistics. We are one of the most disadvantaged communities in the country. We are in the year 2021. I think with Health there is a lot of concern and a lot of questions need to be raised around Health. The more you look into it, the more you will see and uncover out here for us. That is probably [inaudible] years, 37 for a male and 41 for a female. We got three health organisations, and that is our life expectancy in Wilcannia. I am 39 years of age now. Every day I wake up, I thank God, our god, that I am still alive.

Monica is in another very difficult situation, where the nearest dialysis machine from Wilcannia is 200 kilometres away. Travel three days a week for dialysis. That is a 1,200-kilometre-a-week trip for them. That is 5,000 kilometres a month that they have to do. We have another lady in Wilcannia, an elder, that is well into her eighties. She has to do the same thing—travel near 5,000 kilometres a month for dialysis. We are in the year 2021. We got three health organisations. It is very frustrating around health out here, with a lot of issues—with suicide, with the amount of travelling that people have to do, and just all of the other underlying health issues that we have in our community.

The CHAIR: Thank you. That is very helpful, Mr Kennedy. That adds to the important information that Aunty Monica was able to describe to us in her opening statement. Is there anything else you would like to say in your opening statement? Or could we move to questions? What would you like? Move to questions?

Mr KENNEDY: Yes, you could move to questions. That is pretty much my opening statement.

The CHAIR: Thank you very much. That provides approximately 10 minutes each for each of the groups around the table. We will start with the Opposition, the Hon. Walt Secord.

The Hon. WALT SECORD: Mr Kennedy, people in Sydney—the most recent knowledge or reference that they would have had involving Wilcannia has been the COVID outbreak. What is the situation at the moment? How is the community responding post the outbreak?

Mr KENNEDY: There is still a lot of fear around. There is still a lot of uncertainty because there is always things changing around COVID. It is such a young virus that there is still things being learnt about it. So there is a lot of uncertainty and a lot of fear. Everyone in the community—their anxiety levels, their stress levels, depression levels are all pretty high at the moment because we have just been through so much, you know, the COVID outbreak in the community. Then, as Aunty Mon said, she lost her son to suicide. But we have also had another young lady, in the community, that was lost to suicide. We had another male that was lost a couple of weeks ago through a car accident. This community, over the last few months, has been through a real—it is just frustrating. It is heartbreaking. It is stressful. It is depressing. But we try to find a way each day to keep going.

The Hon. WALT SECORD: You mentioned and Aunty Monica mentioned three health organisations. Is there duplication? Is there overlap? Or is three not enough? What is the situation? You mentioned, several times, three health organisations. Can you bring me up to speed on that?

Mr KENNEDY: I think the three health organisations is enough. I think we should be a lot further ahead with three health organisations. But I think one of the main problems is they just simply do not work together. The three organisations are run by different departments. They really do not communicate to one another. They are just not on the same level or not working together. All our communities out here—you can get the best outcome with three health organisations. I think the main problem is they are just not working together.

The Hon. WALT SECORD: Aunty Monica, how do mental health services work in with the Aboriginal community, Indigenous community out there?

Aunty MONICA KERWIN: I do not think any of Mental Health actually phoned any of the COVID cases. I am just going to go from COVID and then right across the board with this because the thing with it is, when COVID hit our community, the local [inaudible] their mental state was a lot of fear. "Is this it? Is this the

day I am going to die?" They had Health ring them about symptoms. No Mental Health has rung them regarding the mental side of what they were experiencing. A lot of the family—they were really scared.

The CHAIR: We may have just lost Aunty Monica, the connection.

Aunty MONICA KERWIN: Are you there?

The CHAIR: Yes. We have got you back.

Aunty MONICA KERWIN: Mental Health really did not step up to the plate here, not out of any of those organisations, like the three that we said: Greater Western, Maari Ma and Royal Flying Doctor. Since losing my son, I had the Royal Flying Doctor come in. Maari Ma did not come in. I am a Maari Ma client. They get funding because I am a statistic. But they have not been doing what they supposed to do in our community regarding mental health, and not only mental health but a lot of the other underlying health issues—chronic disease. We have a lot of things around. A lot of our people have got chronic disease, diabetes, heart troubles and all of this. Then we got hit with a virus. Not one of them came to the table to even do a little simple welfare check on people.

I understand that, from a lot of the families, when I spoke to them after all this COVID came and went—I asked them about whether Mental Health rang them. They said, "Health rang us. They was asking questions, how am I feeling." It was more so towards the symptoms is what the people were saying, that they were asking questions around, not their mental health side of it, not the shock and the fear and all of that. Was more so they were concerned about the symptoms. It scared a lot of people because nobody actually asked them about their wellbeing. They were scared. They were angry. It felt like they were alone and nobody really cared.

Just like what Michael was saying, they need to be more out there. We see a lot of the assets in our community—their pools of cars, their houses—but we do not see what they are supposed to be servicing us with. We do not see the clinics on the ground, the home visits, even things like—we do not see a lot of that. Like I said with the dialysis, they are still trying to—I do not know what they are doing but we do need a dialysis. I am not just saying for my husband. Like Michael said, there is an elderly lady, as well another elderly lady living away because she cannot come home. X-ray machines—we need a lot of mental health on the ground building relationships with people. [Inaudible] people. We like to talk face to face.

But I think we need to know that you actually genuinely care as opposed to somebody who will dial in and we say they are only in the job for pay packet. So I am angry with Health. I am. And it is not just with the mental health side; it is right across the board. Michael said there is a decay in health now in our communities—three health organisations. People are dying. People are dying, and not from COVID, not from a disease but from all the other things that they have been denied.

The Hon. WALT SECORD: Mr Kennedy, maybe you could assist now. You both have referred to kidney dialysis and the great distances that people have to travel. So is there no kidney dialysis chair in Wilcannia at this moment?

Aunty MONICA KERWIN: No.

The Hon. WALT SECORD: Has there ever been a kidney dialysis chair in Wilcannia?

Aunty MONICA KERWIN: You asking me or Michael?

The Hon. WALT SECORD: Whoever wants to answer. Aunty Monica, you have got the microphone.

Mr KENNEDY: I have never known a dialysis or kidney chair to be in Wilcannia since I have ever lived here. Everybody that suffered from dialysis has had to move to Broken Hill, which is 200 kilometres away, or do what Aunty Monica and the other old Elders do in the town: travel over three days a week.

The Hon. WALT SECORD: Are there enough people who need kidney dialysis in Wilcannia to have a chair there?

Mr KENNEDY: We have three at the moment and before the three that we have got here, we had two that had moved away. One of our other old Uncles who [inaudible] Broken Hill and then lost his life in Broken Hill. Us as Aboriginal people, for us to move off our country where we are originally from, that is one of the biggest heartbreaking things that could ever happen to us. We cannot leave our country. We are too spiritually connected to our country, where we are from and which tribe in the country. For Elders like that to move 200 kilometres or 400 or 600 kilometres away for dialysis, that is probably killing them just as much as the actual disease is. Because mentally and spiritually they are disconnected from their country and it breaks our Elders down massively because of that. I do not know if Aunty Monica has anything to add to that.

Aunty MONICA KERWIN: Yes, we desperately do need one. Like Michael said, we never have or had one in Wilcannia in all my 50 years. I turned 53 last week. Never. The talk was on the table but nothing was—there is no dialysis here whatsoever.

The Hon. EMMA HURST: Thank you both for coming. I want to say sorry, Aunty Monica, for your loss and thank you for your strength for coming today. I understand, obviously, the reason you are coming here today to talk to us, even though you are going through such a difficult time, is because you want to make sure that the community has a spokesperson. I wanted to ask a really open, broad question. Being somebody that is speaking on behalf of your community, what do you think the Government needs to really know and understand about the day-to-day experience of your community? What needs to really change?

Aunty MONICA KERWIN: The Government needs to listen a lot more to grassroots people on the ground—not an employee in an organisation that is government funded but actual grassroots people living in the daily conditions that we do live in. And we need changes in our health structure. According to statistics that they have, chronic disease—statistics with diabetes. All these areas need to be properly addressed by our health services and the health system under government. The funding needs to be spent properly, according to our community and the people's health issues.

I have diabetes. We do not know very much about diabetes, but to a lot of our Aboriginal people that has been the "silent cancer" killer. There is not a lot of advertising out there or knowledge as to how you get diabetes. We know that unhealthy living is one of them. Well, start looking at the housing condition. Your house is falling down and you have to pay high rent. You cannot afford the food and things where you live. Not everybody can travel to Broken Hill. Health plays a vital role, if not the leading role, in our wellbeing and our survival. If you look at all the social and emotional stuff that comes under health—just not with heart disease and things but a lot of the mental side and all of that.

Health provides, if not the major role in looking after our people and catering properly for our people—you go to meetings in your community and you are dictated to by health professionals or people employed in service providers. We do not need dictators. We need the proper health care that the Australian Government can possibly give us. Our river system, the way that is—health plays a very big, important role in our community and it needs to be addressed properly and it needs to be looked at. Not only that—I will just go a minute here. But listen to the grassroots people: the people that have ill health, the people that are going through what they are going through on a daily basis. They are the ones the Government needs to listen to on the ground. I do not know if I answered it.

The Hon. EMMA HURST: No, you have. Following on from what you said, you used the word "dictatorship"—that it almost feels like there is a dictatorship within the health system and that the people at the grassroots are not being listened to. Do you feel that that has really destroyed the trust in some way with the local healthcare system? That lack of proper consultation?

Aunty MONICA KERWIN: Yes. Because, with the three health providers we do have, all of them have a duty of care to the people. You go in there and they palm you off to Maari Ma. You go into Maari Ma; they will palm you off to RFDS. We do not know who is supposed to be actually servicing us or providing the service to our community in health—but more, you know, "Oh, you need to see this one." But when you question them, you are spoken down to. It is like you throw your hands in the air and walk away and say, "I don't want to even bother with talking to any one of you." So a lot of our people are, you know, sick of being mistreated and dictated to, or spoken down to, or like they are goats or cattle, and they have never been in hospital where all these services providers operate out of. But they have forgotten their own health so they do not know what to expect.

The CHAIR: We will move to Ms Cate Faehrmann. We have just lost our connection with Mr Kennedy, which we hope to restore. So presently we have just got only Aunty Monica with us.

Ms CATE FAEHRMANN: Hello Aunty Monica. I so want to say I am very sorry, so sorry, to hear about your son Mark. Thank you for still coming here today to talk. It is so important and thanks for having the courage to do that. If you are able to, I want to ask you specifically about what is available or should have been available. I think Michael Kennedy just spoke—not I think; he did—earlier about recent suicides. What would you have liked to have seen in place to help Mark and others like him in Wilcannia?

Aunty MONICA KERWIN: We would like a mental health worker living in our community you know; maybe two or three of them? But we definitely need one, one that has to build a relationship with the people because that is important that our people trust. They talk about there is confidentiality, but it is not about the confidentiality. It is about the trust, you know. I have to really trust somebody to go and talk to them about everything and anything. Really we need it within community, mental health workers. I do not mean we needed a busload during COVID. I said, "No. We need to isolate people. Don't bring us a busload of counsellors in here

to wander around doorknocking just randomly wanting to talk to people for the sake of talking to them. Build a relationship with people so they trust you enough."

Like Michael said, that young girl she was in her 30s. My son was only 34. They are a month apart—you know, a month apart when they committed suicide. She is a young mum of four. Whatever mental issues were going on behind closed doors for both of them, my son included, at least if a counsellor was available every day in that community, nine to five every day, my son would not have died the way died. He would have been able to know that that is how it can go—"I know this fella. I can have a talk with him." That young girl, "I know this counsellor. I built a relationship." That is what it is about—building trust, building the trust up to get the people talking. That is what is needed.

Millions of dollars got poured into mental health and Wilcannia never saw one counsellor through COVID that we know of, so they do not know whether it was money that was wasted. I do not know where it went to, but our little community never received a phone call from a mental health worker. People that I know, we have got checks on them every day. It is good enough. Those others involved in the car accident a few weeks ago, the survivors of it, they need mental health. You know, the husband and wife, they are going through hell because they blame one another. They have the trauma of losing the son that died in that accident. They are in their 50s or 60s. They need counselling. These are very private families. We need counsellors but we need them to live in our community, not come in on clinic days, three days a week.

Ms CATE FAEHRMANN: Thank you, Aunty Monica. That is very much heard loud and clear. Can I also ask—this question is similar in terms of the services available—if somebody wants to take alcohol and other drug treatment, what is there available in Wilcannia? Are there any services? We have just been speaking to people previously in Walgett, for example, about the lack of services there. Is Wilcannia similar or are there services in Wilcannia for alcohol and other drug treatment?

Aunty MONICA KERWIN: We have drug and alcohol counsellors come in but just because of the substances.

Ms CATE FAEHRMANN: Yes.

Aunty MONICA KERWIN: That substance abuse, we are talking about what is the underlying problem that has been grinding them down day after day and it is that mental side of people's issues. We do have drug and alcohol but they are ordered through court a lot of the time. You know, people are ordered to see them through the courts. There is not a lot of choice. To get out of jail they go, "I'll go and see a drug and alcohol worker." But drug and alcohol is not the issue. There are other issues. That is a bandaid. Drug and alcohol among our community and our people is a bandaid. They want to run from whatever it is and it is altering us daily without end.

Ms CATE FAEHRMANN: Yes, to clarify, Aunty Monica, I have been asking all witnesses about mental health and about our alcohol and drug rehabilitation support services in regional and remote New South Wales. I absolutely just wanted to get your perspective on services. I am not saying that is the number one driver of the issue at all. I just wanted to clarify that. I want to ask just one last question on another issue, Chair. I want to check as well on dental services in the area. Is there anything available there? What happens for dental treatment?

Aunty MONICA KERWIN: Yes, they do. They do have that—once a week. Hello?

Ms CATE FAEHRMANN: Yes.

Aunty MONICA KERWIN: Yes. Once a week they come, or fortnight.

Ms CATE FAEHRMANN: Thank you.

The CHAIR: Thanks, Ms Faehrmann. We will move now to the Hon. Trevor Khan.

The Hon. TREVOR KHAN: Once again, Aunty Monica, can I express my regret and sympathy for the loss of your son. It must be very difficult. I think it is an outstanding tribute to you that you have been prepared to talk to us today in the circumstances. I hope it gets better for you. I am not quite certain who I should ask this to, but I think I will ask it to Michael Kennedy because he raised these three health services that are available. I just want to get some clearer picture as to who is doing what. Do I take it that Maari Ma provides the primary health care? Is Maari Ma your first stop?

Mr KENNEDY: Yes. It pretty much is. It is pretty much the choice of yours who you want to go and see, whether it is the RFDS or Maari Ma itself. Yeah, the choice is basically yours who you want to go and see, who you feel comfortable to see.

The Hon. TREVOR KHAN: How does RFDS deliver its services in the town? I am not being funny when I say this: Does it fly in and provide services as required, or does it actually have a footprint, a building, in the place that is staffed full time?

Mr KENNEDY: No. They do not have full-time staff here. They fly in from Broken Hill, depending on what it is—you know, three days or so a week, I think, that their doctors are in town. All the RFDS staff, they are flown across the river but none of them are actually based in Wilcannia.

The Hon. TREVOR KHAN: So Maari Ma—what is their position? Are they, in a sense, locally based?

Mr KENNEDY: Local health workers, but [audio malfunction] obviously what they can do. The GPs and dental and counselling and everything else like that all comes from Broken Hill and other locations.

The Hon. TREVOR KHAN: Then there is the local health district—the Far West Local Health District. They also have a footprint in the town in the same way, do they?

Mr KENNEDY: Yes, their nurses are based in Wilcannia but anybody outside of that is pretty much the same—everyone comes into town.

The Hon. TREVOR KHAN: Mr Kennedy, in terms of the nurses, are any of those nurses local First Nations people?

Mr KENNEDY: Not that I know of.

The Hon. TREVOR KHAN: And Aunty Monica is saying no to that as well, I think.

Mr KENNEDY: There has been one, which was my aunty, but she passed about six years go. She was the only qualified nurse that I knew of in our community.

The Hon. TREVOR KHAN: My understanding is that there are about 750 people who live in Wilcannia. Is that right? Is that around about the population?

Mr KENNEDY: Yes, probably a bit less. But, yes, it is around that.

The Hon. TREVOR KHAN: Is there a local hospital there or is it something else?

Mr KENNEDY: It is a local hospital that we have here, yes.

The Hon. TREVOR KHAN: Is that an MPS?

Mr KENNEDY: What was that, mate?

The Hon. TREVOR KHAN: Sorry. Is that an MPS—a multipurpose facility?

Mr KENNEDY: Multipurpose—pretty much, yes.

The Hon. TREVOR KHAN: You have been asked about dialysis and the answer is we got a cross on that one. And we have asked about dental services. If I just talk about the kids, what services are provided for the young kids in terms of hearing tests and those sorts of things for the pretty young ones?

Mr KENNEDY: Absolutely none. I have a daughter who was born at 28 weeks old. My partner had to spend three months down in Adelaide hospital with her. When she turned one, we were meant to take her back down to see an eye and hearing specialist in Adelaide. We have not been able to do that obviously because of COVID but, yes, you have pretty much got to go to Adelaide.

The Hon. TREVOR KHAN: That interests me, Mr Kennedy, because Wilcannia is, I think as you have said, about 200 kilometres from Broken Hill, is that right? So do I take it that what happens is, because of the seriousness, your wife, probably while she was pregnant, was getting seen in Broken Hill? Would that be right?

Mr KENNEDY: No, down in Adelaide.

The Hon. TREVOR KHAN: Yes, but was the link Broken Hill? Or was it sort of from Wilcannia to Adelaide?

Mr KENNEDY: It was from Adelaide to Broken Hill to Wilcannia.

The Hon. TREVOR KHAN: Do you know why actually you are not referred to Dubbo or somewhere else that might be a bit closer than Adelaide? That's a heck of a jump.

Mr KENNEDY: I'm not too sure, mate. The only thing I could probably think of is maybe because Broken Hill is kind of like under South Australia, which is a bit funny because it's in New South Wales, but it has a connection as well with Adelaide in South Australia.

The Hon. TREVOR KHAN: Have you heard of other people from Wilcannia being referred for medical treatment in Adelaide, apart from yourself?

Mr KENNEDY: Everyone that is either in our situation or has more serious illnesses and stuff like that, if they cannot deal with them in Broken Hill, then they go down to Adelaide. The only time they'll send them to Dubbo or Sydney is if there's no room or beds or stuff available in Adelaide.

The Hon. TREVOR KHAN: When your wife was being sent from—I think this is as I understand it—Broken Hill to Adelaide, how did she get there?

Mr KENNEDY: Most of the time either you can drive down—they will supply fuel for you. There is a bus that runs down there once or twice a week. And then aircraft—they might put you on the plane to fly down and back.

The Hon. TREVOR KHAN: And that is on a commercial flight—that is not the Royal Flying Doctor Service?

Mr KENNEDY: Yes, that is a commercial flight. The only way you will get there by RFDS is if you've been at [audio malfunction] and they have to take you down there for medical reasons.

The Hon. TREVOR KHAN: How long does it take to get by bus from Broken Hill to Adelaide.

Mr KENNEDY: Well, it takes us from Wilcannia when you drive—it is about a 7½-hour drive.

The Hon. TREVOR KHAN: Sorry, I missed that.

Mr KENNEDY: When you drop Wilcannia, it is about a 7½-hour drive. On the bus I think it is closer to eight or nine hours because the bus has to do its stops along the way. To fly down, it is about a 45-minute flight from Broken Hill.

The Hon. TREVOR KHAN: Hardly entirely satisfactory. My questions have finished. I want to thank you both again. It really has been helpful and, quite frankly, concerning. Thank you for the evidence that you have given.

The CHAIR: That brings us to the conclusion of this session. Can I, once again, thank you both for participating this afternoon. It has been a very significant contribution. Aunty Monica, our sincere condolences, of course, to you and your whole family and the mob there who have lost an important and valued member of the community. We are thinking of you and we do hope that over time the pain will lessen but no doubt, though, you have lost a son and that is something that you can never replace. Mr Kennedy, thank you very much for the leadership you continue to show in your community. The material you provided us today is very raw indeed but on the other hand very rich in detail, which we will be able to use in the preparation of our report and recommendations, which we sincerely hope will contribute to the improvement of matters, health services and delivering outcomes for your part of New South Wales.

Can I just say in conclusion, it was our intention, both of you, that we would come up and spend some time with you as part of our inquiry but, as COVID cut its way through the landscape, so to speak, we had to alter our plans some months ago about the wiseness or otherwise of coming up to see you directly in the community and, on balance, the decision was taken that it was best not to do that in the circumstances. We think we have lost an opportunity, obviously. This is the second best option but nevertheless we wanted to take it up and ensure we are able to collect the valuable evidence you have been able to give us this afternoon. Once again, on behalf of the Committee, to you both, thank you very much.

(The witnesses withdrew.)

BOB DAVIS, Chief Executive Officer, Maari Ma Health, before the Committee via videoconference, affirmed and examined

HUGH BURKE, Public Health Physician, Maari Ma Health, before the Committee via videoconference, affirmed and examined

CARL GRANT, Chief Executive Officer, Bila Muuji Aboriginal Corporation Health Service, before the Committee via videoconference, sworn and examined

CHRISTINE CORBY, Chief Executive Officer, Walgett Aboriginal Medical Service and Brewarrina Aboriginal Medical Service, before the Committee via videoconference, affirmed and examined

KATRINA WARD, Operations Manager, Walgett Aboriginal Medical Service and Brewarrina Aboriginal Medical Service, before the Committee via videoconference, affirmed and examined

The CHAIR: I thank our next witnesses to the inquiry for joining us this afternoon. We really appreciate you making your time available. I know you have got various things on your plate to keep you busy and you have had to carve out some time to spend with us this afternoon, so thank you all very much. We effectively have three organisations; two of them have got multiple witnesses: two each. What I will do is provide an opportunity for each of the organisations represented to make an opening statement. If you are agreeable, once that has been complete, we will move into the questioning of yourselves by the Committee members around the table. Are people happy with that format?

Ms CORBY: Yes, thank you.

The CHAIR: Good. Thank you very much. We will start with Maari Ma Health. I am not quite sure who will be giving the opening statement. Would that be you, Mr Davis?

Mr DAVIS: I will do that, Mr Donnelly. Thank you very much. I will limit it to three key points. You guys are only going to give me three minutes to talk.

The CHAIR: We will give you five.

Mr DAVIS: I will time myself, so it will be three minutes and 25 seconds. Maari Ma's submission provides a much more comprehensive overview of our advice to the inquiry. Maari Ma's region actually covers all of far western New South Wales. It is also part of what we call the Murdi Paaki region, which occupies the north-west and Far West parts of the State. It also covers some of the most arid and remote parts of New South Wales. The geography of the region is seen by those who live there as a great strength because it reflects the traditional and the contemporary movement of the past and linkages of families and communities along the Barwon-Darling river system. The river system, in turn, provides a strong collective identity. The name "Murdi Paaki" is actually derived from the traditional language of the region, "Murdi" meaning black man and "Paaki" meaning river.

People living in the Murdi Paaki region have lower socio-economic circumstances, worse lifestyle risk factors, limited availability of the local health professionals and infrastructure, and poorer access to health services due to distance and cost. The combined impact of these circumstances is that Aboriginal and non-Aboriginal people in the region have poorer overall health and health literacy compared with people who live in the metropolitan areas. There are also a range of issues relating to both social and cultural in terms of health that hamper Aboriginal people accessing care, including experiences of discrimination, racism and poor communication with healthcare professionals, a lack of affordable transport and healthcare services, the perceived lack of confidentiality, a lack of culturally appropriate services and information on available services, and different perceptions and understanding of health, illness and treatment. Together, these difficulties make the navigation of a fractured and complex health system that is poorly suited to remote communities and smaller populations a very big ask, indeed.

Briefly, the first one I want to focus on is the greater focus in remote New South Wales. Over the last 10 to 15 years, governments and their departments have slowly fragmented. An example is NSW Health's responsibility for remote New South Wales is split between two LHDs, or local health districts, and transferred responsibility for the executive management of service plan, design and decision-making for the Murdi Paaki region to centres of outside the region—for example, the Western Primary Health Network, or the Western PHN, headquarters is ostensibly in Orange and viewed by some out our way as a Central West-centric PHN. This consolidation to Canberra, Sydney and the Central West has only increased the distance and gaps in understanding of local needs, autonomy and solutions and is unsatisfactory on many levels. The one-size-fits-all approaches, coupled with complex and competitive tendering and grant arrangements, do not provide the flexibility to respond

to the unique geographical and cultural challenges of the region and lead to fragmented, duplicative, siloed services that are not suitable or sustainable for providers or communities.

Centralisation of bureaucracy is also mirrored by the demolition of major non-governmental organisations with governance and senior management functions based in metropolitan regional areas, which have increasingly resulted in services being delivered from outside the Murdi Paaki region on a fly-in, fly-out basis and telehealth basis as well. Since the establishment of the LHDs and PHNs, remote communities in New South Wales have experienced disinvestment on a scale that has never been seen previously. Without a joint remote primary health care strategy, including mental health, there is ambiguity of responsibility, a preference to force a fragile market to compete to deliver options, poor population health intelligence and plan. Commissioning practices are poorly prepared and place little confidence in local or other organisations and networks.

The second point I wanted to refer to was Aboriginal Community Controlled Health Organisation [ACCHO] engagement and leadership. Aboriginal health institutions are amongst the most stable and consistent providers of primary health care in remote New South Wales. However, this clinical and cultural knowledge and authority is not reciprocated in authentic partnership, investment, nor advocacy from LHDs or PHNs. Given the growing Aboriginal population in the region with continuing health disadvantage, a declining non-Aboriginal population and market failures in both the public and private health systems in the Murdi Paaki region, the ACCHO sector needs to be engaged and supported to take a greater role in planning, design and delivery of the region's health services to ensure their sustainability, accessibility and quality, because the ACCHO sector is a sector of the future.

A remote health strategy must recognise clinical and cultural leadership of ACCHO to secure health improvement. The ACCHO's unique comprehensive primary healthcare model of care and the more recent Commonwealth Government's Health Care Homes program have the potential to address the failing primary healthcare landscape in the Murdi Paaki region. However, ACCHO leadership and push will be required on a regional level to achieve the necessary integrated, system-wide practice and primary healthcare reforms. To rely on the mainstream, and in particular the western PHN, for such innovation and drive at this stage would be a mistake. There is an obvious need for greater investment in the primary care organisations that have cultural authority and industrial agility, live and work in the communities and are regionally governed.

My last point is a case for change. General practice of primary health care in small towns in western New South Wales has reached a critical point. Projections show that 41 towns and approximately one-quarter of the population in the Western NSW PHN region are at risk of not having a general practitioner practising in those communities over the next 10 years unless remedial action is taken now. The challenges facing rural and remote health services with respect to workforce are widely recognised. The provision of quality primary care services requires availability of a skilled workforce of doctors, nurses, Aboriginal health practitioners, allied health professionals and ancillary staff. Remote New South Wales, like most other rural and remote settings, has experienced increasing difficulties in recruiting and retaining such primary care workforce. The impact upon the provision of primary care services in the Murdi Paaki region of the continuing difficulties in recruitment and retentions has been substantial. It has led to discontinuities in services and, in some cases, service closures. It has led to impoverished business and clinical systems and services for chronic disease management, and worsening health outcomes.

Practices have incurred substantial costs in the employment of locums. Frequently practices have had to rely more on overseas-trained doctors and less on locally trained doctors, many of whom have been prepared to stay on until they meet registration requirements and who have required substantial additional support to adjust to cultural contexts. The high turnover of GPs is also having a negative impact on the continuity of primary care, especially for patients with chronic and complex conditions. This is particularly an issue in remote health care, where there are increasingly fragmented services.

Without a regular GP who has good knowledge of both the patient's medical issues and the referral pathways available, many patients experience undue difficulties in accessing services. Poor continuity of care also particularly affects the Aboriginal patients, many of whom are anxious in unfamiliar clinical situations and with unfamiliar practitioners, and who respond best to trusted longer-term relationships. While the ACCHO sector has grown in its capacity and capability to deliver general practice services, it is also constantly challenged by the poor supply of general practitioners and GP registrars.

Finally, instead of the siloed, competitive approaches of the past, what is needed now is a wider collaborative general practice workforce and training strategy for western New South Wales, also known as the Murdi Paaki region. What is really disappointing to all of us out there is that following the Western NSW PHN's dire assessment of the vulnerability of general practice in western New South Wales in 2009—i.e. some 41 towns

and 25 per cent of the population will not have a GP in 10 years—nothing substantial has been done to address this critical issue in the subsequent three years after. Thank you very much.

The CHAIR: Thank you, Mr Davis. It was remiss of me not to acknowledge and thank Maari Ma Health for its submission to the inquiry, being submission No. 716, which is the number it was given when it was processed. It was a very helpful submission. It has been processed, as I said, and uploaded to the inquiry's webpage and sits as evidence to this inquiry. The additional evidence in your opening statement is helpful and we will no doubt have some more information from you soon from the questioning. Mr Grant, would you like to make an opening statement?

Mr GRANT: Good afternoon, panel, Chair and Committee. I would probably just like to really back up what Mr Bob Davis is saying. I have not gone to the lengths that he has been able to share with us today, but I pretty much would agree with everything he has said. Bila Muuji is a little bit different, in that I suppose we were established around 1995. It was a group of CEOs from Aboriginal medical services that came together. What they were looking at doing, I suppose, was having a bit of a regional voice. We represent the western New South Wales region out to Bourke; I think one of our members is at Coomealla, so it is a bit further south; and Walgett and all of those areas as well. Ms Corby and that used to be members of our organisation. The aim of the organisation is to be an advocate for the ACCHO sector.

Everything that Mr Davis has said, I totally agree with. We are finding, amongst our members, challenges in getting GPs to work for us. Some of that is around the criteria used to assess whether or not we can get subsidies and all that type of stuff, as member services will probably attest to. As you would probably know, the health statistics for our mob—I think if you go just about anywhere in the country they are always a challenge, in terms of chronic diseases that we are suffering from and access to services. Bob made the point, and I imagine all my members would say exactly the same thing, that our mob will go and visit services that they are comfortable with. If they are comfortable with those services then they will go and get the care. If they have to go up to the emergency department because they are not comfortable visiting a GP practice in their local town or whatever, then they have got to deal with the systems that we all make, and you can run into issues when you are running a big centre.

What I will probably add is that, as you know, Dubbo was one of the first communities, in terms of Indigenous population, that was hit with COVID-19. We have had, I think, 13 deaths in our community—not all Indigenous, but a fair whack. One of the things I found refreshing was the fact that when it really came down to the chips, the NGO sector and the government sector, both State and Commonwealth, we all worked together. We formed a committee and we got out there and helped all our members of the community that were in need. Where I have seen that was probably a challenge was that in some of our smaller towns, like Brewarrina, you might have one person that sort of takes that lead because they are passionate about community. They just got burnt out during that process because they had a lot of agencies wanting to help but there was no sort of coordination.

I think the point that Bob made around the PHN, the local health services and the ACCHO sector working together, I think if you look at the Aboriginal Health and Medical Research Council [AHMRC] documents around that, there are documents saying that we should all sort of partner up. I suppose what I am saying is that in terms of the COVID response, even though it was a crisis, that brought everyone together. We are hoping to maintain some of that work here in Dubbo around continuing that work on the ground. I think what you will find locally is that people on the ground do come together and work together. They do not worry about where the funding has come from, whether it is Commonwealth or State or whatever. They will get in there and do the work.

It is, I suppose, when you get to our level—when we are having debates with State health, Commonwealth health or the Commonwealth Government around funding—that we see some of these issues that Bob mentioned. Even within our service we have got two positions—clinical and counsellor positions—at the moment that we have been funded for and we cannot fill the vacancies. I am about to re-advertise those jobs in January. We essentially went out to recruit, we were able to recruit both roles but they have since moved on now. In terms of the skill set, it is difficult to get some of those skills in your smaller areas now. I am new to town so I do not know how Broken Hill and Dubbo compare population-wise, but I am sure that Walgett, Christine and Katrina probably face the same issues in terms of getting clinicians and staff out to these smaller regions. It is a challenge, but as I said, our argument will always be that community is comfortable visiting our services when it is our mob they meet at the door and then they build up that trust and rapport with the GPs. That is probably all I would like to add at this stage.

The CHAIR: That is good, Mr Grant. That adds very nicely to what has already been provided this afternoon. Moving onto the next members of the panel, I understand that both Ms Corby and Ms Ward have an opening statement. Do you both want to separately make one?

Ms CORBY: Yes please, thank you.

The CHAIR: That is fine. Can we start with you, Ms Corby? I invite you to make an opening statement.

Ms CORBY: Thank you very much. As I said earlier, good afternoon everybody. We are on Gomeroi country here in slightly western New South Wales, dare I say. We are on two rivers at Walgett and knee-deep in water at the moment. My family is Gomeroi from here, my mum, and my dad is English so I pay respects to traditional owners past, present and emerging. It is lovely to hear my colleagues in Broken Hill. Mr Bob Davis' succinct statements about the overview of the health system was like listening to our plight as well. I really thank you, Bob, for that wonderful opening statement. It is quite clear that things have not changed for me, who has been working in the business for 35 years. With Mr Carl Grant, while you recognised my association with Bila Muuji, certainly I was one of the three CEOs at the time that instigated that regional consortium, and unfortunately both Brewarrina and Walgett are no longer members for businesses of change, I suppose.

I listened earlier to the Walgett Shire Council and they spoke about the demographics and also particularly about telehealth. Nurse Betty Kennedy is our chairperson of the board, even though she did not mention it. There is a bit of Walgett connection again in her presentation about her knowledge of the hospital system. With Betty, I think she said she was 41 years in the game. We are a bit of old chooks around the table at the present time, with the exception of young Carl.

It is with privilege that I am the founding CEO of Walgett Aboriginal Medical Service [WAMS], but over time I have seen the changes. We have endured and grown to provide a deep-placed space, culturally safe, family-centred primary healthcare service not only to the Walgett community but the surrounds, including Brewarrina, Collarenebri, Goodooga, Pilliga and some of the other further afield communities according to the funding arrangements. For Walgett AMS and Brewarrina, we treat everybody both Aboriginal and non-Aboriginal. We currently have 75 personnel, are the biggest employer of Aboriginal people in our community, and certainly with COVID's impact our workforce has suffered with 15 vacancies. Those vacancies are broken up to five RNs, two doctors, one dentist, four Aboriginal health workers or three admin personnel. That in itself, as was mentioned earlier by the other speakers, the workforce per se and the ability to attract in our regional areas is slowly diminishing if not non-existent.

Successful services in our community require consistent long-term relationships with health workers and GPs face to face. We know our community needs its Aboriginal medical services and we certainly know how to respond to them. We believe we have the relationships and deep community knowledge that enables the primary healthcare service to succeed. We believe we are the experts and need the health system to be managed by fair leadership to work in partnership with us. I would like to just summarise a few of the services that have been concerning us for many years, and one of course is workforce.

Certainly for the past two years, COVID has affected our way of life. We encountered several issues, particularly with people who returned to their border States and did not return at all. The pool to recruit was for New South Wales, and all of us, whether we lived at Broken Hill, Walgett, Bre or anywhere, had one pool of workforce in New South Wales. We completely understand that the health system needed that workforce for the crisis that they encountered, but for two years as a business we have been really restricted and hampered in the way in which we can provide a productive responsive level of care to our community.

Just on workforce and what Betty Kennedy spoke about in her presentation about the RN on country, I will just give a bit of clarity around that. The RN on country proposal is an initiative of the Walgett Aboriginal Medical Service in partnership with the University of Newcastle. We are looking at training people, be it Aboriginal or non-Aboriginal people, to become registered nurses and not necessarily RNs but also enrolled nurses [ENs], assistants in nursing [AINs] and other forms of allied health professions. We had the opportunity to go to Canberra last year and present to several Ministers about our great idea. While it was warmly received, the dollars have not been forthcoming. With the members of the Committee and the questions they asked Betty, we would be certainly willing to answer any questions in regards to the queries they have about this initiative that we think can really work out here. We believe not only TAFE would help, as Betty indicated in her presentation, but we are also working as an Aboriginal medical service to give registered training accreditation as a registered training organisation [RTO]. There are ways around, I believe, in attracting a workforce and securing local personnel.

Another issue in summary I would like to speak about is oral health. Through the RFDS and RARMS and a few other presenters today I share the same sentiments. It is certainly difficult to recruit dentists. It is more difficult to have patients come for preventative care, I think, for fear of the dentist drill. The old scenario was, we tend to know, sitting in the chair and having a tooth removed or filled. Prevention just does not really work in our client base. How we attract and encourage people to present, I really do not have the solution. We do offer in our community oral health programs, and in schools we have actually been fortunate with philanthropic money to secure some chilled water kiosks down at the local public primary school to encourage children to drink water as opposed to those wonderful soda drinks that we know that are so popular.

On a reporting point of view, again with COVID, I believe NSW Health has this crazy system called dental weighted activity units. In consultation with our dental consultant, it seems to have no bearing on the actual services that are provided. I am glad Dr Bourke is shaking his head, which I think I believe is some consensus with what I am saying. With that, as maybe part of our recommendation as health services, it would be wonderful if the key performance indicators actually reflect the service because right now we are looking at two years where we have to return some of the money to the various governments because we did not spend it due to COVID, despite our argument to carry over to keep that money as a kitty, I suppose, when times flourish—you know, the boom times, flourishing times. Until we can actually retain and recruit staff, we would hate to see some of the money taken from us. Then our ability to offer the opportunity to recruit people, which would be ideal for us, is then missed. I hope some—

The CHAIR: Ms Corby, I do not want to cut you off but it is now 2.50 p.m. and we have still got one more opening statement to go. Could I invite you—

Ms CORBY: I shall pass to Ms Ward.

The CHAIR: I do not want to miss our opportunity for questions because they will elucidate a lot of the points that have been raised. I apologise. I do not mean to cut you off, but—

The Hon. TREVOR KHAN: But you are.

Ms CORBY: [Disorder].

The CHAIR: But I am, yes. There is no nice way of saying it. I have just cut you off so I apologise. We will circle back. Do not worry. I invite Ms Ward to make an opening statement.

Ms WARD: Yes, certainly. Thank you again for the opportunity. As I said, my name is Katrina Ward and I am a strong Ngiyampaa woman from the Wangaaypuwan nation on the western side of the Bogan River. I was originally brought up around Nyngan, but I have been working in the health industry for most of my life in the Far West and north west regions of New South Wales. I am very familiar with a lot of the issues, and I have seen a lot of change over the years in the nearly 38 years I have been involved in health. It is unfortunate for our communities out here and it is something that we need to strive to get back to be able to provide our primary healthcare focus.

For those who may not be aware, Brewarrina Aboriginal Medical Service is located in a small town on the Barwon River. It is the location of great cultural significance of the Aboriginal fish traps, which has a very strong cultural connection and historical identity for our region and people. It was a place where all of our tribes came together and did the bartering system, and also sought those medicines as well in the old days and looked out for each other. There was the commencement of the overall holistic health and wellbeing occurring on those riverbanks. That is something we are trying to rejuvenate within Brewarrina.

I have been working originally as the manager of the Brewarrina Aboriginal Medical Service for just on four years. I have just in the last couple of years with COVID moved over to working alongside Ms Christine Corby, operating both out of Walgett and Brewarrina. During my time in Bre—as Brewarrina is affectionately called—we only had two doctors coming as an outreach service two days a week. That has been increased to one locum GP five days a week, due to the demand of what was occurring out there and trying to increase the services, and the allied health services have been ongoing from the local needs.

Brewarrina town holds per head, per capita the highest number of Aboriginal people in the whole of New South Wales: Nearly up to about 68 per cent of people identify as Aboriginal in our township. The vast majority of them, unfortunately, suffer from many chronic illnesses. In the local hospital there are at least eight renal dialysis chairs. It is a constant one-in, one-out rotation for members of our community. That can give you an oversight of the seriousness of the disease of what we have had. Even across Brewarrina and Walgett, there is a high number of sorry business we have had to attend to. Family members have people who have succumbed to these illnesses that have been impacting their lives for many years. Our goal is to continue these services in Brewarrina, and there is the real scope there and the demand to keep services coming.

Unfortunately, we are in a rental building there and we have come across a situation a couple of years ago where we could have been evicted from those premises. We sourced funding streams to try and obtain the funds to build a new AMS, which would also help us in the bid to be able to have enough space to have those services increased and have additional services come for the people. Unfortunately, they have not been successful as yet. There is always a cloud over our head as to whether we are able to continue operating out of our existing building. At the moment, it is starting to come down into disrepair as well. Because it is not our building, we cannot source any funding to do any repairs to it. That was just evident a couple of weeks ago when I put a simple funding application in to repair a two-door roller door, which was a WHS issue as well. Because we could not get

any members of the government—both Federal and State—to identify who were the owners, I had to change my scope of practice of where I wanted that money to go.

That problem still exists, but we are talking about sourcing some of our Medicare income to try and overcome that for the safety of our staff. It is very disappointing that governments are unable to at least give us a clear answer as to where we stand—whether we are going to be evicted or whether they are able to gift us the building and then we take on that ownership through Walgett Aboriginal Medical Service. Then we will be able to either do renovations to it and, of course, put the required money in to fix up the cracks in the floor and the walls, et cetera, and do the basic maintenance it needs. We are strong people as it is, but we have got to have a facility behind us as well as being strong and fixed to give that overall appearance that if you come here you are going to walk out feeling a lot better.

The CHAIR: I will just note that you have been speaking for five minutes. Sorry, it is hard to be subtle about this. Perhaps in another couple of minutes, if you can bring your comments to a close, we will open up for questioning. I know there are lots of questions.

Ms WARD: One recommendation across the board—I know I have often discussed it—is the way funding streams are decided from the government organisations. For example, we have funding for mental health, drug and alcohol, social and emotional wellbeing and suicide prevention. They are all comorbidities; they all overlap with each other, and we are all doing similar services to community. If it was just in one pool of money, it would be one lot of reporting. We would still have the same amount of staff delivering the services, but at least they can complement each other. It will also help us to be more concise with our reporting and avoid duplication.

As I say, we have had great recruitment support that came up out of COVID with the remote AACHO workforce response program. I believe once COVID dies down, I certainly hope that kind of support does not just disintegrate as well because recruitment, as we have all identified, is going to be an ongoing problem. We need to have additional workforce support there that takes off some of the financial pressures and also the pressures of trying to find people on the ground in needs of due crisis.

Transport is always a major problem from us as well. A lot about people have to travel great distances. There is the need for regular and more frequent palliative care teams to be coming out to our communities. We should not be expecting these people to have to do—from Brewarrina's perspective—an eight-hour round trip to Dubbo, and it can be a four-day trip if we have to go to Sydney. We need to have these specialist care people coming out to our areas more regularly. That is the same with the Aged Care Assessment Teams as well. We are becoming an ageing community and there are certainly not enough people around to be able to keep us as well as we can in our homes and take that economic burden off the hospital system and the overall health system.

The CHAIR: Thank you very much. There is a great deal of information that has been provided to us in all of those opening statements. I sincerely thank you for all of those. There is so much there to work our way through. We will now move to questioning.

The Hon. WALT SECORD: Thank you everyone for your evidence today. Ms Corby, I have a question about your proposal to train AINs and nurses. Would you in fact be able to get enough students if you were given RTO training status, and how would such a program work? Would it be a program similar to—I think a number of years ago there were Aboriginal health practitioners, or a special category of someone like that. How would your proposal work?

Ms WARD: May I answer that on behalf of Ms Corby? The training program would line up with the Australian Health Practitioner Regulation Agency [AHPRA] and the New South Wales registration board. All the syllabus components would be matched accordingly. There are no shortcuts in this training program. It has been intensively researched through the University of Newcastle. The nursing team there have been liaising with both AHPRA and the nurses registration board to ensure that everybody becomes as competent as need be for anybody who would go to university and move away. The concept is that we would have people from our region particularly trying to upskill existing staff at our Aboriginal health practitioners, plus other staff coming through, and reaching out to our neighbouring communities as well.

We would like to start it off as a pilot program, but we really can see this working well because the main times when there would be a—people would still have to go off country to attend some placements, but the majority of them, particularly in the early stages, could be achieved through our local health organisations and our AMSs. They would also have educational support for people who may have some literacy issues, and there are programs within the university which would provide that support and would be able to get the individuals up to the required level from doing essays and what is required to pass. There would also be a lot of hands-on teaching in the out-of-school environment.

The main idea is to keep people at home and reduce that risk of people having to travel and putting a strain on family. A lot of people out here have children a lot younger as well, and that is often a barrier for them to go and source adequate skills to look to the future and for them to get a career basis. Predominantly it is open for Aboriginal people but, if needs be, we are quite happy to take on non-Aboriginal people as well. We have done a lot of research into it. We do have a proposal and we are happy to forward that to anyone who is interested. They might find it quite impressive and we really see it as really doable. There are going to be different expert [inaudible] for individuals as well if something comes up. A person might start, they get to the AIN status and then they might fall pregnant, have a child and need to take time off, and then they can re-enter later down the line. We have got all those avenues for people and strategies in place as well.

The Hon. WALT SECORD: Could you forward the documentation that you have involving this proposal to the secretariat? Or we will have the secretariat reach out to you.

Ms CORBY: We will send it.

Ms WARD: Yes, we will do that.

The Hon. WALT SECORD: Thank you very much. Now I will question Mr Davis. Mr Davis, you referred to in 41 towns, a quarter of the population is at risk of having no GP within a 10-year period. I have heard this figure before. Is that an old study or is that a recent study?

Mr DAVIS: It is recent, and the best person to speak about that would be our public health physician, Dr Hugh Burke, who has been involved in collecting some of that information. He will not like it but I will defer it to him. Otherwise I will take it on notice and I will come back with the same answer.

The Hon. WALT SECORD: No, I will take Dr Burke. Dr Burke, the show is yours.

Dr BURKE: It has come from the Western NSW Primary Health Network. I think the original quote has been referenced in a number of PHN documents. They contracted the Australian Healthcare and Hospitals Association [AHHA] to do the work. It was looking at the vulnerability of general practice in western New South Wales. I think the original quote came from a 2019 report. I suspect the reason you hear it a lot is because the figure is so stark and so concerning. I assume that is the reason that other people who have presented have raised the figure as well. As Mr Davis said, the concern that we have is it is one thing to identify a problem, the more important thing is to fix the problem. We do not underestimate how difficult it is to fix this issue, but we as a group—and that is the Aboriginal community-controlled sector—would be of the view that there has not been a lot of traction since that assessment was made. I would be the first to admit that COVID could be an issue for that for the last couple of years, but really we cannot hide behind COVID forever and a day. The longer this goes on, the worse it gets.

The Hon. WALT SECORD: Mr Davis also mentioned that there is a declining non-Aboriginal population in your region. Where is the non-Aboriginal population going? Are they going to Broken Hill, Orange, Dubbo—

The Hon. TREVOR KHAN: Tamworth.

The Hon. WALT SECORD: —Tamworth?

The Hon. TREVOR KHAN: Major regional centres.

The Hon. WALT SECORD: Do we have a situation where the smaller communities will now be virtually solely Indigenous communities and the major centres will—you are nodding? Mr Davis?

Dr BURKE: Slowly over time that senior—obviously there is a migration effect from the north-west into Dubbo. There is a similar migration effect of the surrounding communities outside Broken Hill into Broken Hill, and obviously the southern communities into Mildura. There is obviously that regional impact. But, having said that, even Broken Hill, if you actually—and I am sure your secretariat can look at the population data. I was looking at the census the other day and looking at children under five. If I compare 1996 to 2016, there has been a drop of near 450 non-Aboriginal children under five in Broken Hill in that 20-year period—that is nearly one-third of it. Interestingly, though, there has been an increase of 70 Aboriginal children under the age of five. It has gone from 90 to 170, so close to doubling. Even somewhere like a regional centre like Broken Hill, the population movements are really important to consider with regard to health service provision.

The Hon. WALT SECORD: Mr Davis, that is going to magnify or multiply the challenges that we have now attracting GPs and medical nurses to work in smaller communities. It is going to become even tougher.

Mr DAVIS: It is tough now.

The Hon. WALT SECORD: What I am saying is it is going to become even tougher.

Mr DAVIS: That is right, yes. Can I make another comment following on from Dr Burke and your question to him, Mr Secord, about the general practice dying or disappearing in the next 10 years?

The Hon. WALT SECORD: Yes.

Mr DAVIS: We should not underestimate the role of the ACCHO sector in those regions because, as I said earlier, they have been a stable institution. They are a general practice in their own sense, we just use the words "Aboriginal health", or what we were incorporated. But they still survive. As in the case of Ms Corby, who has been a CEO for as long as me, which is 35 years—we went straight from school to being CEO. They are still standing there. They are stable institutions despite general practices slowly disappearing. The point I am saying and the thing I want to get through is that is why they should be supported, because they will still survive for many more years to come.

The Hon. WALT SECORD: That is where I was going to go with my next question; you jumped to it.

Mr DAVIS: I apologise. If you want to ask about it, go ahead.

The Hon. WALT SECORD: You are emphasising that there will be a need to support and strengthen Aboriginal health organisations into the future.

Mr DAVIS: Exactly, yes. Because, in the end, they may be the only general practices in those remote sectors surviving and standing tall. They still are. Like I said, Walgett has been around for 30 or 40 years. It is still there, a stable institution despite, as Dr Burke just explained, the fact that some of them will slowly die, those smaller general practices.

Ms CORBY: May I say to the Committee—and Mr Bob Davis has just prompted my recall with some of the comments he mentioned regarding services at the hospital. You are quite right, Bob, as an Aboriginal medical service I suppose the question needs to be asked: What does ACCHO actually do? With that, we have inherited quite a lot of the allied health specialist services over the years. We have been quite fortunate with the Rural Doctors Network [RDN] or contracted businesses. We provide the cardiology, where you do not have to travel away to Orange four hours one-way. The podiatry come to us. It is a whole mix of respiratory—it is wonderful how us as a business has grown, and also compliments to Maari Ma too for the footprint that they have.

Again, into the future, if it is Aboriginal medical services, they are going to be something in our image. I did hear RARMS mention that that is what they believe they are. Well, to a degree but not really. They are not autonomous. They are not a primary healthcare practice. They do not practise the social determinants of health under the World Health Organization, let alone most of the National Aboriginal Health Strategy. Acute care is not our business. Whilst we have touched on oral health, that used to be a body part by the Government. Now I think slowly the heads are turning to recognise anything that goes through the mouth affects the rest of the insides which, of course, is a chronic disease. So the logistics of us, as Aboriginal Medical Services, and our definition of health and keeping that body healthy are quite different to GPs in private practice, with respect, and also the hospital system.

The Hon. EMMA HURST: I want to throw either to Mr Bob Davis or Dr Hugh Burke in regard to your submission. In that submission, you note:

> Aboriginal health institutions are amongst the most stable and consistent providers of primary care in remote NSW …

Yet you also say this is not recognised or supported by LHDs. Can you talk a little bit more about that and what support you would like to see ideally from the LHDs?

Mr DAVIS: You want to ask the tough ones. This is probably a difficult one for me to answer because I think in the case of our LHD it is sort of based on relationships more than an organisation to organisation. So the partnership is not exactly great but what we have, though, are individuals who work within the organisation and have relationships with people who are connected to some of the programs that we run. The thing that I would like to say is that we would like to be respected for the work we actually do. I will give a good example. It is around COVID. In a town like Wilcannia, for example, where, as everyone of you guys around the table know, three-quarters of the town are Indigenous. Despite us being a major player—a big player—in the delivery of primary health care in that town, we were not the ones that took the lead role in the rollout of COVID there. It was other agencies that did it. In fact, we came along not necessarily mopping up but actually coming along in the background supporting those agencies because they did not have access to the people.

So I suppose, in our sense, if you could go back in time, the rollout of that, for example, we should have been the lead role in the delivery—the rollout of COVID in Wilcannia. We are the biggest primary healthcare provider in the town. It is a majority Aboriginal population. I might also add, the Aboriginal community actually expected us to do that. So I suppose the respect is not there. This is my personal view. It is not the view of

Maari Ma. You asked me a question; I will answer probably I suppose on a personal basis. For me, the respect from the other agencies is not there.

Ms WARD: Can I also comment on that if you do not mind, Bob, in the sense that from a Walgett perspective when we had positive cases as such? Being an ACCHO, we were able to respond and react immediately. I spent a lot of time on the phone and got additional vaccines brought in and additional staff, but for our outreach communities we were able to jump in vehicles and go straight out and commence that vaccination, plus our people lined up here, and get it done. Then it was two or three days later the team—the LHD and the Australian Defence Force—just turned up in town and put up their pop-up clinics. There was no consultation with "Where have you been?" or "How could we help you?" It was like, "Here we are. Come to us now." It did cause a lot of confusion within the community, and I personally believe there was no respect from the other organisations back to us as Aboriginal health organisations—that respect of acknowledging that we are very competent healthcare providers.

You used the word "mop up", Bob. That is exactly what we had to do out here because they would put advertisements on Facebook saying they were going to be at this community or this community to do vaccinations, but it would be a day or two before we were going out to do second vaccinations. So then community members were confused as to, "Do I go to this fella or that fella?" So there was a lot of behind-the-scenes work from us in doing that reassurance and that advocacy for our community members, which just put additional strain on us. But that is what we do because we do have a passion for our communities and we do try to fulfil their needs. We even had Minister Hazzard come out here, and then it was all about the western LHD. Even when he was on TV every day, it was all about the western LHD—about the Walgetts and Brewarrinas and the Aboriginal people. Not one mention about what AMSs were doing on the ground.

We were the ones that were carrying the burden of it all and taking some slack from our own mob too along the way, but we took that with our grace, as we usually do. So it was very disappointing from that point of view. It would have been nice just to say, "Hey, look, we want to come to town. We were thinking of doing this. Do you need that or would you prefer us to go somewhere else?" That comes up where we even took on doing a lot of vaccinations from outside our LGAs, which I received criticism for from different government organisations—that I should be just doing my own LGA. But I had the vaccinations there, they are our mob anyway, we were still travelling through these communities, so the faster we got everybody vaccinated, the better off we were for it.

The Hon. TREVOR KHAN: The better.

Ms WARD: At the time I am getting criticised, but now I am being commended for doing it because it got the ball rolling a lot quicker. As I said before, all I did was stacked up somebody else's data, but in the long term I kept our communities safe because they were still going to be travelling down the road to either Bourke or Dubbo or somewhere like that, so they had to pass through these towns.

Mr GRANT: If I could just quickly add I suppose in terms of the LHDs, essentially what Bob Davis said is true. If you do not develop a good relationship with the people, in particular as an AMS, then you do not get the benefits of that stuff. So it is around formalising some of those partnerships so that there is a commitment on both sides. That assists you with your workforce and that assists you with patient flow as well so that clients are not falling through the gap. That is all I would add there.

The CHAIR: Thanks, Mr Grant. Cate Faehrmann?

Ms CATE FAEHRMANN: Thank you all for appearing today and for the wonderful work you do for your communities. I have a question for Walgett AMS, firstly about what you have said so far about the urgent need to train, recruit and retain workers. What about incentives from government? For example, I assume housing is an issue for healthcare workers, I assume needing a car for the job. What could be done to incentivise? Fifteen vacancies is frightening. Obviously, that is not working—just throwing positions and money—so what more needs to be done?

Ms CORBY: Money is the issue, may I say, because whilst Katrina Ward touched on the workforce, the recruitment agency fees are exorbitant: 20 per cent of the salary of a GP or a locum nurse—absolutely terrible. That is budgeted items. The Commonwealth and the State Health, particularly the Commonwealth I suppose, are not really ready to release money so willingly. So we are not competitive with the salaries for the doctors. We are not competitive with the salaries for the nurses. From NSW Health, and Betty Kennedy Williams indicated a bit earlier in the piece, there was the opportunity out our way—it might have been Wilcannia as well, Bob—where there was an incentive of $5,000 I think after they tenured for a few years out here. So people would go and work for the hospital system, as opposed to working for the Aboriginal Medical Service, because they knew at the end of the day they would receive a bonus per se. For us, as Aboriginal Medical Services, we were restricted by

government requirements. It would be lovely if there were packages for accommodation, a vehicle. We have to do that ourselves. We have to submit for additional money for a house; it does not come as a package.

If that is your question then, no, we do not have the luxury of having such incentives. We have to be creative and be patient until such time as the Government is ready to actually fund us for such programs and such opportunities to attract staff. Additionally is the notoriety of the west. Too often we are in the media for all the wrong reasons. Ms Ward and Mr Davis touched on COVID. The responses, the positivity of us as Aboriginal organisations and Aboriginal people, and the achievements we reached in those trying times with [inaudible], the LHDs and other government departments—I say forget about that, because we need to put ourselves in a positive light. Whilst you have the media and people who fly in and out on all of these goodwill whistlestop tours and say "I've been there"—how good are they? It is not a solution. It is just a spot check, I suppose, or public relations, may I say. The notoriety of our organisations—we need to remove that from the airwaves.

Ms CATE FAEHRMANN: Thank you. I have quite a few questions which we are not going to get time for, unfortunately, so I did just want to say in terms of your submissions—

The Hon. TREVOR KHAN: I am happy to concede our time, if that helps. I know we are working to a schedule.

The CHAIR: Just keep going, Cate. Thank you, Trevor.

Ms CATE FAEHRMANN: Thank you, Trevor. I will keep going. I have a question around, firstly, drug and alcohol and mental health services and whether Walgett Aboriginal Medical Service is receiving funding for that.

Ms WARD: Yes, we do receive funding for it. We also have funding for social and emotional wellbeing. They are all out of separate funding streams, so there are three different lots of reporting there, which they all want on the same day. A lot of the activities that are involved around it complement each other, so often we will be putting one activity on and trying to bring it all into the same reporting. But the Government likes to keep it as "This was specifically for drug and alcohol, or specifically for social and emotional wellbeing; hence, mental health". We have to be more creative to divide that up. "Well, this one can be allocated against this funding, and vice versa for the other regions." If it was all in us together, I believe it would be far more beneficial for the client, because you are addressing all of their needs from the one team.

You are not having to go and see this person for drug and alcohol and this one for your mental health. It would help, particularly with our people, where you do not have to retell your story all the time to several different people, and then they want to go through "You are self-medicating because of your anxiety or depression", or vice versa. It is about bringing those comorbidities together and having them as one funding over a three- to five-year time period. To make any difference in those fields—it doesn't happen through six visits. It takes that long to build up a trusting relationship, or longer. Our people are very suspicious. We do not want to share a lot of the negative impacts that happen within our life. There is a lot of trust building that needs to occur.

Ms CATE FAEHRMANN: Can I also check in with that? You did mention the trust needing to be built up. There have been some comments today, but there are criticisms of how many organisations are being contracted to provide services, potentially sometimes at the expense of the local workers, who know the community well. I have an example in front of me. I am not saying they are not a wonderful organisation—we have heard from them today—but the Royal Flying Doctor Service, I understand, is contracted to supply drug and alcohol and mental health services in a fly-in fly-out model. WAMS, this is to you, as well: Are there issues with that type of model? I am not wanting to criticise the RFDS, though.

Ms WARD: Personally I believe—I am an Aboriginal woman too. I do not like telling my story to someone else. If anything is going to happen, it will happen as soon as the plane has flown out of town, you know? And then they come back and rely on the people who are here on the ground. That often becomes our Aboriginal health workers or their own family and their mob, who then take on the burden of care for them. They become distressed from looking out for their loved ones, particularly if they are in a mental health crisis. I have extensive experience with mental health and social and emotional wellbeing. I have done a Masters in mental health and am about to endeavour on a PhD involving Aboriginal mental health, so that is going to be an interesting pathway. I have been touching on these kinds of issues that occur within that. It is about having those support periods for when those people who fly in and fly out are not here.

I know the RFDS model happens in Cobar at the moment, and it has a couple of staff on the ground there, but they are not clinical staff, as such. They are good for health care and promotion, per se, but when it comes down to the nitty-gritty and someone is in crisis, they are up at the hospital and they are having a mental health assessment over the telephone. That happens here in our local hospitals. Often, particularly in Brewarrina, connectivity with IT is not the best. As much as Telstra will tell you that it is everywhere, it is not; it is down more

times than it is working. That causes other barriers for a person who is having a crisis, particularly when they feel they are not being listened to in the first instance. They go to get on for a telehealth conference and it blanks out or they cannot hear properly, and that is why they get more agitated.

Ms CATE FAEHRMANN: Thank you, Ms Ward. I have absolutely heard you. I have one more question.

Ms WARD: You could let me go all day.

Ms CATE FAEHRMANN: It is a completely left-field question, actually, but it is around dental health. It has not come up in this inquiry yet, but I understand that this is an issue, and it is around the fluoridation of water in terms of dental health and town water. I understand that for Walgett there have been funds allocated under the fluoridation capital works program under the NSW Oral Health Capital Strategy and that Walgett drinking water is not fluoridated. I understand there are issues with council prioritising it and training staff to do that. I assume that is a big issue in terms of dental health. Would you like to comment on that? It would be good to include a recommendation around this, to be honest.

Ms CORBY: You have done your research, and you are quite right. It is disgusting that the Walgett Shire Council has not employed two people—I have been told the situation with Michael Urquhart. I have had several conversations over time and before he started, as well. The issue, I understand, is that they just cannot find staff to rotate managing the water unit to install the fluoride. It is absolutely ridiculous. We are a population of 2,500 people. There is one supermarket in town. All of you city people who can go to Coles, IGA and Woolies—we had our one supermarket burn down twice in four years. Can you imagine the increase in takeaway and the increase in soda drinks? I will not mention that gentleman's name from across the ocean, but soda drinks rule here. Poor oral health—oral health surgery on two-year-old children. That in itself is an indication.

For us, as an organisation, to source philanthropic money through Rotary and another generous donor for a water unit at the primary school—the Catholic school said, "Can we have one, too?" I said, "Well, the education system should be supplying that." We were just generous and recognised the need, because at the time the education system said, "We don't have the money for that. Water isn't a problem. Clean drinking water isn't a problem." I cannot understand that. So, you have researched well. I just wish something would happen. I really do not know, because bottled water is not the solution. That in itself has been an issue when the river has dried up for many months. We had to rely on packaged, bottled water. Everyone was saying, "Because the water isn't fluoridated, don't drink it." So you drink the water that is no good. It is crazy. It is cyclical. So if the Committee can find a solution it'd be wonderful.

The CHAIR: Thank you for that answer and indeed thank you all, first of all, for participating this afternoon. It has been an extensive session. I think we have covered a great deal of ground, much in your opening statements and followed up by the elucidation of a number of points in very comprehensively answering a whole range of questions from members. On behalf of the Committee, thank you all for participating. But, perhaps more importantly, thank you for the wonderful work that you have been doing over what in some instances are decades of contribution to matters to do with health outcomes and services for our Indigenous but also isolated populations around New South Wales. Thank you very much.

(The witnesses withdrew.)

(Short adjournment)

UMIT AGIS, Chief Executive, Far West Local Health District, before the Committee via videoconference, affirmed and examined

DALE SUTTON, Executive Director, Nursing, Midwifery and Clinical Governance, Far West Local Health District, before the Committee via videoconference, affirmed and examined

TIMOTHY SMART, Director, Medical Services, Far West Local Health District, before the Committee via videoconference, sworn and examined

The CHAIR: Good afternoon and welcome to you all for what is the last panel session of our hearing today. First of all I thank you for making the time available. We know that you are all very busy with respect to your important obligations and tasks that you have before you, so we do genuinely appreciate you carving out the time that you have over the next hour or so to provide some evidence this afternoon. Before moving into questioning I invite you, if you are wishing to do so, to make an opening statement, if that is what you have got prepared. Perhaps over to you, Mr Agis—will you make the opening statement?

Mr AGIS: Yes, I will. Thank you, Chairman. I would like to begin my statement by acknowledging the traditional owners of the lands within Far West: the Barkindji, the Muthi Muthi, the Wilyakali, Ngiyampaa, Wadigali, Malyangapa and the Wangkumara peoples. We acknowledge and pay respect to the Elders past and present, and their ancient wisdoms. We acknowledge the communities of today and the Aboriginal community members who are part of our communities. I would like to thank the inquiry for the opportunity to contribute for the improvement of health service across the rural and remote regions of New South Wales.

I would like to start by giving the inquiry a geographical context of our district. Far West Local Health District covers an area of just under 195,000 square kilometres. This is more than the total landmass of Denmark, the Netherlands and Cuba combined. The same three countries have a combined population of more than 34 million people. Far West has a total population of about 31,000. This, I hope, gives you a sense of the enormity of the landmass relative to the size of our population in the region. It is against this vast geographical backdrop that the health services are provided across our region. The remoteness of our region represents one of the biggest challenges to provide accessible and timely health services. To this end, our services are delivered across nine sites, comprised of two hospitals, including Broken Hill Base Hospital and Wentworth hospital, and two multipurpose services, being in Balranald and also in Wilcannia.

The delivery of a public health service relies heavily on the commitment of its workforce. In Far West we have one of the most dedicated, community-minded workforces. Part of the reason for that is the person they are treating is likely to be their own family, friends, neighbours or someone they know. So this is as much personal as it is professional commitment for them. This was particularly evident during the recent COVID outbreak. Our staff worked tirelessly for days on end because they knew it was their community who needed them during the most challenging time in the history of our health service. They were equal to the task by demonstrating their willingness and resilience in the face of significant adversity. And they did it with the customary Far West smile.

Our commitment to engaging with our community is also exemplified by the fact that our executive team live within Far West, which contributes to enhancing their connection to their communities. The result of such connection, I believe, was evidenced in the recently released 2020 Broken Hill patients survey, which showed that 98 per cent of patients stated that their care was either very good or good. Our doctors and nurses received the same 98 per cent satisfaction rate from our patients. Innovation and strong partnerships are critical to overcome the challenges of remoteness and recruitment to key roles.

Additionally, we have used telehealth and virtual care as an adjunct to face-to-face service delivery to either improve or create access to services. This was particularly evident during the COVID outbreak and constant border closures, as we are flanked by three States, being Queensland, Victoria and South Australia, and the fact that we rely very heavily on visiting specialists from other regions and interstate—in particular, of course, South Australia. We have continually improved our clinical governance and invested in our workforce and in vital infrastructure, including the new $30 million Wentworth hospital and the $9 million Buronga HealthOne service in Dareton. This is in addition to capital improvement in recent years to our palliative care services, BreastScreen and the community health service in Broken Hill. Ivanhoe and Tibooburra have also undergone a rebuild and refurbishing of their own health facilities. We have also prioritised redevelopment of our mental health inpatient unit at Broken Hill Base Hospital to improve our patient care.

In the last seven years we have seen an increase of almost 23 per cent in our budget, an increase of 108 staff or just over 16 per cent of our total workforce. As an LHD that is committed to providing the best possible care to its communities, we acknowledge the issues our communities have raised and continue to raise, which often are embedded in broader, multilevel issues, and embrace the opportunity this represents for improving

our services across the Far West, through ongoing engagement with our communities and health partners. Thank you.

The CHAIR: Thank you very much for that opening statement. That is very helpful. Of course, as you know, NSW Health has provided a whole-of-government submission to this inquiry, which underpins the whole position with respect to NSW Health and the Government's position on health with respect to this inquiry. That opening statement carves out some specific comments for the great work that you do out in Far West New South Wales.

The Hon. WALT SECORD: Thank you, Mr Agis, for your opening statement. I have been on this Committee since the very beginning. I have to say that is the most deficient opening statement I have heard. Your local health district has been under enormous pressure. I would have expected an apology in your opening statement. There has been an Ombudsman's investigation into systematic failures in your health district—and not an apology! You have had patient suicides. You have had preventable deaths. You have had 30 nurses leave in a two-year period. You have had 10 out of 18 senior doctors leave the town. Can you please explain to the Committee what is happening at Broken Hill Hospital?

Mr AGIS: Thank you for the question. In terms of the challenges of providing health services in a remote setting—

The Hon. WALT SECORD: No, sir—

The Hon. TREVOR KHAN: Let him answer, Walt.

The Hon. WALT SECORD: I want to hear practical steps and measures. Sir, lay them out.

The Hon. TREVOR KHAN: Point of order: The member has asked a very lengthy question—indeed, a diatribe. Having put that lengthy proposition, it is really over to the witness to respond to the multiple assertions that were made without interruption.

The Hon. WALT SECORD: I take your point of order; I accept that. I will sit here quietly and I will listen to the chief executive officer respond to those statements of documented facts. Those were not made up.

The CHAIR: Proceed with your answer, Mr Agis.

Mr AGIS: Thank you, Chair. Again, there were a number of questions. Of course I will try to remember. If I neglect any, I am sure I will be reminded. He talked about suicide. It is one of the challenges, certainly, of our time, not only in remote communities but right across rural communities—indeed nationally and internationally. The numbers do suggest that we need to do more. As with any other health service, that is our commitment. And I do absolutely and sincerely give condolences to all the families who have had to endure suicide. Having worked in the field as a clinician for over 20 years in mental health, I can tell you firsthand the experiences of both clinicians and families in response to suicide and mental illness. So I speak with some authority in that regard. In terms of the nurses leaving, there is nothing unusual in that. We have a churn of staff every year. What made it more challenging, absolutely, is COVID in the last two years. But if you look at the numbers over the last two to three years, the number of people—the churn has been very similar and I am more than happy to provide that figure on notice.

The CHAIR: If you could do that, that would be good.

Mr AGIS: We have had additional residents, absolutely. One of the challenges has been the border closures. We do get some of our, obviously, workforce from interstate. As soon as the borders were opened, because of the uncertainty of the environment, a number of them have left, not because they had grievances but because they made a decision for themselves and for their families to leave the State. In terms of doctors, in fact, what I would argue is that—and I will certainly get Dr Smart to comment on this—we in fact have actually strengthened, not weakened, if you like, our doctors. We have invested heavily.

We have—in fact for the first time in a long time now—heads of departments, which we did not have and which other local health districts [LHDs] have taken for granted. That was a significant gap for us. We have addressed that. On top of that, we have actually been successful in recruiting a lot of GPs. In my earlier statement about the importance of engaging and employing local GPs, we have done that. The result of that has been a greater continuity of care and also providing longevity of employment, if you like, for our LHD. Absolutely, I will apologise for the fact that we can do better. That is our commitment to the community that we work with. I am happy to pass to Dr Smart particularly around the medical workforce.

The Hon. WALT SECORD: Ten out of 18 doctors have left and 30 nurses have left in the last two years. I would like to get that in perspective of the overall workforce there. Has there been any investigation into why they have left?

Mr AGIS: Certainly. Part of our process is that we do an exit survey of every employee that leaves. We give that opportunity and then we certainly record that. It gets reported to our executive as part of our planning and understanding as to the reason why people leave, because obviously it is in our interest to know to actually prevent. One of the challenges for us is—I think it was raised earlier. It is not just about recruitment. It is about retention. And, for us, you have to understand what the issues are for our staff who are leaving. As I indicated earlier, a large number have left because they made a personal decision to leave. There may have been others. They may have left because they are not happy, absolutely. This is a very challenging environment and therein lies one of our challenges. We have invested really heavily in terms of, particularly, diversity in workforce. I am happy to get Ms Sutton to comment on this in terms of providing extra support to our nurses. It is a tough gig out here. We are doing everything, certainly, we can, with the help of ministry, to create support systems so that people do not leave.

The Hon. WALT SECORD: Could I hear from Dr Smart to respond to the question?

Dr SMART: Thank you for that. Firstly, I would like to make a couple of statements of fact. Then I would also like to give some context. Firstly, the statements of fact—we have more doctors on the floor on any one day then we have ever had. On any one day we have 37 doctors rostered. It is a hybrid model, which is both specialists—that is, both subspecialties and some of the core subspecialties such as general surgery, medicine, paediatrics et cetera. We also have the intermediate levels and we have younger doctors, the trainees, who are rotated out from Concord and Canterbury hospitals in south Sydney. In addition to that, we have developed a rural generalist training pathway. At the present moment, we have four local general practitioners on that. Our component of that is to do the advanced skills training, which we do. We had our first graduate a month ago from that and we continue to encourage local doctors to join us. In terms of actual numbers, we have a significantly larger number than we had even two years ago.

The second thing is—the additional component is that the preferred engagement that doctors have in New South Wales is what we call a visiting medical officer. This is where they are paid on a sessional rate, an hourly rate and/or what you call a procedure rate based on the number of procedures they do. The common contract that is given—and this is the New South Wales award—is what we call a "zero hours" contract, so they have flexibility. They can do as little or as much as they wish. This, if you look across the whole of New South Wales, results in quite a churn as people find opportunities to work in other places. Inevitably, in any medical staffing situation, there is sometimes dissatisfaction, particularly if people have been called to account in terms of their professional levels of service delivery. When we do require that, some people prefer not to stay.

The Hon. WALT SECORD: I want to stop you right there. Can you roll back a little bit? I would like to explore that. So doctors have left because—

Dr SMART: There may be simple things in terms of commitment, attitude or clinical variation from what we expect, which is one of our significant key performance indicators [KPIs] that we monitor, and a lot of the people who come out here are flexible because they are visiting medical officers and they can move. They are not contracted in terms of staff positions—

The Hon. WALT SECORD: No, what do you mean—

The Hon. TREVOR KHAN: Let him answer.

The Hon. WALT SECORD: He is rolling past, getting upset about being questioned about clinical variation. What does that mean? Are we talking about adverse outcomes? Are we talking about—

Dr SMART: Will I answer or should I answer this new one?

The Hon. WALT SECORD: I want you to answer the question. You said doctors—

The Hon. TREVOR KHAN: Point of order: The witness has started to answer a question and then part way through the answer—and I accept that the Hon. Walt Secord has areas of inquiry he wants to go down. But the witness should be entitled to finish answering the question before he is taken up on part of it. Otherwise, none of us will understand what is going on.

The CHAIR: It is really important that we—because we are doing this remotely—direct our questions specifically to an individual, that individual acknowledges they have received the question and then provides the answer back. That is probably the way.

The Hon. WALT SECORD: Why don't we start from the premise that—I am concerned you said there are 37 doctors rostered at any given time. Ten out of 18 doctors have left but you said that there is a "churn of doctors" and some of those doctors have left because they were questioned about clinical variation. What does that mean?

Dr SMART: In fact, there are other things as well, including clinical variation. So I will start with clinical variation and, if I may, cover the other reasons why people leave, and it is largely out of the locum workforce. There are a couple of reasons we have people move. Clinical variation is a start. When we are looking at any delivery of clinical service for any particular conditions, there is basically what we call our best practice or practice based on research. If you have three or four doctors and of that group of doctors—say four doctors—three of them use the best practice and one doctor is off on a tangent using treatment that may well be acceptable to some extent but is not considered best practice, we will question that. That is clinical variation.

The Hon. WALT SECORD: How many doctors have left because of clinical variation, meaning not following best practice but going off and doing what they thought was best?

Dr SMART: I do not have that number for you and I am not sure I would even be able to find it at this stage, but we could certainly try and find that information.

The CHAIR: Can I just make this point very clear. I will jump in here. That is quite a significant acknowledgement, if I could use that word, Dr Smart, that you have made, from the probing question. I understand that. Surely that information is available. It surely cannot be the position that the number cannot be identified over a particular period of time—surely.

Dr SMART: Absolutely, and as I said I am happy to take it on notice—I should have used that phrase, sorry—and provide that information.

The Hon. WALT SECORD: It has been a number of years since I have been shadow Minister for Health—

The Hon. TREVOR KHAN: The witness had indicated—

The Hon. WALT SECORD: He just took it on notice.

The Hon. TREVOR KHAN: —that there were a number of areas, apart from those matters. I am not quite sure whether he finished answering the reasons for separation, apart from that particular one. Because he said he was going to come back and answer it more fully.

The Hon. WALT SECORD: Okay. Put it to him.

The Hon. TREVOR KHAN: I could be wrong but I thought that is where he was.

The Hon. WALT SECORD: I was given the impression that he had finished his answer—

The Hon. TREVOR KHAN: And you might be right.

The Hon. WALT SECORD: —and that he had taken it on notice and I was moving on to my next question.

The Hon. WES FANG: We could ask him.

The CHAIR: Move along.

Dr SMART: Thank you. Should I continue, Chair?

The Hon. WALT SECORD: Yes.

The CHAIR: Yes, please continue, if you need to.

Dr SMART: In fact, when we are talking about some of the reasons why people leave and we have talked about before here the number of people who have left in the last few years, preceding my time here, but what I was talking about were the reasons that we see more people leaving and certainly within my experience here. Amongst those are individuals who have contracts where they can increase or reduce their work at will in terms of their commitment to us, and the majority of them leave for their own reasons or other opportunities or other areas where they might be able to do visiting medical officer work. But that is usually their choice. That is the answer to that component.

The Hon. WALT SECORD: Dr Smart, back to my question earlier. A number of years ago when I was shadow Minister for Health, there were major adverse outcomes in hospitals and I think they were called—maybe the terminology has changed since—

The CHAIR: Sentinel events.

The Hon. WALT SECORD: Sentinel events. Thank you, Mr Chair. Are they still called sentinel events?

Dr SMART: We have a new classification of clinical incidents, of which there are sentinel events in some instances, yes.

The Hon. WALT SECORD: So what are they called?

Dr SMART: It is not commonly used but it would be used at times, yes.

The Hon. WALT SECORD: What are they called now?

Mr AGIS: We might get Ms Sutton to answer that because in fact she is our director of clinical governance and she is well across this area.

The Hon. WALT SECORD: Ms Sutton, if you could answer that question. So give me the terminology of what they are called and how many are there at Broken Hill Hospital at the moment and how many had there been last year?

Ms SUTTON: Okay, thank you. They are actually called HARM scores, so that they break between HARM score 1, which is a death, unexpected—that is one example—to HARM score 4, which could be a near miss or you gave a patient the wrong medication and there was no adverse outcome. They could have had a slip or a trip—that is a HARM score 4. I will have to take that on notice around how many HARM scores we have. We do collect that information but I do not have that information in front of me.

The Hon. WALT SECORD: Would you give me an indication: Are there many for a hospital of your size?

Ms SUTTON: I cannot answer that. I do not have that information in front of me.

The Hon. WALT SECORD: Can you take that information on notice? Back to Mr Agis, you mentioned in your opening statement that 98 per cent of patients reported "very good" and "good". What do you base that on?

Mr AGIS: That is the Bureau of Health Information report. That was a media release. I am more than happy to provide that information, if you please.

The Hon. WALT SECORD: So 98 per cent of people who visit Broken Hill Hospital think they received very good or good treatment at the hospital. You stand by that?

Mr AGIS: Correct.

The Hon. EMMA HURST: Thank you all for coming here this afternoon. I am not sure if you either read the submission or saw any of the evidence today from the Aboriginal health services that have come in today but one of the themes that they brought up was that they often felt that there was a lack of communication or cooperation with some of the community groups and the LHDs. I just wanted to get your response to that and whether that was something that had come to you previously and whether there were any actions being taken forward to prevent that.

Mr AGIS: Thank you for the question. I certainly listened to the evidence that was given. Obviously I can speak to the links that we have within Far West. Walgett does not fall within my jurisdiction. In terms of our relationship, perhaps I can give an example of the COVID outbreak, just to reflect the level of partners that we do have. The success of Wilcannia was the result of the partnership, particularly our reference to the community. That is where we needed to focus a lot of our attention. And that was really a partnership between RFDS, Maari Ma and the health service, and I do believe that the results speak for themselves.

We in fact developed teams that were a combination of our partner organisations, including the Mental Health Commission, I might add, who visited the community on a daily basis. You cannot do something like that without a strong base of partnership. That partnership really continues right across our region. For example, in recognition of the significant role our Aboriginal Medical Service played in our region, in conjunction with the Ministry of Health, we fund positions to the value of $2.2 million in Maari Ma because we believe they are the best agency to be able to inreach into our regional communities and we work very closely certainly with the staff on the ground. We have regular meetings and put it on records. We have involved them in our planning, certainly around COVID. In fact, Ms Sutton was the chair of our emergency response team and can certainly attest to that.

We held meetings daily on a lot of occasions where we modelled our partners, including Maari Ma and other services. An example of the strength of our relationship is Coomealla Health, which borders the other side of our region and borders on Victoria. One of the challenges for us was they were really creating access for patients who sought mental health services. There were challenges there. We really sat down with the leadership and looked at how best we can actually address that. What we ended up doing was that we funded a mental health worker within CHAC, which is what we call Coomealla Health, and that person became the bridge, if you like,

between our two services. What that has seen is it has improved mental health services for the overall communities in that area. Is it adequate? I do not think at all adequate. I think we need to continue to work.

The Hon. EMMA HURST: Maari Ma were particularly concerned, as you would have seen in their submission, about the erosion of the community health spending, with a greater focus of the LHD budget going to hospital rather than to preventative and community care. I am wondering if the LHD are doing anything to improve or to change that.

Mr AGIS: Certainly. In terms of the actual figures, I do not have it in front of me. As I said, overall we had an increase in our budget over the last five to seven years of just under 25 per cent. We really distributed that funding on the basis of need and activity. We are absolutely mindful of the important role our community teams play in preventative work. As I said, we also fund other services, like Maari Ma—$2.2 million, which equates about 10 FTE in the community for that purpose. We will continue to certainly focus certainly in the coming months and years to invest more and more into the community, because we know that if you can stop chronicity in the Aboriginal community, that will have a positive impact both in the patients' lives but also the impact on the hospital system as well.

The Hon. EMMA HURST: I might just dig down on one of the examples that Maari Ma Health Aboriginal Corporation stated in their submission in regard to some of the concerns they have. I will quote directly from their submission. I do not have the page number in front of me, sorry, but they said:

> … LHDs are putting substantial pressure on the dental providers to achieve daily/weekly/monthly … targets that do not seem to take into account the service delivery landscape … or the clientele.

They are concerned that this is leading dental providers to move outside the LHD. Is that something that you are looking into?

Mr AGIS: Just on that, as a bit of background information, majority of our dental services are provided by the Royal Flying Doctor Service [RFDS] through funding from the ministry. We provide a level of service for children in Broken Hill. We have obviously regular meetings with our service providers to make sure that our community get equitable distribution and service delivery in terms of oral health. In fact, Far West probably performs the worst in terms of oral health access. We are working with our partners to look at how we can improve that. We want to focus more on preventative work but a lot of it is on acute, disproportionately. We certainly are working, as I said, on shifting that from acute to more preventative work so that we can actually get in early and actually provide better health outcomes. When it gets to acute extraction, you have missed the boat, basically.

The Hon. EMMA HURST: Absolutely. A number of submissions also—and something we talked about this afternoon as well—were about short-term planning with funding, whereas they would like to see much more longer-term planning with funding to assist particularly around recruitment and planning. I wanted to get your response to that and whether or not there is anyone looking into undertaking more longer-term funding.

Mr AGIS: That certainly is, I guess, a contract arrangement between the ministry and partner organisations—clearly RFDS. We are certainly absolutely supportive of longer-term funding because it is very challenging to recruit to remote sites on a short-term basis. Certainly our contract, for example, with RFDS is usually around five-plus years. That is done through the ministry. Certainly we would be supportive of any attempt to increasing the life cycle of the contracts, given the challenges of recruitments in our region.

The Hon. EMMA HURST: Thank you.

Ms CATE FAEHRMANN: I wanted to go to, firstly, the situation in Wilcannia. What KPIs has the LHD set for increasing the life expectancy there for males, we heard today, from 37 and for females from 42?

Mr AGIS: I think setting a KPI or an expectation that is less than—that is freely enjoyed by the general community will be doing a disservice to our Aboriginal communities. Our expectation—as, indeed, the expectation of the ministry for this—is that every citizen should be able to live to the full extent of their lives. I guess, from that point of view, our aim is to make sure that our Aboriginal community enjoy the same length of life as everyone else does. I hope that answered the question.

Ms CATE FAEHRMANN: No, it does not, actually. I am sorry but it does not. It is not a new revelation that the life expectancy of Aboriginal men in Wilcannia has been—I have always thought it was 36; today we have heard 37 from the witness Michael Kennedy. Firstly, is that correct? Is that the average life expectancy for Aboriginal men in Wilcannia?

Mr AGIS: I will have to take that on notice. It is certainly—look, I will take that on notice. [Disorder].

The CHAIR: Dr Smart might know.

Dr SMART: Sorry. I am new to the area. I do not have that record, but certainly we can provide that information on notice, yes.

Mr AGIS: That would usually be held by our public health unit. Certainly I am more than happy to also give more detailed understanding, on notice, around the life expectancy and what contributes to life expectancy. Obviously it does not necessarily indicate that every person reaches that age and passes away. There are a number of factors that are taken to consideration in determining life expectancy, such as stillbirth, suicide. All of those factors impact.

Ms CATE FAEHRMANN: Yes, that is true. They all do impact, that is right. Mr Agis, how long have you been in the position for, if I could just ask?

Mr AGIS: Sure. I will be coming up to my second—completing my second year in the middle of January next year.

Ms CATE FAEHRMANN: Okay. So maybe the question then is, let's say—and take it as a fact—that Michael Kennedy was correct today, the Wilcannia witness, along with Aunty Monica Kerwin, who tragically lost her son to suicide just recently; in fact, we had a one-minute silence for her son, Mark. So let us take that the average life expectancy for Aboriginal man in Wilcannia is 37. What is the LHD doing to address that and to ensure that that life expectancy starts to increase?

Mr AGIS: Sure. Again, if I can just perhaps preamble that, life expectancy is not obviously necessarily the outcome of, if you like, health per se. Health has a number of factors that are impacted. I am talking about social determinants of health. You can talk about housing and you can talk about education. I guess I cannot speak to the whole raft of factors that impact. In terms of what we do, as I said, we are working closely with primary healthcare partners such as the Royal Flying Doctor Service [RFDS] and Maari Ma around primary health for preventative work with our primary health network [PHN] partners. We are investing in mental health to have an impact, particularly on suicide. As recently as this year, we have in fact opened up our Safe Haven Cafe in Broken Hill and also have invested heavily in community education right across the district around suicide prevention and education. They are some of the actions we are doing to contribute to improving the health outcomes for our regional communities.

Ms CATE FAEHRMANN: You said you are investing in mental health support, but we heard from the Wilcannia witnesses today about the lack of mental health support and how they very much need Aboriginal people who live locally who could provide that mental health support and trained mental health counsellors who are ideally from the local community. What is being done there?

Mr AGIS: Our aim always is to create local opportunities and employ locally. That is not always possible, and that is why we have the likes of RFDS and others who really do a visiting service. We are working with, again, Maari Ma. Maari Ma provides primary mental health services alongside RFDS, and LHD provides the more, if you like, seriously acute level mental health services in the area. In terms of local employment, again, as I said, where there is an opportunity we certainly do so but that is not always possible.

Ms CATE FAEHRMANN: I would suggest to you, if I can, that it is not working and there is not enough mental health support. We had two witnesses today say that they do not have the Aboriginal mental health workers who are there 24/7 in Wilcannia. You have just talked about fly-in fly-out from the RFDS and you have talked about Maari Ma, but we did not hear that today from the Wilcannia residents from the local Aboriginal community there. They were saying that there have been recent suicides of young people and that is not unusual.

Mr AGIS: Certainly I have heard that and certainly will be looking to both communicate—I think that there is fairly enough communication there as well—in terms of what is available and also looking to invest in the gaps that the communities have spoken about.

Ms CATE FAEHRMANN: On the absolutely terrible health situation in Wilcannia, I have just asked about KPIs and I suppose what I am trying to get is some idea of the level of priority to address the suicide rate in Wilcannia for starters.

Mr AGIS: It is an absolute priority. Our Aboriginal communities still have the worst outcomes, and that has not shifted. There has been slight improvement but not to the level that we would expect. It is an absolute priority both of the Government and of course the LHD. To say anything else would be really understating or denying reality.

Ms CATE FAEHRMANN: What further support will they get, recognising that suicides are still happening? We have had witnesses today saying that they do not have mental health support workers that are needed in Wilcannia. That is just one example I am assuming. What additional support are you advocating for in this area? What is there at the moment is not working.

Mr AGIS: Sure. We have been keen to engage the community and really explore where the gaps are. We have a number of services already on the ground provided by a number of services. I did hear that that is not clearly meeting the need. I think we need to obviously meet the community and understand more in terms of where we can target more services. As I said, we have received a number of, if you like, funding from the ministry during COVID, and it continues to be the case. We have embedded in our community support teams during COVID, mental health clinicians for both adults and children. We are aware of the need. As I said, it is an ongoing challenge. We will continue to look at ways of investing and meeting the gap.

Ms CATE FAEHRMANN: I will just move on. We have heard from a number of witnesses that there is not a Broken Hill drug rehab centre. Dubbo is about 700 or 800 kilometres away in terms of people accessing that service. Again to the CEO, are you advocating for a drug rehab centre in Broken Hill either to NSW Health internally or to the Minister?

Mr AGIS: The short answer is yes, but the long answer is a bit more involved. In my previous life I was head of drug and alcohol services in Tasmania, so I have got some understanding of the complexities of the service. There are two parts to it. One is the withdrawal, which we do, but that is clinical in dimension and we use our hospitals for that purpose because it has to be supervised by a clinician. Then there is the other, which is residential rehab. Often those services are managed by NGOs rather than clinical services. Clinical services tend to provide clinical input and guidance but not necessarily run them. A recent application was made. It is a joint proposal that puts both to the Commonwealth and the State through our local PHN to actually look at developing a hybrid model. Those details are not clear yet because we want to get the funding first.

But as I said, there is an absolute commitment. We know that it is a challenge for our community. People are going to Dubbo and they also go to Orange, Narromine and South Australia. It is not a satisfactory answer—absolutely not—because engagement of people in this journey is so critical. You can have the withdrawal but you need to be able to marry that with the rehab, particularly for certain clients. To get someone to undertake the journey to Dubbo or Orange, they have to be highly motivated, and we do have those, absolutely, but there are those for whom travel may be a disincentive and we need to really minimise that and capture that moment. We are committed to creating a facility within far west.

The Hon. TREVOR KHAN: Just to follow up on that, Mr Agis, if there has been a funding proposal that has been put forward to the State and the Commonwealth, are you able to share with the Committee that funding proposal?

Mr AGIS: Actually, we are not the lead agency for that; it is actually the PHN. They have taken the lead, so I do not have access to the actual funding proposal details.

The Hon. TREVOR KHAN: I accepted from your previous answer that you were not the lead agency, but if you can, it would be very interesting to see it. If you can get it, we would love to see it, if I can put it that way. But it requires your cooperation and the PHN. It is the sort of thing that I suspect the Committee would like to support if we can. Can I just go on to some specifics, and, again, I am going to talk about Wilcannia. I am getting old, but it has been many years since I have been there. It would have been 10-plus years since I have been there. It was concerning when I was there then. Plainly, nothing has got any better than when I was there. Let me ask you this, you have got an MPS there, is that correct?

Mr AGIS: That is right.

The Hon. TREVOR KHAN: What facilities are available at that MPS?

Mr AGIS: We have a number of aged-care beds and an emergency unit [EU] service for low-level, if you like, category three, four and five. The acute-care obviously get transferred to Broken Hill, a tertiary hospital.

The Hon. TREVOR KHAN: That it is understandable.

Mr AGIS: And then we have a number of what we call sub-acute beds as well in Wilcannia.

The Hon. TREVOR KHAN: What is the level of population that is required to, for instance, support a renal dialysis chair or bed, depending on how you describe it? There is not one in Wilcannia, is there?

Mr AGIS: No, there is not. I guess it is a function of demand, certainly, to make it work, but also you need to have the right clinical environment to deliver that service safely. At the moment we have, I think, two of our residents from Wilcannia and we also have two residents from Menindee who come to Broken Hill for their dialysis service.

The Hon. TREVOR KHAN: Sure, but Menindee is an hour away, as I understand. Wilcannia is two-plus, am I not right?

Mr AGIS: Yes, that is right. In fact, I think it is probably more like 2½ hours if you drive safely.

The Hon. TREVOR KHAN: Indeed.

Mr AGIS: If you drive fast, it is that bit shorter. But it is a significant impost, we certainly acknowledge that. What I will do, in terms of the clinical safety element, is to keep it in simple terms around what we can and cannot deliver in some of our, if you like, remote sites. I will get Dr Smart to speak about the clinical aspect of it and the operational elements within that.

Dr SMART: Thank you for that. There are some constraints in terms of being able to deliver the renal services, the haemodialysis in particular, in those remote areas. We are contracted to the Royal Adelaide Hospital for our renal services. They looked at and took into consideration being able to provide their specialist care or outreach to these small areas and found that they cannot do it. We do not have a neprhrologist support out there, that is the first thing. The second thing is that the other trained staff, like nursing staff, renal staff et cetera—once again, there is a recruitment retention component. We do have the capacity in some of those smaller areas for people to do their own home dialysis, home care. The two cases in Wilcannia, for example, one for medical conditions—in terms of medical conditions, the public patient is unable to do that and is required to come to a proper satellite unit like Broken Hill for their service. The other one has been offered the opportunity to be trained—and does require training—in home care, has declined to accept to do that and has chosen to come down here.

The public patients in terms of the other areas where we offer that, the majority of the individuals who we are dealing with have multi-organ failure and, in particular, cardiac complications, which preclude them from the home dialysis care, and they have to be very carefully chosen and trained. It is a combination of a lack of pathology unit support, trained staff onsite and then the ability to the able to get them to do the home dialysis care, provided they meet the criteria and accept the training. But the vast majority of our cases—of the two in Menindee and the two in Wilcannia, only one was eligible and declined because they felt that they could not cope with the training, for example. So it has been a significant challenge.

The Hon. TREVOR KHAN: I think I am principally talking about in Broken Hill, on the basis of what we have heard already, but what percentage of your frontline medical workforce is Aboriginal? It is directed at you, Mr Agis. You are the best one to ask.

Mr AGIS: I have got the numbers here. I will see about the medical but—did you ask medical or in general?

The Hon. TREVOR KHAN: I am interested in essentially your medical and allied health professions.

Mr AGIS: I cannot give you the breakdown of the specific disciplines, but what I can tell you is 6.5 per cent of our total workforce is made up of someone of Aboriginal descent.

The Hon. TREVOR KHAN: Mr Agis, I am not being dismissive of the intent to provide employment to Aboriginal people. In fact, that is great. But am I right that in terms of the whole of your health district, is it 12 per cent who are Aboriginal?

Mr AGIS: About 13 per cent, actually.

The Hon. TREVOR KHAN: It is one thing to have people employed as catering or cleaning staff, it is another to have them in health and allied professions where they might work in country and stay. That is what I am interested in seeing. What are you trying to do to build a stable workforce with people who the Aboriginal community might relate to and aspire to become themselves, if that sounds in any way coherent.

Mr AGIS: It does, certainly. My apologies, I did not want to give the answer [inaudible]. Again, I can take that detail on notice. But in general terms, we have a number of Aboriginal health practitioners within our service. I know for a fact that Menindee has a number of them. We have at least one nurse unit manager. In fact, the Wilcannia nurse unit manager is an Aboriginal person.

The Hon. TREVOR KHAN: That is good to hear.

Mr AGIS: We also have a number of Aboriginal liaison officers, if you like. We also have a number of training positions. At the moment, for example, we have school-based training. If I can give you an example of the kind of pipeline, if you like, of training, we have had Aboriginal young kids as part of our program starting working for us. Whilst they are doing year 11 and 12, they come and work and do admin. They go to acute sites and do some admin work. They get a sense of it and they actually become AINs, assistants in nursing. We also have a number of them who then become trainee nurses. We currently have a number of those studying to become nurses. At this stage I might throw to Ms Sutton because a number of trainee programs come under Ms Sutton's leadership. If I can get Ms Sutton to cover that.

The Hon. TREVOR KHAN: We would be very interested, thank you.

Ms SUTTON: We run a school-based apprenticeship and traineeship [SBAT] program, which Mr Agis has just described. Currently we have 20, but the majority are doing either certificate II, which is Aboriginal health studies, to then move on to become an Aboriginal health worker or an Aboriginal health practitioner. Eight out of 20 are Aboriginal and we support them in that role over the two years. We offer assistants in nursing. We have got quite a few Aboriginal nurses who are assistants in nursing and they are currently undertaking studies externally with South Australia and campuses like Charles Sturt University, which offer a fantastic external program. We employ them as AINs as we support them to undertake enrolled nursing because we have a TAFE here, and we support them through that pathway and then on to undergraduate. We provide two Aboriginal cadetships, that are supplied by Premier and Cabinet, and we have two students who work with us in the school break and go to university in Adelaide through the school year. They are paid an average wage while they are at university, earn book studies and assistance with education. There are quite a few different pathways into nursing, and we do have Aboriginal nurses.

The Hon. TREVOR KHAN: Ms Sutton, is there a target in terms of—this is the adjunct to the question I was asking Mr Agis. Is there an adjunct to the number of allied and health professionals that the health district is seeking to employ who are Aboriginal?

Ms SUTTON: I will have to take that on notice. I will hand that over to Mr Agis.

Mr AGIS: If I can just add to that, certainly our board's view, which obviously we support, is that we want to match the actual overall number of Aboriginals employed in our services—13 per cent. In terms of how that breaks down, to be honest, we have not really set targets within that, but I think that is a really good point. Although we have a view that we need to have Aboriginal health workers right across all disciplines, we have not set targets as such, but I think it is something for us to really consider.

The Hon. TREVOR KHAN: Wes, did you want to ask in terms of—

The Hon. WES FANG: I did, thank you. If you would not mind, I just wanted to ask briefly about the issue of telehealth, which has become a bit of a common theme during this inquiry. In the short time we have available, I just wanted to see if you have some positive examples of how telehealth has actually provided support to the patients in the far west of the State and how it may have made a difference in, for example, telestroke patients or the like.

Mr AGIS: I might ask Dr Smart to take this question.

Dr SMART: We have a comprehensive program we have developed. Some of it has also been ad hoc during the COVID time, clearly because we did not have all the subspecialists coming out, particularly the 17 specialists who could not visit us from Adelaide. So we have been providing services here to our outpatients on a virtual consultation [VC] basis to try to keep up with their patients. That was a less formal one. We have a number of formal projects going at the moment. One is the chronic respiratory diseases one, which is one where their service is provided by VC and monitoring provided by VC to the peripheral sites. There is the mental health service as well, which is provided, particularly around the drug and alcohol. So that is another service. We are in the process of developing once again, or transferring literally from broader Adelaide to Sydney, the telestroke project. We are still running that with Adelaide but early next year we will be converting to the Sydney-based service, which they will be providing us.

We have the e-intensive care unit [eICU] project. We had an interim project during the COVID time, which we managed to get in place to support us, and that is 24/7 cover with our intensive care unit, availability of a COVID physician 24/7 and MDT meetings, or multidisciplinary team meetings, and ward rounds, so to speak, on a daily basis. We are now formalising that in a project, which has been funded by the New South Wales Government, and we will have a formal, comprehensive eICU program in place with the Royal Prince Alfred Hospital. The official commencement date—in fact, our update is 14 February next year. We actually anticipate we will probably have that in at the beginning of February, and the model of care has been finished. The technology behind that has been sorted, and now we have got to the sponsors' approvals, to CEO sponsors. These are a number of the, shall we say, fairly significant projects that we have.

We are also working on, obviously, the formal delivery of outpatient services or ambulatory services. That is not only professionals sitting here providing services out in the community but it is also where there are some services that they cannot visit or are unable to visit or can only visit intermittently. We look after the patients at this end and they provide the service from wherever they come from. There are a number of those projects going on as we speak at the present moment. We are also looking at other technology enablers as well to see if we can develop those. We are looking at, for example, like Queensland has with its cardiac patients, real-time monitoring of cardiac patients, real-time monitoring of respiratory patients et cetera. For example, if they get into

trouble, we can contact them immediately and, if necessary, retrieve them and bring them into Broken Hill and/or take them to one of the peripheral sites, where either RFDS, Maari Ma and potentially in the future people like the Coomealla Health Aboriginal Corporation go. The Coomealla Aboriginal health service down south will be able to, obviously, provide services on site as well.

Mr AGIS: If I can just add the comment, obviously telehealth is not a new concept. It has been around for many, many years. It is one of the key, I guess, platforms that rural communities have been using, remotely have used for a long, long time. I think it is an adjunct and not a substitute, if I could just make that point clearly.

The Hon. TREVOR KHAN: Hear, hear!

Mr AGIS: Secondly, without it, we would be significantly curtailed in terms of meeting our goal of local access. If I can give you an example—you asked for an example—imagine somebody who is actually becoming acutely unwell in a very small community. That happens quite regularly. I am talking about from a mental health point of view. We do not have psychiatrists in small communities. What we do have, we can provide the assessments through telehealth, through a screen. We can actually engage a psychiatrist right away, do an assessment and then refer that person. If that person requires inpatient treatment, we get them treated quickly—out of there, through RFDS, to one of our facilities. That is just one example where we actually do use telehealth to, if you like, increase access. Without that, that person would have to be driven somewhere and not necessarily get the service they require.

The Hon. WES FANG: Thank you so much for that input. Thank you for providing some positive experience to the telehealth input into this inquiry, because we have seen quite a bit of negative commentary around it. I do believe that there are many positive aspects, and I thank you very much for providing that evidence to us today.

The CHAIR: Just before we go, the Hon. Walt Secord needs to clarify a matter that he raised in a question. I defer to him to raise what he wants to.

The Hon. WALT SECORD: In my opening statement, Mr Agis, I referred to a number of cases. What is the status of the case of 18-year-old Alex Braes, who died of an infected toenail, and of the newborn baby Alani Clark, who died.

The Hon. TREVOR KHAN: Point of order: That is not a clarification of a point. It is a new line of inquiry. Each group has been given a designated period of time. What we are going onto here is something, really, entirely new. It may well be something that can be put on notice, but otherwise the length of time that may be required to answer this will take us well and truly beyond what was proposed.

The Hon. WALT SECORD: To the point of order: When I was asking these questions in my block, the Hon. Trevor Khan took several points of order and gave lengthy explanations, which cut into my time. I was going to provide these examples and then ask a question that brings them together. If they decide to take it on notice, that is fine, but I would still like to—

The CHAIR: If I allow some latitude to draw this to a conclusion, I am not quite sure how much further you are going to extend beyond those couple of examples that you have given. I will provide a little bit of latitude, but the fact is that if there is quite a long list, it will take a long time to answer. So let us see.

The Hon. WALT SECORD: Let us go back to what were formally called "sentinel cases", and I will end it at that. I would like to know in the last financial year and in 2017-18, 2018-19, 2019-20 and 2020-21 and the current financial year, how many—you gave them four classifications, but I think we can all agree what were formerly known as "sentinel events" occurred at Broken Hill hospital? I will leave it at that. Thank you for your time.

The CHAIR: Once again, thank you very much for making yourselves available this afternoon. Obviously, you are all very busy in your important roles with respect to the Far West Local Health District. I appreciate the frankness of your comments and your responses this afternoon. There will probably be some follow-up questions, which are questions on notice or perhaps even supplementary questions as well. The Committee secretariat, if it is agreeable, will liaise with you in regard to those. There is a 21-day turnaround period for them. On behalf of the Committee, thanks very much for coming along and participating remotely in our hearing this afternoon.

Mr AGIS: Thanks for the opportunity.

(The witnesses withdrew.)

The Committee adjourned at 16:44.