REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

CORRECTED

Virtual hearing via video conference on Friday 10 September 2021

The Committee met at 9:15.

PRESENT

The Hon. Greg Donnelly (Chair)

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

The CHAIR: Good morning and welcome, everybody, to the ninth hearing of the Portfolio Committee No. 2 – Health inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. My name is Greg Donnelly and I am the chair of the Committee and this inquiry. 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 respects to Elders past, present and emerging of the Eora nation and extend that respect to other Aboriginal people viewing this broadcast all around the State today.

Today's hearing is being conducted virtually. This enables the work of the Committee to continue during COVID-19 without compromising the health and safety of members, witnesses and staff. As we break new ground with the technology I ask for everyone's patience during any technical difficulties that we may experience today. 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 are hearing from a number of stakeholders including private citizens, peak bodies and universities. I thank everybody for making the time to give evidence to this important inquiry. Before we commence I would like to make some brief comments about the procedures for our hearing today. Whilst parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the virtual hearing. I therefore urge witnesses to be careful about comments you make to the media or 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.

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

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

ELIZABETH HAYES, Private citizen, sworn and examined

JAMELLE WELLS, Private citizen, sworn and examined

The CHAIR: Thank you very much to both of you. I commence by welcoming both of you sincerely. I would like to make some general comments for everyone listening just to set some context for this evidence which we are about to receive. These two women who are joining us now to provide evidence are well known to many of us—indeed, to many Australians. They are both well known for their lengthy involvement in the media, journalism and the public square. They are highly regarded by their peers in particular and the Australian public in general for their astuteness, professionalism and decency in the way in which they have gone about their professional work as journalists and commentators. They have highly well regarded reputations. I make the point, though, that both are daughters of what were and have been and always will be outstanding men—senior Australians in this State who died in tragic circumstances. It is on the basis of those experiences that both bring evidence to the inquiry.

The circumstances of their respective fathers' passing were tragic and difficult and none of us would want to find ourselves in such circumstances. I would like to take the opportunity on behalf of the Committee to thank you both for your strong public advocacy on the matters that you have brought before the inquiry. It was the advocacy from both of you that, at least in part—perhaps not an insignificant part—has contributed to this inquiry being undertaken, so I thank you both very much. We will commence now with an opportunity for both Ms Wells and Ms Hayes to make a short opening statement, which will provide the maximum opportunity for questioning by Committee members. I note for the record that with respect to both our witnesses, your submissions have been received and stand as evidence to this inquiry. I am sure you are aware of this, but, Ms Wells, your submission stands as submission No. 351 to the inquiry and, Ms Hayes, your submission stands as submission No. 613. Take those submissions as read; the Committee has read them and studied them. I will invite both of you now to make a short opening statement and that will be followed by some questioning. We will start with Ms Wells.

Ms WELLS: Thank you, Committee, for asking me to speak today. I am a journalist at the ABC and I am giving evidence at this inquiry as a private citizen. My submission, as you know, is about my father, the late Allan Wells from Cobar. All eyes are on country towns in the State's west right now because of the threat of COVID. There is concern and panic about hospitals not having enough resources. It has even been called a humanitarian crisis. This was a reality before COVID and I experienced it with my 85-year-old dad two years ago. You know from my submission the ordeal that he was put through after being flown to Dubbo Base Hospital to have a broken hip repaired. I thank the frontline staff who tried to help him, but they were unsupported in a big base hospital that was overburdened and under-resourced.

There were signs from the start that the hospital could not cope, and my dad was treated like a bed-blocker. He had two operations in five days after something went horribly wrong with the first one. The wrong surgeon's name was above his bed and in his records. Just hours after we fought an attempt to discharge him, he went into cardiac arrest. Staff then suggested not resuscitating him, even though he had a full resuscitation plan in place. My dad defied their expectations and he pulled through. What happened next was inhumane. Dad begged for food and water on a long weekend because a manager said the hospital could not afford to roster someone on to do a sip test to see if he could eat and drink safely.

Soon after that I read a front-page story in a Dubbo newspaper about a new $30 million car park for Dubbo Base Hospital. You have a copy of that story. How a decision gets made about using hospital funding in that way just beggars belief. I still cannot get my head around it. My father's ward ran out of morphine; it ran out of Panadol; staff were stretched beyond safety limits. An unsupervised junior intensive care unit doctor fought back tears over the distress he caused Dad by three botched attempts to insert a tube in his nose. Staff with no geriatric care training wrote "dementia" in Dad's records, even though he never had any reason to be diagnosed with it and he passed all hospital mental acuity tests 100 per cent. Dad was bundled out of Dubbo hospital back to Cobar by road ambulance in 40-degree heat. He arrived in Cobar at night and "not to be returned" was written on his discharge papers. He was soon discharged from an empty Cobar Hospital too.

The health service continues to be defensive. Staff tried to exclude my concerns from a review that was ordered by the Minister. I was charged $600 for medical records that are shambolic; they have a blood checklist missing, and records of another man mixed in with my dad's. I get daily correspondence, almost, from other families and overworked hospital staff in this area. They have some expectation that because I have spoken up I can help them, and some of them are too scared to speak up, but I do not know how to help. What I do know, Committee, is that my dad deserved better and other country people deserve better too. Thank you.

The CHAIR: Thank you very much, Ms Wells, for that very clear and precise opening statement. Ms Hayes?

Ms HAYES: Thank you very much. I am a journalist with the Nine Network. I would also like to thank the Committee for this opportunity to speak, although how I find myself here gives me no joy. You have read my submission so I presume you, too, wonder how in a hospital in Australia in the twenty-first century my father could firstly be overdosed on his prescribed medication and then, unbelievably, die after not receiving his essential anti-stroke medication. Both hospitals where my father was treated acknowledged their errors. Both said they would be making changes to ensure that what happened to my dad would not happen to someone else's family. But here we are, two years later almost to the day, and I am not filled with confidence, and now there is the other "c" word—COVID. How dreadful that it takes a virus that not even the biggest hospitals in Sydney can cope with to expose the substandard health care for people in rural areas.

The people of the Manning—a region with the oldest demographic in Australia, with the worst cardiac outcomes and a large Indigenous population—have good reason to be concerned. Just isolating patients in their 50-year-old hospital will not be easy. More than a few patients with COVID, I am told, would be a disaster. Staff are rightly nervous. The corridors of the hospital are so narrow, for example, they can barely do their jobs without physically running into each other. And then all the other regular horror stories and Health Care Complaints Commission [HCCC] investigations continue. A woman was taken to Manning hospital's emergency department. She told me that despite feeling very unwell and fearing she had COVID, staff decided she should go home. Without transport and living a half-hour away, she was handed a bus schedule. She lay on the grass outside the hospital while she waited for an elderly neighbour to come and pick her up. Her GP then had her admitted to Forster Private Hospital, where she spent a week being treated not for COVID but for pneumonia.

And it is not just patients. I saw an internal email just this week talking of patient safety being compromised because of serious staff shortages. In that email a doctor asked, "Why do we have to wait for a disaster to be reported to the media or the HCCC to act?" So who is not listening? The Committee heard in Taree evidence that at Manning hospital cleaners had been asked to sit with dementia patients. That was not something the CEO of the Hunter New England Health District, Michael DiRienzo, thought was true, yet I have cited an email from management at Manning hospital saying staff should make use not just of cleaners but wardsmen, administration staff, families, and even other patients to be sitters. So why would Mr DiRienzo not know or why would not someone tell him how bad things are?

Since telling our stories, Ms Wells and I, as she said, have had literally hundreds of people contact us and also our colleaugue at the Sydney Morning Herald, Carrie Fellner. People are angry, frightened, frustrated and feeling very alone, and if they are health professionals they believe speaking out will cost them their jobs. It is my opinion it is time for someone to own this issue. The buck must stop with someone, and that someone has to change the rural health model because it is not working. You know that; I know that. I am sorry but it is a very sick rural health system. Thank you.

The CHAIR: Ms Hayes, thank you very much for that very concise and clear opening statement. We will move now, if the witnesses are agreeable, to questioning. We have members from the Opposition, the crossbench and Government, and with the remaining time left to us through to 10 o'clock we will divide that time equally between the three groups. The questions will proceed and will rotate through the three groups. Are you both agreeable to that format?

Ms HAYES: Yes.

Ms WELLS: Of course.

The CHAIR: Thank you both once again for appearing. We will commence with the Opposition, the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you, Mr Chair. Thank you, Ms Wells, and thank you, Ms Hayes. I also wish to echo the Chair's comments at the very beginning. I know as daughters it was very difficult for you to come forward. I know that you can take heart in the fact that the passing of your fathers played a role in you going public in this inquiry and the establishment of this inquiry. That is something that I think you should take away. Ms Hayes, I acknowledge that tomorrow is the anniversary of your father's passing, so thank you for coming forward too, especially at this very difficult time. We make recommendations based on the evidence that we receive. Both of you have been following this inquiry, and I can tell from your submissions that you have made today that you have been continuing to follow it. What recommendations would you like to see this inquiry make involving rural and regional health? Ms Wells?

Ms WELLS: There are so many. I think the main thing that people who are contacting Ms Hayes and I are feeling is that they cannot speak up about what they want. That includes patients, it includes grieving families and it includes staff—most importantly, frontline staff working in regional health. They say they do not have enough resources. They say they are told to discharge patients too early. They say they have to work under

management quotas and percentages and budgets that are dictated to them. They say they fear for their jobs if they speak up about what they need at the front line to get the job done. So the main thing I would like to see is more transparency and people—from staff to patients—feeling that they are more empowered to speak up and tell it like it is and for the area health services to not be so defensive about that. What we are getting in the media and what we have had since my dad passed away two years ago is this constant spin about how everything is all right. Ms Hayes and I have been even portrayed by some as grieving daughters who cannot let go. Well, that may be true, but we have had hundreds of letters and emails and phone calls from other people in our position in country towns and they really do deserve better. They pay the same taxes as we who live in cities pay.

The Hon. WALT SECORD: Ms Hayes, what recommendations would you like to see? And I do have to admit that I re-watched the documentary on both your fathers last night and, sadly, a year later we are still in the same situation. Ms Hayes?

Ms HAYES: Yes, it is sadly that we are in the same situation. I echo what Ms Wells says: We have had, literally across the board, patients, health workers—you name it, anyone who has been within the health system—come to us and ask us to tell their stories because they are fearful of speaking up. I was shocked at experts, and doctors in particular, fearful they would lose their jobs and I wonder why. What has happened that in an environment for everybody, where the common good is what we are talking about here, people are frightened to speak up because of repercussions? Clearly I am seeing that there is a toxic environment where people cannot speak their truth in an orderly fashion, obviously because they do not trust the system. So they have lost trust in their ability to speak up; they do not believe that anyone is listening and they believe there will be reprisals for speaking up.

I think we found during our investigations there is seemingly a disconnect, and I raised Mr DiRienzo only because I would think he would want to make things much better. But how come he is not aware of these things? Why is someone not able to go and say, "We have got cleaners being asked to sit with patients"? What has happened that there is this conversation that has gone out the window? Bureaucrats are feeling as though they just have to take control of a massive situation and do their best, I guess, but in the end what has happened? Why are people not able to speak up and why do bureaucrats or health Ministers not know about this? I am shocked by that.

The Hon. WALT SECORD: Ms Hayes, in your opening statement today you made mention of an email in relation to patient safety and cleaners asked to sit with dementia patients, and then you made the extraordinary claim that staff were encouraged if they could find patients to look after other patients or monitor them. How recent was that email? I understand confidentiality, but is that a recent email or is that from several years ago? When was that from?

Ms HAYES: That email that I have cited was in 2018 and it was sent to staff. Clearly, there was a meeting which took place to say things were not good. So I investigated; I looked at this email, which mentioned wardsmen, cleaners, administration staff and, not only that, other patients to maybe sit with other patients. And then I was told just very recently administration staff have been asked to do that as well—the secretary. So it is not like anything has changed. And the horror of that is not that people are being—well, the horror is that they are being asked to do it, but nothing has changed. Nobody is seemingly allowed to speak up. I think if this was in Sydney or Melbourne, we do know that that would be a front-page splash. That is just an appalling scenario.

The Hon. WALT SECORD: Absolutely. Ms Wells, you mentioned COVID and people now describing it in western New South Wales as a humanitarian crisis. Has COVID, in fact, put the spotlight on the state of far western New South Wales and western New South Wales health? And what is the latest information you have?

Ms WELLS: It has because people are now asking why are there hospitals out west that have no permanent doctors? They are asking why are people being triaged in hospital car parks? I heard—and you have probably read about the story a few weeks ago—a woman waited in a hospital car park at Walgett in winter for about four hours waiting to get triaged before she could get an appointment with a doctor via telehealth because there was no doctor at the hospital. People were shocked by that. I was not shocked by it because I have known for years, and since going through this with my dad, that there are brand-new hospitals out in the west that do not have permanent doctors. They have no patients, some of them. There is a saying that is now going around my dad's home town of Cobar. Whilst there are some excellent staff at the hospital, some excellent nurses, they are saying it is the hospital with no patients because people are not allowed to stay there for very long. And we have heard at this inquiry those frontline staff in many country hospitals out west are without basic tools and equipment: suturing kits, blood, antibiotics.

My father's neighbour in Cobar, who had toes amputated because he was not given antibiotics in a timely fashion, was chatting to me the other day and he said, "I don't want to speak up about the care we don't have anymore because I am frightened. My family have to go back to that hospital." He said, "You and Liz Hayes lost

your dads. I only lost my toes; I can live without them." That pulls at my heartstrings because it tells me that people out in the bush are content with getting second best. I feel, Mr Secord, in a very privileged position because I grew up in that little town and I moved to the city, where I can walk into any big, busy public hospital and although the staff are run off their feet I get the basic health care I need and I get it in a timely way. My friends and relatives still living in the country do not get that.

The Hon. WALT SECORD: Ms Hayes, how do you feel when people say that there is a two-tier system and country people should move to the city if they want to get proper treatment?

Ms HAYES: I understand it. I hear that a lot. I hear other doctors say it from regions in rural areas. I feel like we have let our country families down. I feel they are second-class Australian citizens when it comes to health. None of us wanted that, none of us intended that, nobody wants to hear that, but that is what has happened; that is where we are. The Committee must know that by now. You have heard so many stories; you have heard as many as we have. It is not about beating someone up here, although you do feel like you have to do that sometimes. It is about saying loudly, all of us, this is not good enough. Country people do not expect the open-heart surgery unit to land at their doorstep; they just want really basic, good care, and I think we all agree on that. I do not think there is a member of the Committee who would disagree with that. What I am saying is that that is where we have arrived. You cannot afford to live in the country. People make decisions about living in the country because of health, or lack of it.

The Hon. WALT SECORD: Thank you, Ms Hayes, and thank you, Ms Wells. My time has expired.

The CHAIR: We will move to the crossbench now. The Deputy Chair, the Hon. Emma Hurst.

The Hon. EMMA HURST: Thank you, Chair, and thank you both for coming today and for sharing your story. I am very sorry to hear about your experiences as well. Ms Hayes, we have talked a little bit about the fear of people coming forward, and in your submission you also talk about whistleblowers who have experienced threats and warnings for coming forward. Where are these threats and warnings coming from? How is this happening in play?

Ms HAYES: How it is landing on my doorstep is when I ask doctors or health professionals generally to speak up, and without exception every one of them is nervous and every one of them says that there will be reprisals. The reprisals come in the form—when I ask who and how—of you will be perceived as a troublemaker; you are bringing trouble to the town; you are causing bureaucrats difficulty; you are saying management is not good. That is how the perception will be and therefore you will not be re-signed—your contracts will not be re-signed. You will suffer and therefore your patients ultimately suffer. And that is the balancing act of a lot of medical practitioners in particular. It is that balancing act: "Can I afford to cause trouble", if you like, "because if I am sent out that is a whole lot of other patients who have not got a doctor again or a specialist, even". So it comes in the form of from up above. I mentioned this to Brad Hazzard, the health Minister; he said he did not believe that was true. I can tell you it is true; they are very much of the opinion that they cannot rock the boat. And this is not just recent times; this is for a long time now.

The Hon. EMMA HURST: Ms Wells, you mentioned that with your own experience you were trying to investigate exactly what happened but that you were still struggling to even find answers, even though you had this background as a journalist. You talked a little bit before about transparency. Can you talk a little bit about how this system is failing to provide people answers when things do go wrong? In your experience what do you think is happening there?

Ms WELLS: I think there is a culture of cover-up. I think my own experience was that I was charged $600 for medical records for my dad, who was a pensioner. They were my dad's property; they were family property. The fee should have been around $30. That fee would stop most people from getting their loved one's medical records. Key documents are missing from those records—a blood checklist. Surgeon's reports had inadequate information. There are wrong names on those medical records. So I think most people would not even have the nous to do that. They would go, "$600—I can't afford that." There was a ministerial review of experiences at Dubbo hospital that the Minister called for after media reports about my dad and other patients.

The health service had a team go and visit various hospitals and a meeting was scheduled with me one working day before they were to report back to the Minister. At that meeting I said to them, "Are you serious? You have got one working day to take my feedback and give it to the Minister", and they said, "Yes, we will extend the deadline because you are giving very good information and it is very serious." Then I got an email from the western area health service, from an executive, a couple of weeks later saying, "We actually couldn't fit your feedback into the report for the Minister." So I had to call on the Minister to intervene, which he did; I wrote to him and he responded to my request. So that gave me not a lot of confidence that the area health service is

willing to seriously take the feedback on board and make real changes and incorporate patients' and families' feedback in those changes.

My feeling is that every time there is a negative story or a patient speaks up about something that has gone wrong, there is a whole lot of good publicity that goes out to try and sort of cover it up. Well, that is all very well, but it is not changing things. This is just a cycle that continues. I also got a report back from the Clinical Excellence Commission on that review that the Minister had ordered. There were errors in that report, which does not give me a lot of confidence in the review process. So, to answer your question, I am still looking for answers about what happened to Dad. It is as if no-one wants to take ownership for some of the things that happened to him when he was in hospital.

The Hon. EMMA HURST: Thank you both. My time has expired.

The CHAIR: Thank you very much. Cate Faehrmann.

Ms CATE FAEHRMANN: Thanks, Chair, and thank you both for appearing today. I wanted to continue that line of questioning. We do not have much time to ask questions of you, unfortunately. What you are saying, Ms Wells, is essentially that there is something within the health bureaucracy, which, instead of looking for ways to find solutions and improve the health system, is trying to almost—I think you used the word "cover-up"—cover up the extent of the crisis in our rural health system. Is that what you are saying today?

Ms WELLS: Yes, that has been my personal experience, and I will give you an example. The western area health service, every time a complaint or an issue is highlighted, will put out a patient survey and they will say 90 per cent—that is not an exact figure, but they will say, "Most people surveyed are happy with our service." I was in Dubbo Base Hospital when one of those surveys was conducted. A trainee nurse came to the ward with an iPad and looked at my critically ill father and said, "Can you answer these questions? Are you happy with the care, with the food?" And, of course, a frail, old person who is critically unwell in hospital is going to say, "Yes, yes, yes." They are too scared to say "No" because they are worried about what will happen to them in the hospital. Our confidence was so low in the care our father was getting, we virtually slept at the hospital around the clock. We made sure a family member was staying with him because we had concerns about some of the care. Some was good and some staff tried very hard; I acknowledge that and I do thank them again, but a lot of it was very inadequate.

Ms CATE FAEHRMANN: Can I just jump in with another question on this? Are you both aware of the NSW Rural Health Plan: Towards 2021? This is a State Government plan that was in, I think, 2014-2015. Basically this plan to have this amazing health system by 2021 says in the introduction by the Minister at the time, Jillian Skinner, "Rural health is a priority for the New South Wales Government. We want to make sure people in rural areas can access the right care in the right place at the right time." How do you think they are going with their plan? I will go to you, Ms Hayes. Do you think their plan is a success?

Ms HAYES: I think it is obvious that the reason that you are here, that the Committee is here, is because there is a problem; it is not a success—it is absolutely not a success. If anything, I think the evidence would show, from at least the investigations Ms Wells and I have done, rural health has deteriorated. We have hospitals without doctors. Virtual doctors are okay in some cases, but that is the situation we are in now.

Ms CATE FAEHRMANN: Underpinning the whole health strategy, which was launched in 2011—basically the Government was saying they were going to reform the health system in 2011. There are four strategies underpinning it, and the four are workforce, research and innovation, eHealth and infrastructure. The only strategy that does not mention investment is workforce. Do you think that is a key reason why we are seeing such a decline in rural health: that the Government has not invested in the workforce? Is that what is going on?

Ms HAYES: I think that is part of the problem. Part of the problem—and we have spoken to many doctors about this, and medical professionals—is that everyone wants to go to the city and those who stay in the country do not have resources. They are not backed up. They do not have staff. Locums fly in and out; there is no connection with the local people. It does require staff and, Lord knows, there are so many staff there but they are all in the city. But it is about getting staff, yes, and getting staff to be prepared to invest in a country town.

Ms WELLS: Ms Faehrmann, can I just jump in there? As one of the nurses has previously told the inquiry, bricks and mortar does not save lives; it is people who do that.

Ms CATE FAEHRMANN: Thank you. My time has expired.

The CHAIR: We will move now to a Government member. Would that be the Hon. Wes Fang?

The Hon. WES FANG: Yes. Ms Wells and Ms Hayes, thank you very much for making yourselves available today. I note that throughout our hearings, particularly across rural and regional New South Wales, you

have been predominantly at the hearings. I think that is really valuable and important that you have seen the process and you have engaged at all stages, so thank you very much for that engagement. Ms Wells, I will start with you. I was listening to your testimony to the other members and you talked about some of the reports that have happened post the incidents that you have described. You talked about some errors in the report—I think it was from the Clinical Excellence Commission. Is that correct?

Ms WELLS: That is right, yes.

The Hon. WES FANG: Are you able to expand on what errors were in the report?

Ms WELLS: There was an incorrect surgery written in the report; some of the dates were incorrect in the report; and there was conflicting evidence in the report about who actually performed a surgery. So I wrote back to the Clinical Excellence Commission, to be fair, and pointed those errors out. They addressed them and sent the report back to me. But my confidence in the reporting process was knocked out from under me from the get-go when Dubbo Base sought to exclude my feedback from Minister Hazzard's review into some of the issues at the hospital. That gave me no confidence and I was being very defensive after that because I thought, "Why can't I speak out?" My dad was 85, but he was a good man and he paid taxes and he was as good as the other people whose families have been allowed to speak as part of the review.

The Hon. WES FANG: Thank you very much for that. Were the errors that you have identified corrected in the subsequent report that has been released?

Ms WELLS: As I mentioned, yes, the Clinical Excellence Commission got back to me, but only after I wrote to them again.

The Hon. WES FANG: Is there the opportunity for feedback with those people that are actually doing the investigation? Do you have the opportunity to meet with them and to discuss the issues? How does that process work?

Ms WELLS: Yes, you do, and I did have a lot of confidence in that because I was contacted by one of the review panel, a doctor from Orange Base Hospital, who phoned me one afternoon at home and said, "We are investigating what happened to your dad. Would you like to come to a meeting and tell us what happened and give your point of view?" So I was filled with a lot of confidence and I turned up for the meeting—it was on a Thursday afternoon—and I gave my feedback at the meeting. I had a time line of things that had happened to my dad. I had all the medical records. I had a long list of issues and unexplained things in the medical records. I was given a good hearing by that committee. There were two people—there was another doctor from a hospital in Sydney—and, as I mentioned, they said to me at the end of my feedback, "This is very serious. We are going to ask for the Minister's review to be extended so we can look into what you have given us very thoroughly and provide you with a full explanation of what happened." I then was gutted about a week later, Mr Fang, when I received an email from an executive at Dubbo Base saying, "Your feedback missed the deadline. We couldn't include your feedback in the Minister's review".

That is why, Mr Fang, I wrote to Minister Hazzard and brought it to his attention and then he did the right thing: He intervened and had that feedback included as part of his review. But, as I mentioned, that gave me no confidence in the review process from the start. And, remember, I am a journalist with over 30 years' experience, so I do not give up very easily on researching things and getting the right answers. Most people would not do that; most people would take that as a real kick in the guts and just walk away and say, "No-one really cares what happened, so I am going to stop there." Remember, country people are sometimes not good about speaking up and complaining or just highlighting things that are wrong, and my dad was one of those people. He was very stoic and very brave; they sort of take it on the chin. But I think it is wrong what has happened to my dad and a lot of other people, so I am not prepared to do that.

The Hon. WES FANG: I admire your determination. In fact, I have found that country people are usually very determined. I lost my father as well, so I can at least share the pain that you feel. In that instance then, given that you have got no confidence in the Clinical Excellence Commission's investigations, have you had the opportunity to, I guess, close that loop and feed back to them that you have not got the confidence and what you think might be things that they could actually do better into the future to not only look at the investigations but also give the family confidence that the situation is being looked at through the proper lens?

Ms WELLS: I have provided feedback in the letter to them pointing out the errors in their review. As you can appreciate, sitting through what has happened to a loved one at meetings with review panels over and over—it is traumatic. There is not a day that goes by when I do not think about what happened to my dad, and I am sure Ms Hayes does the same with her father. So sitting through that over and over is reliving that. I have done a lot of that already. I am prepared to give them more feedback. At the moment I am still dealing with the hundreds or thousands of letters and emails and phone calls and messages that Ms Hayes and I are receiving after coming

forward. To me, trying to get the voices of some of those people out there is very important. There are only 24 hours in one day but I am prepared to do more of that in the future, Mr Fang, yes.

The Hon. WES FANG: Thank you very much. I really do appreciate your evidence. I will pass to my colleague Mr Khan.

The Hon. TREVOR KHAN: Ms Wells, I am wondering if you have any comments with regards to whether the structure of the Clinical Excellence Commission could be in some way strengthened and made more transparent.

Ms WELLS: I do not know how to answer that, Mr Khan. My only experience of the Clinical Excellence Commission was to sit through that review process—to be called up on a Thursday afternoon by a panel to pour my heart out and relive everything that happened to my dad at two hospitals and put my trust in that panel to take what I had said to them back to the Minister and include it as part of a review, and then to have that trust betrayed in an email from the base hospital saying that I had missed the deadline. I might add that that review process was recorded with the consent of both parties, so I have word for word what was said and the promise that was made to me that my feedback would be included and that the deadline would be extended.

So I do not really know how to answer that. I have not studied the structure of the Clinical Excellence Commission in great detail. Perhaps it would be having more independent people come in on the review process. I met with a doctor from Orange hospital, which is in the same area, and a doctor from a Sydney hospital, and apparently there was a third person as part of that review panel from Dubbo hospital who I have never met and never spoken to. So whether it is that outside people come in and do those reviews—that may be something. I am not sure how to better answer your question.

The Hon. TREVOR KHAN: I was looking for guidance as opposed to anything else. In terms of the backwards and forwards correspondence that you have referred to, would you be prepared to provide copies of that correspondence to the Committee? I am not suggesting it would be published, but for the purposes of just getting some further background, noting our shortage of time.

Ms WELLS: I am happy to provide some of the letters that went back and forward to the committee. The documents are confidential, the review is confidential, so I would need to talk to other family members. I think the significant point is the letters that went back and forward. Remember, too, that doing all of this is exhausting. I have been letter writing for nearly two years and these letters have been going back and forward, and some of the letters I get back from Dubbo Base Hospital—the information changes every time I get a letter back. So just when I think I have got an answer to something, it will change in the next letter, which makes me think what is really the truth here? I think what grieving families and staff who are overworked want in these reviews is honesty and transparency and they want to have confidence that the review will be transparent and will honour what it says it will do.

The Hon. TREVOR KHAN: Thank you to you both.

The CHAIR: Thank you, the Hon. Trevor Khan. To both of you once again, on behalf of the Committee, I thank you very much for participating in the public hearing today. As I said earlier, the advocacy by both of you did play an important role in bringing this important inquiry about. It is our clear intention to produce a report with recommendations that will assist in bringing about the much needed improvement of health services and health outcomes for the citizens of regional, rural and remote New South Wales. Once again, on behalf of the Committee, I thank you both very much.

(The witnesses withdrew.)

(Short adjournment)

SCOTT BEATON, Vice President, Australian Paramedics Association (NSW) and Intensive Care Paramedic, Station Officer, Gilgandra Station, sworn and examined

LIU BIANCHI, Delegate, Australian Paramedics Association (NSW) and Intensive Care Paramedic, Extended Care Paramedic, Tuncurry Station, affirmed and examined

RYAN LOVETT, Chair, Australasian College of Paramedicine, affirmed and examined

ALECKA MILES, Chair, Rural, Remote and Community Paramedicine Special Interest Group, Australasian College of Paramedicine, affirmed and examined

The CHAIR: I thank our four witnesses in this panel for making themselves available. We appreciate that. We know that you are all very busy. I acknowledge that, with respect to the Australian Paramedics Association (NSW), you have made a submission to the inquiry. That has been received, processed and stands as evidence to this inquiry. That is submission No. 664. With respect to the Australasian College of Paramedicine, a submission has been received, processed and stands as submission No. 275 to this inquiry. All members have had the opportunity to study those submissions, and you can take them as read.

I now invite opening statements. The most efficient way, if it is agreeable, is to have just one from the Australian Paramedics Association and one from the Australasian College of Paramedicine. If in fact there was a desire for all of you to make an opening statement, that is okay, but we invite you to keep it a little bit shorter so that we can get through four of them, which would then open up the maximum questioning time for the Committee members. Are people happy to proceed on that basis? Thank you. Turning first of all to the Australian Paramedics Association (NSW), I invite an opening statement. I presume, Mr Beaton, you will be making that?

Mr BEATON: That is correct.

The CHAIR: Thank you. Please proceed.

Mr BEATON: Good morning and thank you for the opportunity to appear on behalf of Australian Paramedics Association (NSW) members. My colleague and I have combined ambulance experience of over 40 years. We have both worked in metropolitan and regional New South Wales and both of us are intensive care paramedics [ICPs]. This means we have extra skills and medications compared to the general practice paramedic. In my time as a paramedic I have seen New South Wales health system let down patients, let down communities and let down the paramedic workforce on countless occasions. I hope today that I can shed some light on some of the issues that exist on the front line. The ICP skill set is invaluable in regional and rural communities to provide the highest level of pre-hospital care available. In New South Wales over 80 per cent of ICPs are in metropolitan areas. The recent announcement of 203 ICPs over four years for regional areas is a great start.

However, with almost 200 stations across New South Wales, this is not a large enough increase. Our fear is also that the vast majority of these new ICPs will go to larger coastal emergency department [ED] centres and not to the smaller communities. It is in these environments that our skills, such as intubation and advanced pain relief, are desperately needed. The lack of funding for ICP positions for remote communities has been a detriment to paramedic wellbeing. Currently, any paramedic who wishes to become an ICP must move from regional to Sydney for two years before having to reapply for a position back in regional. They are effectively having to choose between their career and their family and community. While the latest announcement is heartening, we are scared paramedics will still be asked to relocate. Not having sufficient advancement opportunities in remote communities tends to result in high turnover of staff, which impacts both station morale and the trust built up between paramedics and the community.

All ICPs have been trained in new skills and equipment as a part of COVID-19 funding. However, those isolated ICPs in rural communities without new specialty equipment vehicles are not being able to apply these life-saving skills as the equipment is not supplied to them. Metropolitan stations and large regional towns such as Orange all received new vehicles and equipment in the most recent rollout, but rural communities continue to miss out. Two of the most vital pieces of equipment have a combined cost of less than $2,000. What does this say that rural communities are not even worth a $2,000 spending increase? I also wanted to touch on the broader issues facing regional paramedic work. I have never seen my colleagues, and I myself have never been, so exhausted.

We spend a lot of our time acting as a taxi service for NSW Health. This is not to say that patients do not need to be transported—they absolutely need to be in the right healthcare facility for their injury or illness—but much of the time we are transporting patients who do not require our level of clinical care. When we transport these patients we are taking the only resource away from a small community. For example, I frequently undertake transport that takes five hours overnight. I once undertook a transfer that took three days. When I am on these transfers there is no-one on duty or on call in my community. If someone has a heart attack, they have to hope

that there is an off-duty paramedic who is available and fit for work. There are only five paramedics who work in my station, and with two of them out of town your chances are slim. There is a solution ready made for this: our non-emergency patient transport vehicles and patient transport officers. They do amazing and vital work but they are not a 24/7 service and they generally only service major regional centres.

One of the biggest contributors to our workload is the lack of mental health facilities in regional areas. This is one of my biggest areas of concern for our patients as well. Right now at many stations across western New South Wales the closest declared mental health facility is two or three hours away. For example, Lake Cargelligo goes to Griffith for mental health patients. This takes the patient away from their support network, increasing their anxiety and often exacerbating their condition. Thank you again for your time today. I hope to be able to shed light on the issues that are impacting paramedics and patients alike in regional communities. We are really hurting badly. I look forward to sharing my experience with you and contributing to this important inquiry.

The CHAIR: Thank you very much, Mr Beaton. That was a very good opening statement—very clear and very precise. I move now to the Australasian College of Paramedicine. I was wondering: Was the intention that one or both of you would be making an opening statement?

Mr LOVETT: No, I will make the statement on behalf of the college.

The CHAIR: Thank you very much, Mr Lovett. Please proceed.

Mr LOVETT: Thank you, and thank you to the Committee for the opportunity for the college to present to you today. The college is the peak professional association supporting and representing over 10,000 paramedics and paramedic students across Australia and New Zealand. Our purpose is to advance excellence in paramedicine and out-of-hospital, patient-centred care across Australia. To the key question at hand, which is whether health outcomes and access to hospital services in regional, rural and remote New South Wales are appropriate, adequate and on par with metropolitan centres, the answer is clearly no. Demographically, we know that regional, rural and remote populations in New South Wales are older, poorer and suffer a greater burden of ill health and lack the access to quality and consistent health care, with a patient experience well below what is available in metropolitan areas.

As you have heard from my colleague Mr Beaton, rural paramedics attend to a wide variety of patient presentations ranging from critical, traumatic injury to chronic, complex geriatric syndromes in aged-care facilities. They respond to mental health illnesses, substance abuse and they are often there during the final days of a person's life, providing palliative and end-of-life presentations. Most of these attendances have traditionally fallen within the domain of primary and preventative care; however, due to the prolonged shortages of rural doctors and limited availability of community nursing, patients are increasingly being managed by the paramedic workforce in these areas. This is exacerbated by the lack of options for out-of-hours care and the geographical distribution of health services. Communities are increasingly relying on paramedics in the delivery of routine health care, particularly when primary healthcare services are difficult to access or not available at all.

The college is here today proposing the utilisation of community paramedicine, supported with a scope of practice focused on providing holistic, evidence-informed primary and preventative health care, in addition to our traditional role of urgent and emergent care. Community paramedics could be employed in the community by ambulance services, by local health districts, by private health clinics, all contributing and supporting the activities of other health professionals in delivering quality, patient-centred care. We propose that community paramedics would work as part of a multidisciplinary team, delivering team-based care in partnership with general practitioners, specialist community nurses, hospitals and local health districts. There are increasing numbers of successful national and international community paramedic programs that highlight the valuable role that paramedics can play in multidisciplinary team-based health care.

Importantly, whilst other healthcare professions are struggling with a shortage of graduates and staff, paramedics—as a recently registered health profession—have a glut of graduates who are unable to find work with the jurisdictional ambulance services. With a small additional education—generally a graduate certificate or graduate diploma—building on the extensive tertiary education that paramedics currently receive, community paramedics would be ideally placed to work in regional, rural and remote communities, playing a vital role in filling the primary healthcare gap. Thanks again to the Committee for the opportunity to present, and we look forward to discussing this recommendation with you.

The CHAIR: Thank you, Mr Lovett. That was a very good opening statement. It adds very nicely to the very valuable submission that has been made by the organisation. We will now move on to—

Ms BIANCHI: Mr Donnelly, sorry, but I also would like to have an opening statement. My opening statement is a little bit different to my colleague's. Would I be able to proceed?

The CHAIR: Yes. Could you let me know how long you intend to speak for?

Ms BIANCHI: Two minutes.

The CHAIR: Yes. Thank you for that. Please proceed.

Ms BIANCHI: Thank you. I have been a paramedic now for 25 years. I am a qualified intensive care paramedic, an extended care paramedic [ECP] and I am also a registered nurse. I work in the regional town of Tuncurry on the Mid North Coast of New South Wales. I would like to explain to you what ECPs are—extended care paramedics. We undergo specialist training in low-acuity pathways. What Ryan Lovett was talking about—community paramedics—we are a subsidiary of basically that. We focus on treating patients in the community and we refer them on to non-emergency department pathways. The ECP scope of practice is at the opposite end of the acuity spectrum to ICPs: Where ICPs are high acuity, ECPs tend to be low acuity. We have the potential to be extremely effective if we are sent to the right patients. Generally in the city there are about 83 funded positions in metro Sydney for ECPs, but there are no funded positions for ECPs in regional areas beyond Wollongong and Newcastle.

The main role of ECPs centres on the recognition and management of minor illnesses and minor injury. We do things such as suturing, initial wound management; we reduce shoulders, patellas, toes, fingers and then refer people to GPs; we do back slabs and plaster as well as fibreglass for suspected limb injuries and fractures; we have replaced urinary catheters and gastrostomy feeding tubes; and we also do a lot of antibiotic treatment for skin conditions and for community-acquired pneumonia. You can see that our range is quite huge. As an ECP in a regional area, I operate on a dual ambulance, meaning I do not operate on my own. It is a real ad hoc opportunity to attend to patients to prevent hospitalisations and presentations to emergency departments. For instance, I have sutured so many patients already at Tuncurry, and I have put on back slabs and I have reduced shoulders. Those patients I have referred directly to their GP and have avoided an ED. But I am the only one in my area.

I just wanted to talk about quickly the major barrier that I see with NSW Ambulance is sending the right paramedic to the right patient. One of the biggest issues that we have is that once that 000 call comes in the key performance indicator of getting an ambulance—any ambulance—onto a case takes precedence over a KPI that focuses on getting the right patient serviced by the right paramedic. We would like to expand on that further if you are that way inclined. That is what I wanted to explain, that role of ECPs and ICPs, and how effective we can be in regional areas. Thank you.

The CHAIR: That was very good, Ms Bianchi. It was very helpful to provide that level of detail on the two categories. I am sure that is going to lead to some questions from some of the members, so thank you. We will move to questioning. I remind Committee members that we have got through until 10.55 a.m. and then we need to move to the next group of witnesses. To be fair to the next group, we will keep it on time. The time between now and then will be divided equally between crossbench, Government and Opposition. We will commence with the Opposition. The Hon. Walt Secord.

The Hon. WALT SECORD: My first question is actually to Mr Beaton. You made the extraordinary claim about a three-day transfer. What the hell? Why would you have an ambulance and paramedics on a three-day job? Wouldn't it have been better to fly them or do something different? Can you explain the detail of that?

Mr BEATON: Thank you. That transfer was a patient that went from Broken Hill to Royal Adelaide and required a specialist ambulance, a bariatric ambulance. It required us to leave our local town of Gilgandra because my partner and me were working at the time and we were the only two qualified people in the area for the bariatric ambulance. We had to pick it up from Wellington, then drive to Broken Hill, take the patient from Broken Hill to Adelaide and then, of course, we had to get back from Broken Hill to Gilgandra. I believe there was an issue with aircraft at the time—they were not available to be able to transport the patient—so therefore they had to go by road.

The CHAIR: Mr Beaton, could you just explain what a bariatric ambulance is, please, for the Committee?

Mr BEATON: A bariatric ambulance—the ambulance service has a number of them across the State. They are to take your larger patients, those that will not fit into a normal ambulance—a larger stretcher, a lot of equipment in there and able to take the larger patients. That is basically what bariatric is.

The CHAIR: Thank you very much.

The Hon. WALT SECORD: Mr Beaton, what did the community of Gilgandra do for those three days? I mean, were there other paramedics around? What was the situation?

Mr BEATON: I believe they had to try and fill the shifts on overtime. At the time there were not a lot of paramedics doing overtime. They were able to fill one of the shifts for the full 3½ days and they relied on some off-duty paramedics to respond to other jobs. Off-duty paramedics are just paramedics who, in their six days off—we do eight days on, six days off in our town. They are relying on people on their days off, for rest and relaxation, to respond to jobs.

The Hon. WALT SECORD: Ms Bianchi, you were nodding during Mr Beaton's evidence. Why were you nodding? Do you have examples that you can share with the Committee, please?

Ms BIANCHI: Yes, absolutely. Quite often in Sydney when I was an intensive care paramedic at Blacktown I would be the only one available to do these bariatric jobs. Some of these patients have been up to 400 kilograms. That is a really big task. But I would literally be taken off the intensive care vehicle, so there was no intensive care vehicle at all for Blacktown, and I would be sent all over the place to attend to a bariatric patient that might have been at the other end of metropolitan Sydney. I have also been to Lismore and Grafton to take patients to appointments—simply to take a bariatric ambulance from Sydney to these regional areas because they just did not have enough bariatric vehicles around. Pretty distressing to leave your own community to have to do those sorts of transfers. It is not uncommon.

The Hon. WALT SECORD: Mr Beaton, you made reference to ambulances being a taxi service in rural and regional areas. Can you elaborate on that?

Mr BEATON: Yes. Quite often we are used to transport patients that are not high-acuity patients. If we have to transfer someone from a smaller, remote hospital to a larger centre, they just use an ambulance rather than using other resources such as patient transport vehicles or even private vehicles in some cases. Probably the most notable is not that long ago I transferred a patient at two o'clock in the morning who had a sore knee and had had a sore knee for a week. They were transferred just for an X-ray. The hospital that they came out of did not have X-ray, but we drove past two other hospitals that would have had X-ray at eight o'clock in the morning to drive them to the larger town, into Dubbo, to get an X-ray for a sore knee that had been injured a week earlier.

The Hon. WALT SECORD: Do you find yourself in situations just shaking your head at circumstances like this?

Mr BEATON: I used to shake my head and I used to get exasperated by it, but now it is such a common thing that it is just a shrug of the shoulders and say, "Yes, this is what we do." It shouldn't be, but that is the way we get to now.

The Hon. WALT SECORD: But don't you feel that that puts lives at risk because an ambulance is engaged in another activity and it is actually a diversion of scarce resources?

Mr BEATON: Absolutely. It does scare me because if someone is in desperate need of an ambulance in my town or in any other town around where there is no ambulance available, I do not know how they are going to be attended. My elderly mother lives in this town and I worry that there is no ambulance available for her if I am driving hundreds of kilometres to transport patients that probably could be going in lower acuity transport vehicles.

The Hon. WALT SECORD: What do you do when you have a situation? Do you find that you have to do, like, a Sophie's choice? You have to make a decision: "Do we go for this patient or do we go to that?" Do you find yourself in situations like that?

Mr BEATON: I do not get the choice to make that decision. That is made by Ambulance, by the dispatchers, and then there is the extra stress that goes onto them having to find an ambulance. If a cardiac arrest or some serious job comes into your town, they are fully aware that they have no ambulance resource in that town other than trying to find off-duties. I myself probably get called a minimum of once in my six days off to attend off-duty call-outs because the crew are unavailable, either on another job or on a transfer.

The Hon. WALT SECORD: And you cannot say no, can you?

Mr BEATON: I can say no to off-duties but I cannot say no when I am on duty at all. If I am unavailable because I have had a beer or if I am not in town or looking after my kids for homeschooling at this point in time, then I cannot go and do the job—I have family commitments. But probably 80 per cent of the time I go and do the off-duty jobs.

The Hon. WALT SECORD: I would like to ask a question to Ryan Lovett from the college. Do you find that, because of scarce resources in rural and regional areas, paramedics are called to engage in medical procedures and do activity beyond their scope of practice?

Mr LOVETT: I think the education that is provided to paramedics nowadays gives them a really good grounding for how and when and the manner in which they should practise. I would not say they generally are practising outside their scope. To extend on what Liu Bianchi said, when paramedics go to these patients—it might be an 80-year-old person with lots of chronic conditions, lots of medication—paramedics traditionally, who have been trained in emergency and urgent care, they have been trained in how to respond to a cardiac arrest and they have got that educational background. When they find this person that has got all of these things wrong, they are trying to work out how the various medications work together. That is not traditionally the education that has been provided to them as part of their undergraduate degree.

A lot of paramedics—and we take our hat off to them and we support them as part of the college—have gone out and acquired this education independently. They have gone out and undertaken graduate certificates, graduate diplomas to give them this breadth of understanding. Paramedics, I think—the education we do give them is a really great, solid foundation. Unlike some of the other professions, they have got this great foundation and we can build on that foundation. As Liu Bianchi said, you can build on this foundation with extended care paramedic education, you can build on this foundation with intensive care paramedic training, but I think that is why paramedics are really well positioned. We can give them additional education, additional training, give them that exposure to that extra scope and those extra patient presentations and we can really fill that gap.

The Hon. WALT SECORD: Mr Beaton, back to the situation that you highlighted in Gilgandra, what would be the recommendation or the remedy? Is it more ambulances, is it more paramedics or better coordination? What is the response to what you have highlighted that occurs in your community?

Mr BEATON: I think it is exactly what Liu Bianchi talked about earlier: Getting the right ambulance to the right job. So whether a better system in regards to triaging the call—do we actually need two registered paramedics to transport this patient from one hospital to another? In a number of cases we will; there can be critically ill patients. But there are a lot of these unnecessary transfers that could free up the paramedics to still be available in the town. If you asked the question of: Do we need more paramedics? The answer is yes. But how many paramedics do we need to make sure that there is always an ambulance available? That is one of those questions of, "How long is a piece of string," especially in regional and rural areas.

In your larger centres—your Dubbos et cetera—more ambulances would of course assist the community. In Dubbo they are constantly doing transfers to Orange Base Hospital because there is higher acuity care at Orange. So you lose an ambulance for four hours out of Dubbo, do you put another ambulance on in Dubbo? How many more transfers are they going to keep putting on to do that? It is never ending. The more ambulances you put on, there are probably more transfers. There needs to be a better system of triaging to find out what ambulance resource is best suited to transporting this patient.

The CHAIR: We need to move to the crossbench now for their questions. Deputy Chair, the Hon. Emma Hurst.

The Hon. EMMA HURST: Thank you, Chair, and thank you all for coming today. I have a question for Ms Bianchi. You mentioned in your opening statement that the ambulance itself is prioritised over getting the right paramedic there. Could you explain to us what you mean by that and also how we fix it? What needs to actually change?

Ms BIANCHI: The KPIs are obviously a reporting tool that NSW Ambulance use for NSW Health, but what they have is a KPI that overemphasises the 000 call and the time that it takes to place an ambulance, any ambulance, on that 000 call. What that does is it means that you are not putting the right ambulance on the right case because your KPI is directed at putting an ambulance on that call. Even if that ambulance is in Tuncurry and the job is in Port Macquarie, it does not matter because the KPI supersedes every other need because you have put somebody on the job, regardless of where it is in the State. Quite often you get a job and the closest car is hundreds of kilometres away, but you have put a car on it. Do you understand what I am saying there? The flow-on effect is that you then have this ripple effect of ECPs attending high-acuity jobs needing backup and then you get P1s and ICPs attending really low-acuity jobs that are ECP but then have to transport them because they cannot fix that low-acuity case. Then you get all of this ramping at hospitals and presentations at hospitals that do not need to be there.

The ECPs are backlogged looking after patients and waiting for a backup car and you have got the ICPs transporting a patient and waiting at a hospital to offload. Do you understand that flow-on effect just from that one KPI? It is a disaster. If I was to say to you instead, if we looked at a KPI that looked at putting the right ambulance on the right job—you look at somewhere like the Great Lakes area, Manning Valley, you have got 45 per cent of the population over the age of 55. That is predicted in 2021, right? Let's look at the type of paramedic skill sets that you can put in that community. Let's put skill sets that would really facilitate those communities in

geriatric care: falls, catheter care, wound care. They are the sorts of paramedics we should be looking at, potentially, or even the higher end—ICPs—because there are so many cardiac conditions in that older population.

The Hon. EMMA HURST: So it is really about stepping back and having a look at where the experts are needed, but that has not happened. Is that funding issue—a lack of paramedics in the right spaces and not enough in rural areas—is it all just coming back to those same issues and is it just another symptom of that issue?

Ms BIANCHI: Agreed. The ambulance service, to my knowledge, has never placed paramedics really about their skill set other than looking at the number of jobs, the acuity of job and deciding where they might put their intensive care paramedics. That is as sophisticated as it has got, and we need to think a lot smarter—not just more paramedics, but let's look at the skill sets that we have.

The Hon. EMMA HURST: I have a very quick question, though I do not have much more time left, for Mr Lovett or Ms Miles. What could the Government do to really foster the growth of community paramedics in rural and regional areas? What support is needed?

Mr LOVETT: I think Liu Bianchi is exactly right. If you look at some other jurisdictions around the country, they undertake a really detailed community modelling and community profiling program. I know in South Australia they have just completed theirs. It took them about six months, but the Government and the health department have built a real profile of every community and said, "What do we need to service the health needs of the community, not just the ambulance needs of the community, but holistically?" and then developing models of care to suit that community. That might be a volunteer ambulance response, it might be a paramedic ambulance response or it might be an extended care or community ambulance response. So it is about understanding the community and really targeting the service needs.

And second to that, very quickly, many jurisdictions now are focused on the fact that paramedics are owned and operate only in an ambulance service. I think in 2021 that preconception really needs to be broken. A paramedic is an independent medical practitioner, like a doctor, like a physiotherapist, and they can and should be able to work independently. They should be able to work as part of a GP practice, which is what Alecka Miles does—she works as a paramedic embedded in a GP practice. They should be able to work across the health spectrum to service those community needs.

Ms CATE FAEHRMANN: Thank you all for appearing in what is no doubt a busier time than usual for your organisations. I just wanted to go to the Australian Paramedics Association [APA] submission where you talk about the current figures for what cars are needed on the road. You say that the minimum operating level is based on 2010 demand figures—so based on demand figures that are 11 years old. Is that still the case because your submission, I think, was done in January. I am just checking whether anything has changed since then?

Mr BEATON: Yes, there was an Industrial Relations Commission hearing and ruling. That has changed slightly now. The old MOLs, or minimum operating levels, have now moved to a terminology called PAR, which is paramedic agreed rostering. It is the actual filling of all rosters. The levels have risen but it took an Industrial Relations Commission ruling to bring those levels up. There is still probably not enough in some of the metro areas and probably not enough in a lot of the regional areas as well, but it certainly has improved since that submission was put in early last year or late 2019.

Ms CATE FAEHRMANN: This leads into the next question, actually, because your presentations today are clearly full of solutions, in some ways, to the crisis in regional health for ambulances and what paramedics are experiencing. What has been the Government's response or NSW Ambulance's response to the pleas for change and for reform and for some of the solutions that both of you have in your submission? Because it is frustrating, to be honest, to hear this. Why isn't some of this happening? I might go to the APA first. Ms Bianchi?

Ms BIANCHI: Yes, I would like to speak to that. Certainly in the extended care paramedics space I believe NSW Health are absolutely tone deaf about the program. It has really fallen into disrepair. We really are struggling as an extended care paramedic group. The program has fallen onto its knees. On three occasions I have presented to Minister Hazzard that it is really struggling and yet we still are not able to bring it back up to its former glory. It has been in practice since 2007 and unfortunately very little commitment from NSW Ambulance and NSW Health has gone into it, and yet it saves NSW Health millions and millions of dollars. It is such an amazing program, I cannot speak of it more highly.

Our ECPs are critical to the better functioning of regional and metropolitan services. It is amazing what they do. Me alone, in Tuncurry, as the only ECP, I would probably, if I am sent to the right case, I would do almost 100 per cent ECP non-emergency department presentations—and that is only one person. When we look at regional areas, the amount of increase in workload has been exponential. If we look at even Tuncurry and Great Lakes alone, the number of responses in the January-March 2021 year compared to the same time last year,

2020, has gone up 23 per cent. That is the number of responses. Now, our workload is crazy. How can we address all those issues with the amount of staff we have? We can't. We are just chasing our tail all the time.

So I think your question is excellent. The NSW Health department needs to start listening to our ideas and our solutions because they are realistic and they can be implemented, just like Ryan Lovett said. Other States are doing it. Let's be sophisticated about this.

The CHAIR: I think it may be time to move to Government questions. I am not sure which member would like to jump in—the Hon. Trevor Khan, the Hon. Wes Fang or the Hon. Natasha Maclaren-Jones?

The Hon. TREVOR KHAN: I will start, and I think it is with you, Mr Beaton, but I certainly welcome others in terms of making a contribution. It goes back to this issue of ambulance versus patient transport. Is one of the problems that the ambulance service and patient transport are essentially managed by different parts of the health system? Is that one of the causes of the problem?

Mr BEATON: I believe that that is one of the major issues. A few years back—I could not tell you how many; it would be more than 10 years—ambulance actually ran the majority of patient transport. That then moved across to HealthShare and then out here in regional areas we have a different group called vCare that manage the patient transport section out in regional areas. What we find is that they will take the bookings from the local hospitals, they try and put patient transport vehicles on them, but when they cannot do them they just push it across to ambulance. Regularly at five o'clock in the afternoon we get put on a patient transport. Now, we are supposed to finish work at six o'clock at night, but we then get tasked to a transport at five o'clock and we get home at eight o'clock in the evening, so there has been no ambulance in Gilgandra for 2½ to three hours while we have been doing a transport just because patient transport did not have enough cars or crews to actually get that patient down to Dubbo.

That seems to be a lack of foresight, planning, to get the patient transport vehicles around. A lack of patient transport vehicles might be part of the issue. I am not sure. I do not know the inner workings of how patient transport in western work but I am sure there are others that do.

The Hon. TREVOR KHAN: Just before I ask a follow-up question, Ms Bianchi, you seem to be nodding your head. Do you want to make a contribution?

Ms BIANCHI: I will be honest with you, when we had patient transport underneath the umbrella of NSW Ambulance it was a bit like logistics—you never had a patient transport vehicle going somewhere without being loaded. I do not mean to represent patients as a parcel because they are not—absolutely not—but it did not make sense to be moving people in a patient transport vehicle and then doing a return trip without them being loaded. The amount of work that they got done because the dispatchers from NSW Ambulance were able to control the whole picture within the holistic look of what ambulance was doing at the time. Now you might see patient transport vehicles going everywhere unloaded and it does not make any sense.

We need to coordinate this. If we are not going to put more of them on, let's make sure that when they are moving patients to and from that they are making a return journey with at least a patient on board. So there really seems to be a huge inefficiency of the service now. Even the patient transport staff will say, "Wow, we used to be a lot busier." Well, we are taking the load now as well, so it does not make sense—it is crazy.

The Hon. TREVOR KHAN: I will keep my philosophical question for a bit later. It relates to the model of an ambulance service, if I can describe it that way, but I will park that to one side. Mr Beaton, you raised earlier the issue of the equipment in ambulances in rural areas, separated out from regional areas, and the lack of some particular items. Are you able to specify what those items are and whether you have an explanation as to why they are not available in those ambulances?

Mr BEATON: Sure. It is in regards to the intensive care paramedic training that all intensive care paramedics received earlier this year or even late last year in regards to COVID funding. There are a whole bunch of new skills that they gave us, there is new equipment. Two pieces of equipment that I mentioned earlier, one is called an EZ-IO—it is an intraosseous needle, it is a drill, that is used by helicopter crews. Instead of using an intravenous line, if you cannot get an IV line in standardly, then you essentially—it sounds horrific—drill into the bone of someone to administer life-saving fluids or even pain medications et cetera. That drill costs, I believe, somewhere around $550 plus its other parts and pieces. For some reason, I have no idea—I have actually personally written an email to Dr Morgan, our commissioner, who said that the funding just was not there.

The second item is called a video laryngoscope—in order to assist with intubation of a patient. It is a tool that you use so you can see down the throat when you are placing a tube down into a person's throat to help them breathe. This would not only help me if I need to perform an intubation, but it also assists the hospital because they do not have one either. So if ever they need to intubate someone I can be called to go and assist them as well

for the intubation. They are the two items. I believe one costs around $550 and the other one costs somewhere around about $700 to $800 is my understanding as to how much they cost.

The Hon. TREVOR KHAN: I think this is to Mr Lovett and Ms Bianchi, but of course it is Ms Miles' area as well. I want to just come to this issue of the community paramedics. I wonder if you are able to explain to me why—or we can talk in a more general sense—this has not caught on the New South Wales and why others have looked at the model and apparently seen some suitability in it?

Mr LOVETT: I will jump in quickly and then I will defer to my colleagues. Essentially if we look at community paramedic models—for example, in South Australia, which is the recency of my experience—the model in South Australia is co-funded between health and the primary health network in recognition of the fact that they are filling the gap of a general practitioner or primary health care are in that town. Ambulance service funding models—and this is not peculiar to New South Wales; this is nationally an issue, and this is regulatory—generally defer to transport. So an ambulance service will receive more funding if they transport a patient to hospital in the order of four or five times more funding in some places than if they were to manage that patient on the scene.

It is in the order of a couple of hundred dollars if you go to a scene, manage the patient and leave the patient at the scene—that is the funding—or $1,200 to $1,500 to transport them to hospital. There is a perversity of funding that there is no incentive to invest in the models that keep people away from transport. And Liu Bianchi is exactly right: If you look at the total cost of that presentation, not only the ED costs, we know that a patient that presents to ED gets worked up significantly more—more interventions, more tests, they might get admitted overnight for observation. If we can keep that person out of hospital, the whole health system's savings at a State and Commonwealth level cannot be underestimated.

The Hon. TREVOR KHAN: Ms Bianchi, do you want to comment on that? I hoped that was the sort of observation that was coming.

Ms BIANCHI: I mean, the figures speak for themselves. The savings are incredible. I am talking in the $50 million to $70 million a year of non-transport to EDs. I just do not understand how, fiscally, NSW Health and NSW Ambulance are not putting more into the program. Whether it looks like or is called the "community paramedic", we are actually doing it—we are just not doing it with enough support. So we are doing it ad hocly, which is really such a shame because we should be saving not in tens of millions but hundreds of millions of dollars. From a cost perspective, I just do not understand why they are not supporting it more. And ECPs out there, they just love the role—they absolutely love it—because it is so definitive and it has got an endpoint and they actually achieve so much. Listen, I think it is a really big question to be asking Minister Hazzard again and again and again until he starts listening because he is not listening at the moment.

The Hon. TREVOR KHAN: I—

The CHAIR: Thank—

The Hon. TREVOR KHAN: Sorry, Greg.

The CHAIR: No, that is okay. Perhaps that might need to go on notice, the Hon. Trevor Khan.

The Hon. TREVOR KHAN: Yes, that is fine.

The CHAIR: Thank you very much. We are pressing up against our time line.

The Hon. TREVOR KHAN: I apologise.

The CHAIR: On behalf of the Committee, I thank all four witnesses. I have to say, the range of questions and the answers that have flowed have been very instructive in terms of giving us some pretty rich insights into the matters of paramedic services and ambulatory services in regional, rural and remote New South Wales and insights into views and opinions about how they can be enhanced and improved. The Committee thanks all of you very much, not just for your submissions but also for your oral evidence today.

(The witnesses withdrew.)

(Short adjournment)

KRISTIN MICHAELS, Chief Executive, The Society of Hospital Pharmacists of Australia, affirmed and examined

JERRY YIK, Head of Policy and Advocacy, The Society of Hospital Pharmacists of Australia, affirmed and examined

CHELSEA FELKAI, NSW President, Pharmaceutical Society of Australia, affirmed and examined

KAREN CARTER, Fellow, Pharmaceutical Society of Australia and Owner, Gunnedah and Narrabri Pharmacies, sworn and examined

The CHAIR: On behalf of the Committee, could I first of all thank both organisations for making your submissions. For the Society of Hospital Pharmacists, your submission has been received and processed and stands as submission No. 627 to this inquiry. With respect to the Pharmaceutical Society of Australia, equally a very good submission, it has been received and processed and stands as submission No. 250 to this inquiry. You can take both submissions as having been read by Committee members, so in terms of your opening statements you do not need to repeat anything in particular. But I welcome both organisations, through one of their witnesses, to make an opening statement and then will it be okay that we proceed to questions? Is that agreeable with our witnesses? Lovely. Thank you. We will first of all commence with the Society of Hospital Pharmacists. Who would be giving the opening statement in that case?

Ms MICHAELS: That would be me. Good morning, Chair, Deputy Chair and members of the portfolio committee. As I just said earlier, I am the Chief Executive of the Society of Hospital Pharmacists of Australia [SHPA]. We are a membership organisation of some 5,200 hospital pharmacists who work around Australia. We also have hospital pharmacy technicians, hospital pharmacy interns and students who are members of our organisation. In New South Wales in particular there are over 1,300 hospital pharmacists according to the Australian Institute of Health and Welfare and hospital pharmacists account for just over 23 per cent of the entire hospital pharmacy workforce. First of all, I would like to acknowledge Ms Wells and Ms Hayes, who provided evidence earlier this morning about the tragic deaths of their fathers where vital preventive medicines for stroke and heart attacks were implicated.

Hospital pharmacists are responsible for supply of medicines to all hospital inpatients, outpatients and upon discharge from hospitals. It is in hospitals where hospital pharmacists treat patients at their most unwell. It is the value of the pharmacist to patient care outside of supply though that is lesser known, and this lies in their clinical pharmacy activities such as doing daily reviews of medication charts, detecting and managing drug interactions and providing counselling to patients and safe transitions of care upon discharge. However, due to chronic underfunding of hospital pharmacy departments and a lack of recognition of clinical pharmacy services, virtually all New South Wales hospitals are not staffed sufficiently. In other States, hospital pharmacists provide medicines at discharge and provide thorough medication counselling when patients are taking new and different medicines. Our New South Wales members report that a large portion of their patients do not get any pharmacist counselling when being discharged on their new medicines and are often handed a bag of medicines by a nurse on their way out of the hospital.

These workforce issues are of course exacerbated in rural, regional and remote hospitals and this is inextricably linked to over 20,000 medication-related incidents which are reported to the New South Wales Clinical Excellence Commission where hospital pharmacists are unavailable to prevent them. Whether you look at this on a per capita basis per 100 hospital beds or per 1,000 admissions annually, New South Wales hospitals comparatively had the smallest portion of hospital pharmacists compared to any other State. Our hospital pharmacist members in New South Wales know their pharmacy departments are the most poorly resourced, and addressing this workforce gap is key to improving the safety and quality of care for New South Wales patients and protecting them from medicine-related harm. Thank you.

The CHAIR: Thank you very much, Ms Michaels. That was a very detailed and very prescient opening statement which adds very nicely to the submission and I am sure will lead to some questions. Can I move now then to the Pharmaceutical Society of Australia. Ms Felkai, I presume that you are going to give the opening statement?

Ms FELKAI: Yes, thank you, I will. Good morning to the portfolio committee and to my SHPA colleagues. My name is Chelsea Felkai, and I am here representing the Pharmaceutical Society of Australia [PSA] as the New South Wales branch president. I am joined here with Karen Carter, who is a fellow of the PSA and pharmacy owner of Gunnedah and Narrabri pharmacies. The PSA is the national professional pharmacy peak body which represents all of Australia's 34,000 pharmacists working in all sectors and across all locations. In March this year the PSA released their *Medicine Safety: Rural and remote care* document, which has been

provided for your reference. The document outlines the specific challenges faced by our rural and remote neighbours, particularly in the areas of medicine and health service access, medicine safety and pharmacist workforce. Geographical distance to healthcare services such as hospitals and GP clinics makes it difficult for patients to access timely care, sometimes resulting in unnecessary hospitalisation.

Increased disease burden and potentially preventable hospitalisations in rural and remote Australia are up to 2.4 times that of non-rural Australians and cost the healthcare system on average $400 million. At least 50 per cent of this is preventable. This inequality of access to medicine and health services based on geographical location directly impacts on health outcomes of our rural and remote neighbours and should not be tolerated. A number of potential solutions have been identified to decrease this gap in health outcomes due to medicines. Medicines access has been improved since the continued dispensing arrangements were put in place to meet the needs of populations impacted by emergency situations. These examples include when a patient is unable to access more of their medicines and no longer have repeat prescriptions and are unable to access a GP. Medicine safety is a particular risk during transitions of care, as noted by my SHPA colleagues, such as discharge from hospital.

Embedding and funding pharmacists across multiple regional and remote practice sites would reduce medication misadventure associated with transitions of care and establish a more coordinated and integrated care. Finally, pharmacists are a skilled and accessible workforce that could be better utilised. In some communities they are the only healthcare practitioner. Building rural and remote pharmacist workforce capacities and capability is essential to improve access to life-saving health interventions. My colleague Karen Carter will be able to detail examples of the challenges and solutions as they play out on the ground, during the question time. Thank you.

The CHAIR: Thank you very much, Ms Felkai. That is equally a very clear and precise opening statement which sets up the questions nicely. We will now proceed with questions. It is about seven minutes past 11. We go through to around 11.40 or thereabouts, with the time shared equally between Opposition, crossbench and Government members. We will commence with the Opposition first. The Hon. Walt Secord?

The Hon. WALT SECORD: Thank you, Mr Chair. In fact my first question will actually go to Ms Carter, involving Gunnedah and Narrabri. As Ms Felkai said earlier, pharmacists in many country areas find themselves to be the only healthcare practitioner. Can you give us a bit of an insight into being on the front line? What should this Committee respond and recommend in relation to pharmacists?

Ms CARTER: We have a shortage of GPs in our area, so we are a triage service. We often have people presenting with symptoms such as a urinary tract infection, and we know what may be the best medication for this treatment but we are unable to do a counter prescribing on antibiotics—which in Queensland there is a program going on. Other services, I have actually finished a diploma in wound care from Monash to improve my wound care services in both areas. We have a lot of acute wounds and chronic wounds, and so we do a lot of dressings for that particular area. We also triage people who we know need to go and see doctors, so we have medication review services and we can identify people with high blood pressure. These people need to see a doctor straightaway but that has difficulty with access. So sometimes if we could have something like collaborative prescribing we could allow monitoring of people's blood pressure, because they have access to our pharmacies in Gunnedah seven days a week and in Narrabri six days a week. So we do a lot of monitoring of people's blood pressure, and if we had collaborative prescribing we could then allow dosage increases or decreases for just medications for blood pressure.

The Hon. WALT SECORD: Ms Carter, what do you mean when you say collaborative prescribing? What does that actually mean?

Ms CARTER: If a GP was to start someone on a blood pressure tablet of a certain strength and then we were given allowances to be able to adjust the dose after monitoring—so working with the GP to be able to change the dose of the drug.

The Hon. WALT SECORD: I see. Have there been any changes or temporary changes during this COVID period that have enabled you to assist people in the community, or are there things that could be recommended immediately to assist the community?

Ms CARTER: Continued dispensing has been absolutely fantastic for us, so instead of supplying only three days' supply of medication we have been able to supply another month's supply of medication for all medications other than a few. So that means for anxiety and mental health, for cholesterol, for blood pressure, for diabetes, for gout even—to prevent this happening. It is a one-off per 12 months and then we try and arrange for them to then see their GP to have ongoing care. So it is not taking over; it is just a continued dispense of their regular medications.

The Hon. WALT SECORD: Would you like to see that continue in a post-COVID environment for rural and regional areas?

Ms CARTER: Yes. We have had it previously with our oral contraceptive and cholesterol-lowering medications, but with COVID we have been able to use it for all medications. So this would be absolutely fantastic in all settings to allow another month's supply so that they have access to the GP in the next month.

The Hon. WALT SECORD: Ms Michaels, in the Society of Hospital Pharmacists of Australia's submission it says:

> In 2017-2018, NSW patients were 48% more likely to experience an adverse effect from medicines than Victorian hospital patients and 29% more likely … than Queensland hospital patients.

Can you provide an insight into that data?

Ms MICHAELS: That is correct. Our submission does talk about that. We attribute that in part to the staffing ratios. In New South Wales, as I stated earlier, there are around 1,300 hospital pharmacists. In Victoria, by comparison, there are 1,700. Of course, Victoria has a much smaller population than New South Wales, so the service ratios there are simply not comparable. You are not receiving the same rate of management of medication. We do not see that as being sufficient for your population to be managed. When you are seeing those kinds of adverse events, that is not acceptable from our perspective. So those stats reflect the rate of care.

The Hon. WALT SECORD: How does the scope of practice for a hospital pharmacist differ from the work that someone like Ms Carter would do?

Ms MICHAELS: Hospital pharmacists, as a general rule, have a different level of training. One way I would explain it, I guess, is that they operate in different specialty areas as a start. Hospital pharmacists operate on wards. They may have specialty training in areas such as oncology. They may be working with cancer patients. They may be working on a cardiac ward with people who are recovering from cardiac surgery, for example. They may be working on general surgery wards. They are working with complex patients and working with much more complex medicines.

The Hon. WALT SECORD: I think this is our ninth hearing. We have had evidence that there have been hospitals in New South Wales where there are no doctors on duty on the weekend. It would go to say that a small hospital would not have a pharmacist on duty. So what do those smaller hospitals do? Do they do it by virtual—

Ms MICHAELS: That is absolutely correct. They are simply not providing a service.

The Hon. WALT SECORD: So what do they—

Ms MICHAELS: They are simply not providing a service. Yes, that is correct. What we would say is that it is a little—

The Hon. WALT SECORD: So what happens?

Ms MICHAELS: It is a little bit of a lottery for a patient. They may be discharged, as I was saying earlier, without receiving counselling from a pharmacist. They might be handed their medication and simply not receive counselling around how to use that medication and what they should be doing when they get home. As Ms Carter was saying, they might then end up in a community pharmacy, they may end up back at their GP, they may not take their medication correctly, and that is where we do see patients then bouncing back into hospital and that continual circle of incorrect care or inappropriate care.

The Hon. WALT SECORD: You mentioned in your opening statement—I actually wrote it down when you said patients are released or discharged with "a bag of medicine".

Ms MICHAELS: Correct.

The Hon. WALT SECORD: In rural and regional areas with elderly patients that is going to result in higher adverse situations. Is that correct?

Ms MICHAELS: Correct. So that is not what we see as high-quality care. It is not what we aim, obviously, to provide for any of our patients. Seven-day services are what we would like to see across all of our hospitals for all of our pharmacy patients.

The Hon. WALT SECORD: Are there major hospitals in New South Wales that do not have pharmacists on duty 24 hours? I am not talking about small multipurpose services, but I am talking about major hospitals in New South Wales.

Ms MICHAELS: Yes, there are.

The Hon. WALT SECORD: Can you give some examples of major hospitals that would not have pharmacists on duty?

Ms MICHAELS: A number of our major hospitals in New South Wales do not have seven-day services at this point in time. They are simply not resourced to do so.

The Hon. WALT SECORD: But is that an acceptable standard in other States and Territories around Australia?

Ms MICHAELS: There are also other States and Territories that do not provide seven-day services at this point in time, but there are a number that do as well.

The Hon. WALT SECORD: Okay, but I want to take you back, so can you give me—

Ms CATE FAEHRMANN: Sorry, the time. Can I just—

The Hon. WALT SECORD: I just want to know if she could provide the names of those hospitals on notice. Thank you.

Ms MICHAELS: Can do.

The Hon. WALT SECORD: Thank you.

The CHAIR: Thank you. I was not aware the time had got to that. Cate, are you going to commence the crossbench questioning?

Ms CATE FAEHRMANN: Yes, I am happy to. I just wanted to continue some questioning with the Society of Hospital Pharmacists. Ms Michaels, why is it that you outline the public hospitals pharmaceutical reform agreement and the fact that New South Wales has not signed up to that—which I think we were talking about before in terms of that means that patients are not really able to get the Pharmaceutical Benefits Scheme [PBS] drugs for 30 days when they leave hospital. What is the reason why New South Wales has not signed up to this?

Ms MICHAELS: Look, it has obviously been a decision that was made at a point in time. I am not privy to why that decision was made. Governments make decisions at points in time. It is obviously historical and not for me to make that call. The reason that we think it is really important obviously, or the reason we would like to see that decision reviewed, is primarily around that access to medicines. That 30 days of access provides, as we were just talking earlier, for that continuity of care when people do leave hospital with medicines in their hand. It gives them access over those days when they have left to be able to continue with that medicine, to receive that counselling when they leave the hospital, to know what they are doing with those medicines when they arrive home, to have that certainty when they are at home to utilise the medicines appropriately, to continue with that care and to have that time at home before they have to seek care back in the community.

Ms CATE FAEHRMANN: Going back to your submission again—which was a very good submission, so thanks for being a part of this inquiry—and medication-related adverse events in New South Wales compared to other States. What I think is most concerning about the chart that you have provided from 2011-2012 to 2017-2018 is that it has Victoria and Queensland remaining very steady in those adverse events, and in fact we have been increasing year upon year upon year. Clearly something has to happen in New South Wales about this or, by the look of that, those numbers are just going to get worse and medication-related adverse events are going to increase?

Ms MICHAELS: It does appear that way. I mean, I think what it looks like to us is that the continued chipping away at the resourcing issues just—you know, it appears from the data that if you continue to reduce that resourcing in hospitals that it compounds, basically. I mean, obviously those resourcing issues are not simply about human resourcing. They are also about infrastructure resourcing et cetera. As that compounds over time it obviously has an ongoing effect. I think you are starting to see that and, when you look at that table, as you have pointed out, it is quite stark.

Ms CATE FAEHRMANN: I just wanted to quickly go to the Pharmaceutical Society now. Thanks for putting in your submission as well, which is also a good submission. You mention the importance of integrating pharmacists into Aboriginal community controlled health services. I was just wondering if one of you would care to expand upon that? It sounds great. You said there is growing evidence particularly that integrating pharmacists into Aboriginal community controlled health services can help increase life expectancy et cetera.

Ms FELKAI: Yes, I am happy to field this one. Thank you very much for the question, Cate. Integrating a non-dispensing pharmacist in an Aboriginal health service—and what I mean by a non-dispensing pharmacist is one that is not directly involved in the community pharmacy process of dispensing of medicines, so this is where they are using more of their cognitive and clinical expertise with relation to medication management. Integrating these pharmacists in an Aboriginal health service does have the potential to improve medication adherence, to

reduce chronic disease and to reduce that medication misadventure and largely to decrease preventable medication-related hospital admissions, which again is going to deliver significant savings to the health system.

We know that this population is much more vulnerable when it comes to medication adherence, understanding the purpose of medicines and how they impact on health, and also in obtaining access to medicines given that many of our Aboriginal and Indigenous neighbours are in quite remote settings. Ensuring that there are pharmacists who are at that direct interface with these communities will ensure not just education but that we are able to have transparency over how they are managing their medicines. They have much higher rates of chronic disease like diabetes and cardiovascular disease and we need to better manage this particular population.

Ms CARTER: Can I just add that we were involved in an immerse project, and I did spend some time doing reviews out at Brewarrina. So I was not involved in the community pharmacy. This just showed to me the stark reality of the gap in rural health. We also did do this service in Gunnedah, and we have improved our relations with First Nations people. We have also improved compliance. Some people had had a heart attack and had stopped their medications, so we have got them now taking their medication again. To Ms Felkai's point of having a non-dispensing pharmacist, but then it can also work in a community area if you have got good relations with the local services.

Ms FELKAI: A last point on that. It is not just cognitive services that are being provided but actual physical health-related services such as vaccinations. There are numerous outreach programs that are conducted between a community pharmacy and these populations. Given the current climate, vaccination is so important. We know there are low rates in these remote areas and pharmacists are imperatively involved in this service.

The CHAIR: Emma, do you have some questions?

The Hon. EMMA HURST: I do, yes. Thank you. Ms Michaels, you say in your submission that New South Wales public hospitals lack the investment and resources to meet acceptable standards for practice for hospital pharmacy services. Can you just expand on that a bit for us? What standards of practice are not currently being met in New South Wales?

Ms MICHAELS: Sure. To give you some examples, SHPA, as the professional body, we set standards for example on the number of hospital pharmacists who should be working to a bed ratio, similar to—as you would probably be familiar with—a nurse to patient ratio. For example, for clinical pharmacy staff we say there should be one hospital pharmacist for every 20 cancer patients or one for every 15 haematology patients. It is not even vaguely close to that in New South Wales. It is miles and miles and miles away. Where you are is the example I was giving earlier in terms of there being only 1,300 overall. It is not even within cooee. When you are talking about stats that are just so far away, you are not even coming close to those kinds of standards.

The Hon. EMMA HURST: With that in mind, what are the most urgent things that need to be addressed? I know you have covered it a little bit. But when you say that we are so far away, if we were going to prioritise what needs to happen, what are those early stage actions that need to happen before we can get a little bit closer to where we need to be?

Ms MICHAELS: I think on that basis you would have to say you just need to come to a very basic number. Those are kind of the more complex ones. Really, we say that you should have one to every 20 acute patients and that I think is a very basic standard—that is where you should be in the very first instance—or one to every 30 stable patients on the wards. I think that is what I would set as a base level and that is what New South Wales should be absolutely hitting in the first instance. That is not in any way unreasonable. The one to five you are very familiar with in nurses, that is where we should be talking about for hospital pharmacists and that is what New South Wales should be aiming for. When we were talking earlier about coming with the PBS, that is certainly one way for New South Wales to be looking at that. Signing up to the PBS reform agreement is one way to start injecting some funds and coming back to looking at that, which would give (1) the benefit we were talking about earlier with the medicines for patients, which is obviously really effective and really useful, and (2) another way to look at starting to potentially fund some of those workforce, which is desperately needed.

The Hon. EMMA HURST: Considering we are so far away from where those standards need to be, what does that mean for patients on the ground? You talked earlier about adverse medication events, but does that mean that we are seeing higher death rates in rural and regional areas because of medication confusion? What else are we seeing, or what are the most horrific outcomes of the fact that we are so far from those standards?

Ms MICHAELS: You are certainly seeing a lack of service. That is absolutely what you are seeing. You are seeing more people coming back into hospital. We have talked about that. What we are seeing from our end, which is obviously our connection with our members on the ground, people are telling us that they are actually withholding services. From the patient end, that experience is—you know, a lot of the time they do not know the services they are not receiving. That is a terribly unfortunate thing. They cannot say to you, "We don't know what

we're not getting." But they are actually not receiving services, and that is a terrible thing. We already know that in rural and remote areas they are disadvantaged to start with. But, effectively, we are hearing from our pharmacists that they are having to withhold services. They simply cannot provide what they should be providing.

In metropolitan Sydney they are already not providing what they are potentially providing in metropolitan Melbourne, and that is not right. But then if you are coming further back out and you are in rural and regional New South Wales, they are not getting what they are getting in metropolitan Sydney. So it is just further back out in the circle of further and further disadvantage—you know, that circle back of less and less and less service. I think that what you have got to be looking at is less numbers of people on the ground, less numbers of services for patients and you already know that all of that comes back to just a medication misadventure, effectively, in the worst possible way.

The Hon. EMMA HURST: Thank you.

The CHAIR: Thank you, Deputy Chair. Moving across to Government members, who would like to ask the first question?

The Hon. WES FANG: Thank you, Chair. Thank you very much for your testimony today and your submissions. They are really great and we have been able to draw down quite a lot of information from them, so thank you very much to each and every one of you for taking the time to not only write the submissions but to appear today. I just wanted to drill down on some of the information that we have got in front of us, not only from your experience but from other experiences we have had during this inquiry. We have looked at the virtual pharmacies model. We know that we have got this grant that is available where we can actually have clinicians in smaller hospitals getting advice through the virtual pharmacies model and being able to provide that information to their patients with the backup of the pharmacies on that virtual care model. How has your experience been with the use of that, and do you support a wider rollout of that? That is basically to all members of the panel.

Mr YIK: It is Jerry Yik here. Thanks, Mr Fang. Essentially, yes, I think we have to move to a situation where we have to support these type of innovative models, and I would like to acknowledge my hospital pharmacy colleagues as leaders of innovation research in this area. I think these have been introduced because of the lack of workforce, hospital pharmacists, as pointed out by my chief executive and as we all know and have heard. It is really difficult to recruit pharmacists—and not just pharmacists but also nurses and doctors—to rural and regional health services, whether that be a workforce issue or a funding issue. Even if you are successful in recruiting them, retaining them is also equally difficult as well. As you mentioned, Mr Fang, there is a grant at the moment that looks at virtual pharmacy services. I think western New South Wales is one of the recipients of those grants. We actually have spoken to some of our members who are involved with this. Certainly, so far the results that we have heard are really positive, and that is not surprising. This type of model has been used across Australia through pilot trials. Just, I think, last year there was a Western Australian telehealth chemotherapy service which won an SHPA award.

Certainly now, because of COVID-19 and the pandemic, it is actually quite unsafe for certain patients to attend hospital because they are immunocompromised or they are elderly. It is unsafe for them to go to a hospital where there are other COVID-19 positive patients there. It is safer to provide them a virtual pharmacy service where you can do the regular service activities that they are missing out on such as daily chart review, counselling, therapeutic drug monitoring, looking at your medication list, providing your medication management plan, discussing your care plan with nurses and doctors and all those things that currently are not being delivered for rural and regional New South Wales patients because there is not a sufficient workforce in those areas. We absolutely do see virtual pharmacy services where perhaps if you cannot attract a hospital pharmacist to move to a rural or regional area or it is only an MPS with a dozen beds—the business case does not stack up. We understand that. So now we live in the twenty-first century, we would all have NBN, the internet, you can actually use virtual pharmacy services, use telehealth models to deliver the services and collaborate with other practitioners to make sure that they do receive the full scope of pharmacy services so that they do not have an adverse event.

The Hon. WES FANG: On that, I note a question from Ms Faehrmann earlier about Indigenous care providers and the support that they get from pharmacy providers. We know that they are a primary carer and primary care is predominantly a Commonwealth issue. Ms Felkai, you were talking about the support that is vital for those care providers to have. What can the Commonwealth do to actually help support those primary providers to Indigenous healthcare providers, and are things like the virtual pharmacy model of assistance?

Ms FELKAI: I think that there is absolutely a place for using digital technology, and the telehealth situation that we have had during the pandemic perfectly demonstrates the utility of this service. I guess I want to echo what Mr Yik has said in terms of, in my opinion, I always believe that it is better to have someone on the ground. I think that there is going to always be more personability and there is going to be a better uptake of recommendations when you have that personal link with people. However, recognising the particular geographic

logistics with these particular populations, the most important thing is that they have access to the services in the first place.

I do see a role, for example, with telehealth, particularly when it comes to those cognitive services. We are able to deliver home medicines reviews, as an example, where we can review the medications of people with complex chronic conditions and ensure that the medicines are being reviewed and that the doctor—again, it is a collaborative model with a prescriber around the most appropriate use of medicines. It could also include things like counselling, as an example. If a person needed to start on a medicine and they were a long way away from a community pharmacy, there are potential ways for the telehealth model to ensure that supply of a medicine does not occur without appropriate counselling advice along with it. So, yes, the short answer is absolutely there is a role for it. I think that we need to be considerate about how appropriately that role is used.

The Hon. WES FANG: Thank you for that. I know in the area I live—I am in Wagga—the Murrumbidgee Local Health District [LHD] has been trying some innovative models around the way that we have those onsite pharmacies provided to the local health district, almost like an outreach program. I was wondering, in the experience of the people that are providing us the testimony today, have you had the opportunity to have a look at how they operate, and do you think that there is scope that we could potentially widen that experience out to other areas?

Ms FELKAI: I might start, but I think Karen Carter will have the best experience when it comes to this particular model. The only thing I would really like to note is that your example of that outreach program is exactly the kind of boots on the ground that we really require in these areas. Because while that digital enablement is good to an extent, as an example, it loses much of the other physical aspects such as the direct monitoring of blood pressure which a lot of community pharmacies and outreach programs are able to do by being there on the ground—and, Karen, if you had any of those sort of examples in your experience with outreach programs?

Ms CARTER: I think it is important to have people on the ground. You have a better camaraderie and relationship with the patients, and you are there in real time so you can see any adverse effects of medications or any missed medications. We had someone recently who had been to a specialist and their son rang saying, "I thought Mum was getting a new medication for dementia?" We had not received anything. We phoned the GP. There was a letter written, but the GP had thought the specialist had written the script. We then got the medication started that day. There are different examples. Having more pharmacists in outreach areas is fantastic, but also you do have to have some people on the ground in those areas. So workforce issues are one of those things. I love my lifestyle, and I do travel to lots of different areas and love my rural pharmacy, but it is trying to attract those people to come and stay. It is the same with GPs. We are down to low numbers of GPs, and they are overworked and need a rest. We need to get more people on the ground.

Mr YIK: I just want to touch on the points made by—

The Hon. WES FANG: My time has expired. Thank you so much for your testimony today.

The CHAIR: Sorry, Mr Yik, you were going to jump in and say something, I believe?

Mr YIK: Yes, I just wanted to touch on the points raised by Ms Felkai and Ms Carter on outreach programs to prevent readmissions. That is really important.

The CHAIR: Please proceed.

Mr YIK: I will make it a quick point. In other hospitals around Australia there are provisions for outreach programs where a hospital pharmacist will go and visit you in your home if you are identified as a high-risk patient. If you a high-risk patient, if you just had an organ transplant or had a stroke or had a heart attack, you are started on a whole raft of five to 10 new medicines when you leave hospital and go into your home. It is that post-discharge phase and the immediate first seven days, the immediate first 14 days, where you are at the highest risk of having an adverse event, you are at the highest risk of having a readmission, you are confused about your new medicines.

In other States there are programs where you are identified and referred on to the outreach pharmacist in the hospital. That pharmacist will go and visit you in your own home in the first seven or 14 days, make sure that you are going well, make sure that you are settling in, make sure there is no confusion with your new medicines and if you are experiencing adverse effects. That can all be managed in the community with that pharmacist so that they do not end up back in hospital. Because of the workforce shortages in New South Wales, and worse so in rural and regional remote New South Wales, there are practically no outreach pharmacy services. That is when you see people end up back in hospital over and over again.

The CHAIR: Thank you. On behalf of all Committee members, can I thank our two witnesses from the Society of Hospital Pharmacists of Australia and our two witnesses from the Pharmaceutical Society of Australia.

It has been very high-quality evidence, I have to say. There has been a lot of detail provided to us for us to take away and read and understand. It fits nicely with what were very valuable submissions made by both organisations. Once again, on behalf of Committee members, can I thank you very much for making yourself available today. That now brings us to the conclusion of the sessions this morning. We are going to take a break now and we will be resuming at 12.50 p.m. Can I invite Committee members to please mute and turn off your videos for the break before us. I will see you back at 12.50 p.m.

(The witnesses withdrew.)

(Luncheon adjournment)

SARAH WENHAM, Specialist Palliative Care Physician/Clinical Director (sub-acute and non-acute care), Far West Local Health District, appearing on behalf of the Australian and New Zealand Society of Palliative Medicine, sworn and examined

SUSIE LORD, Board Member, Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists, affirmed and examined

PAUL WRIGLEY, Member, Learning and Development Committee and NSW Regional Committee, Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists, sworn and examined

The CHAIR: We will get this afternoon's session underway. Portfolio Committee No. 2 – Health is inquiring into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. We had a very productive morning with some excellent witnesses providing valuable evidence. The Committee members are looking forward to hearing from a number of expert witnesses this afternoon. This session will take us through to approximately 1.35 p.m. Our first witness is Dr Sarah Wenham, specialist palliative care physician and Clinical Director, Far West Local Health District, appearing on behalf of the Australian and New Zealand Society of Palliative Medicine. Also joining us is Dr Susie Lord, who is a board member of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists. Finally, we have Associate Professor Paul Wrigley, who is a member of the Learning and Development Committee and the NSW Regional Committee of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists. I thank the witnesses, who are all very busy medical professionals, for taking time out of your busy days to make yourselves available.

I acknowledge that both organisations have provided submissions. The submission of the Australian and New Zealand Society of Palliative Medicine has been received and processed, and stands as submission No. 458 to the inquiry. It is available on the inquiry's webpage. The submission of the Australian and New Zealand College of Anaesthetists, Faculty of Pain Medicine has been received and processed, and stands as submission No. 475 to the inquiry. Both submissions are very good and provide useful information to this inquiry. I will ask each organisation, through one of their witnesses, to make an opening statement. Given that Committee members have read the submissions, you do not need to go into them in detail in your opening statements. Perhaps if you set up your broad position on matters, that will then facilitate the questioning. We will start with the Australian and New Zealand Society of Palliative Medicine. Dr Wenham, would you like to make an opening statement?

Dr WENHAM: Yes, thank you. Mr Chair and Committee members, the Australian and New Zealand Society of Palliative Medicine, ANZSPM, would like to thank you for this inquiry and the opportunity to appear before you today. As I said, I am Dr Sarah Wenham. I live in Broken Hill and work across the Far West of New South Wales. I am employed full-time as the specialist palliative care physician for the Far West LHD and I am the elected co-chair of the Agency for Clinical Innovation's End of Life and Palliative Care Network executive. However, I would like to emphasise that I am appearing today as the representative for ANZSPM. I am not appearing on behalf of the Far West LHD, NSW Health or the Agency for Clinical Innovation [ACI].

The CHAIR: Thank you for clarifying that.

Dr WENHAM: ANZSPM is the specialist society for medical practitioners who provide palliative care for people with a life-limiting illness across Australia and New Zealand. We promote the discipline of palliative medicine in order to improve the quality of palliative care for patients and support their families. Our members are all doctors with an interest in palliative medicine and include specialists, doctors who are specialists in other disciplines and general practitioners. We have 561 members, including 121 based in New South Wales. Palliative care is an approach that improves the quality of life for patients and their families facing the problems associated with a life-limiting illness. Palliative care is not just for those in the last weeks or days of life, but occurs from diagnosis right through to death and supports families in bereavement. People who are dying and their families require care and support 24 hours a day, seven days a week.

There are a number of challenges in providing palliative care to those living in regional, rural and remote New South Wales. These challenges lead to highly variable access to and quality of palliative care. For example, some patients benefit from dedicated specialist services; others rely on care provided by GPs, community nurses and residential aged care staff. Some patients can be admitted to a specialist hospice; others only have the choice of dying in their local acute hospital if home is not an option. Some patients can access 24/7 palliative care support; others can only contact their clinicians during working hours. Consistent data is not available to determine what the need is; what medical practitioners are delivering care, with what training, to what quality; or what the patient experience is.

Despite the challenges, there are many positive features of providing palliative care in regional, rural and remote settings. Local services offer a sense of familiarity, community and continuity, while clinicians often go above and beyond for their patients and their families. ANZSPM wishes to see equitable, consistent and high-quality provision of palliative care across the whole population. We believe this inquiry represents an important opportunity to understand the exact need of patients' families and communities in regional, rural and remote New South Wales; understand the true state of palliative care in these areas, including provision by the State, Federal and privately funded services and clinicians; and address the need for increased resources to facilitate greater consistency and quality in the delivery of palliative care services, particularly ensuring that trained and credentialed medical practitioners are integral members of the multidisciplinary palliative care team. Thank you.

The CHAIR: Thank you, Dr Wenham, for a very clear and precise opening statement, which will set up the questions nicely. I move to the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists. Dr Lord, are you making the opening statement or will it be Associate Professor Wrigley?

Dr LORD: I will be making the statement today. I am a specialist pain medicine physician and staff specialist with the Children's Complex Pain Service based at John Hunter Children's Hospital and serving the Northern Child Health Network. I am on Awabakal land in Newcastle, representing the Faculty of Pain Medicine. In New South Wales the faculty works closely with the Agency for Clinical Innovation Pain Management Network, which Professor Paul Wrigley is representing today. We are jointly committed to the National Strategic Action Plan for Pain Management, endorsed by Minister Hunt in 2020, which calls for a clear focus on people in rural areas, recognising their high burden of acute, cancer-related and chronic non-cancer pain. I will focus on chronic pain due to burden, cost and inequity but can respond to questions on pain more broadly. The NSW Pain Management Plan 2012-2016 established five part-time chronic pain services in regional New South Wales. These regional services were designed for low-volume, low-complexity care, but they have since been shown to have high-complexity caseloads due to high prevalence of pain, chronic conditions, cultural and other trauma and socio-economic disadvantage.

Timely care cannot be provided with part-time funding. Moreover, recruiting and retaining staff is difficult. The tenuous sustainability of the part-time services is a threat to access and outcomes for people in rural New South Wales and a reputational risk for the ministry. Growing telehealth tentacles from Greater Sydney is not the best solution, but the ministry no longer has an accessible contact with whom to address this problem. We ask the Committee to recommend that the ministry reinstate a contact person or department to re-engage with the Pain Management Network and, as a priority, establish full-time staffing capacity for those pain centres currently serving rural communities. Regional hubs leveraging local connections and the hard-earned trust of their communities are best placed to deliver flexible combinations of face-to-face outreach and virtual care for rural people with pain. Thank you.

The CHAIR: Thank you very much, Dr Lord. We will move to questioning. In terms of political representation, the Committee has Government members, Opposition members and crossbench members. We will move between those three groups and provide them with equal time to ask you questions, which will take us through to approximately 1.35 p.m. Are people agreeable with that format? Does that suit you all?

Associate Professor WRIGLEY: Yes.

The CHAIR: I will commence, as an Opposition member. I direct my first questions to Dr Wenham. For those questions and also for my questions to the Faculty of Pain Medicine, I will draw on your submissions, which I found to be very helpful. Dr Wenham, I will refer to some specific paragraphs in your submission, and my questions will arise from those. Paragraph 2.3 on page 2 refers to the question of the availability of palliative care specialists in regional, rural and remote New South Wales, and the positioning of such specialists in those locations and the challenges that you see around that. Could you please elucidate on that?

Dr WENHAM: Certainly. NSW Health has committed to providing funding for every LHD to have a specialist palliative care physician. I think the challenge with some of that is recruitment to those positions. Each LHD has a physician; like, for myself, I can speak to that out here in Broken Hill. I am based in Broken Hill and I cover the whole Far West Local Health District. But, obviously, there is only one of me, and we cover a very large geographical area of up to 300 square kilometres, so that outreach needs to cover the other areas in our district. I know for certain other areas have either not been able to recruit to those positions funded by the ministry or they have got positions that are funded within a particular geographical area within the LHD, but not within other LHDs.

I think the other challenge within that is it is not just about specialist physicians, but it is also about other appropriately trained medical staff. A number of LHDs or areas will have GPs who have, say, done some advanced skills training in palliative medicine. Some may or may not have achieved their clinical diploma through the Royal

Australasian College of Physicians. Then there are other areas that rely on other medical staff—so GPs with a special interest who may or may not have done specialist qualifications. I think part of the challenge is that we actually do not know what areas have access to either specialists or GPs with specialist training.

The CHAIR: Dr Wenham, in regards to an undergraduate who completes a basic medical degree, how much palliative care training do they receive, to the best of your knowledge? If you need to take the question on notice, feel free to do so.

Dr WENHAM: All universities, I believe, do some basic training, but I think it really depends in terms of which university you go to and what clinical placements you do as to how much training you get. I think some people will get some and other people will not. If you would like me to take it on notice, I can certainly approach the universities to find what is included in their curriculum and actually get that exact information for you. Certainly, ANZSPM would advocate for all undergraduates receiving palliative care and palliative medicine training.

The CHAIR: No, thank you. I have heard examples provided to me in general conversation with people that there are instances where they believe that there is a minimal amount of training in palliative care as part of their undergraduate degree. It did surprise me. They were talking in terms of only hours of training inside a six-year degree. Naturally I would have thought that probably it would have been a unit or so, but if you could take it on notice that would be great. That leads me to my next question about the burden that falls to GPs in regional, rural and remote New South Wales dealing with the palliation of people, not only at the end of life. As you described, supportive and palliative care can be provided over a period of time. Particularly those treating people at the very end of their lives—these general practitioners—if they have not received or sought to do some specialty training in the area of palliative care, are they still able to palliate a person at the end of life through providing some basic pain management?

Dr WENHAM: Absolutely. Any medical practitioner—and we would certainly advocate for that, and that is why our membership is not just specialists; it is specialists with interest and general practitioners—is able to provide end-of-life care for their patients. We would certainly advocate that. I think, even as a specialist, we would advocate for general practitioners to be actively involved in their patients' care journey because they have known them and they have often got that long relationship, not only with the patient but with the family themselves, and they are going to be following the family through into bereavement as well.

But I have to say that some general practitioners have an interest and do their own education and training, do their own credentialing through the clinical diploma. However, there are other general practitioners that it is not really something that they have an interest in. I would say also from a general practice perspective, whilst absolutely all clinicians are able to prescribe pain medications and other medications used within palliative care, I have to admit there is a reluctance, and I think that has recently happened with some of the things that have happened around PBS opioid prescribing. ANZSPM does have a statement on that, which we would be able to provide to you on notice as well if that would be useful.

The CHAIR: On notice, Doctor, that would be beaut. In your opening statement you made a point that I thought was quite salient. You were talking about palliation and palliative care, not just in the context of the individual patient being treated but, obviously, that patient dying in the context of being a person with family members—they might be their immediate family, but extended family as well—and also the local community. We know that communities can be very tight, particularly those outside the big cities. People tend to know each other and often are involved in socialising and playing sports and what have you. Could you give us some insight into the issue that palliation and palliative care is more than just dealing with the patient per se at that very end of life?

Dr WENHAM: Absolutely. The definition of palliative care includes holistic care of the physical, social, spiritual, emotional, cultural needs of the patient and their family. As a specialist within palliative care, we work as a broad multidisciplinary team and that includes nursing, allied health, counsellors, our pharmacists, and we often have volunteers who are members of our actual clinical teams as well. But we really do acknowledge that the broader community is a huge part of providing palliative care for patients and particularly, as you say, in small rural communities. It is around supporting families and people doing the shopping and people dropping off meals and looking after the kids and looking after the grandkids, and I do not think you can ever quantify those types of things that are there.

But I think it does just show that providing palliative care in small communities is much more than just the clinical care, and there is really a need to provide that social, emotional and cultural care too. I think that then moves on to, particularly within our Aboriginal communities, the importance of being able to care for people in their own community and allowing them to be able to be cared for and to die on country if that is their wish, and making sure that we have the services that can actually support that from a clinical perspective too.

The CHAIR: Thank you. My time has expired. I did have some questions for Dr Lord and Associate Professor Wrigley, but I will try to circle back after the other members have asked their questions. We move to questions from crossbench members.

The Hon. EMMA HURST: Dr Wenham, I go back to a comment that you made in your answer to the Chair's question, which I think you also mentioned in your submission, that it is not clear who is providing palliative medicine in rural New South Wales and what qualifications they possess. Can you explain what you mean by that? Is it that it is not being tracked or monitored by the Government?

Dr WENHAM: I think it is quite challenging because there are multiple different providers providing palliative care. It can be provided by specialists like myself. It can be provided by a geriatrician who is caring for somebody who is dying or a nephrologist who is caring for somebody with end-stage kidney disease, or a cardiologist. It can also be provided by general practitioners providing that care in the community. I think it is because that care is being provided by specialists within the State system and general practitioners within the Federal system that there is no single way of tracking that information.

Similarly, we know within a specialist context who has their fellowships with the Australian college of physicians, but actually there is no way of tracking whether a general practitioner has done advanced skills or training or has a clinical diploma. That is really what we are saying: that it can be provided by many different people and should be provided by many different people because, as I mentioned before, of the importance of that care being provided by the right person at the right time in the right place—i.e., in their local community if that is what people want. But I suppose it is just how do we make sure that everybody is getting high-quality care without actually knowing because palliative care is being provided across the State and Federal systems.

The Hon. EMMA HURST: So we could essentially have a situation where there are patients in rural and remote areas where there is nobody with any kind of specialist skills in this space.

Dr WENHAM: Absolutely. They could be being cared for by a different specialist or by a general practitioner who, as I mentioned when I answered the Chair's question, yes, will have their general training within general practice, but we do not know whether they have actually done any specific palliative care training or not.

The Hon. EMMA HURST: You also mentioned in your submission that GPs are not provided with any kind of reimbursement for travel for home visits, and obviously that is going to make it harder for people in rural areas to access this [inaudible]. Do you think that introducing a travel reimbursement scheme would actually encourage more GPs to offer in-home services in rural areas?

Dr WENHAM: I think, certainly, palliative care is something that, as people get more unwell throughout their disease trajectory, it is not as easy for them to be able to travel in to a clinic, and so therefore I think there are two things. It is about making sure that the care can be provided in the most appropriate place and, if that is the patient's home, that the clinician providing that is reimbursed not only for their time but also their travel time. I think that is the other thing. The other real challenge is how we can provide appropriate medical support for people who are living a long way away from the clinicians as well. Certainly I think we need to be much broader, and ANZSPM would certainly advocate for medical practitioners to be reimbursed—not only the face-to-face clinician time but everything that is actually included in providing the most appropriate care to the person in the most appropriate place. If that is their home, yes, absolutely, we need to be thinking about travel time being included in that.

The Hon. EMMA HURST: Do you think that that lack of reimbursement is the biggest barrier or are there other big barriers to ensuring that kind of care in the home?

Dr WENHAM: I think there are probably many different barriers: some of the other support services in providing care in the home and just knowledge, skills and confidence. But I think one of the other things is actually what can be provided in the home. As I said before, palliative care is very holistic; it is not just about the clinical care but it is about the social care, so making sure that particularly people in remote areas have access to appropriate home care services, that people are appropriately trained who can support families and other carers in that home environment as well, because one of the other things that we see is that when people do not have that home care support and they are trying to care for people 24 hours a day, seven days a week, sometimes the only option they feel is for them to be admitted to hospital if there is not appropriate home care support. I think the more rural you get, often the more challenging that can be as well.

The Hon. EMMA HURST: Yes, absolutely, thank you. My time has expired.

Ms CATE FAEHRMANN: I have a couple of questions, either to Dr Lord or Associate Professor Wrigley in relation to your submission. Sorry, I am flicking between screens and not doing a very good job of it. You talk about Aboriginal Community Controlled Health Organisations and say:

> … it is evident that there is a keenness to partner on staff professional development in the fields of acute cancer-related and chronic pain management to enhance Aboriginal Community Controlled Health Organisation pain management …

You recommend that there be more funding for these initiatives. Would either of you care to expand on that and also tell the Committee why that is so important, perhaps by highlighting the gaps that are there now as well?

Dr LORD: Sure. I will start and Associate Professor Wrigley may wish to add. I am also the chair of the Reconciliation Action Plan Committee for the faculty and have a personal interest because 20 per cent of the kids I treat are Aboriginal. We certainly work with Aboriginal medical services and have seen children in those services when that suits the child and family, and work in with the services that provide that care. It is very clear from discussions with them that having secure, protected funding to those services to allow them to choose what educational resources and professional development they would like is really important to those services. That is about education and professional up-skilling of people on Aboriginal medical services.

There is a disparity in the experience of chronic pain. We understand that one in three Aboriginal people experience chronic pain, and in a small paediatric pain service to have one in five come into a tertiary pain service, as inaccessible as tertiary pain services might seem, suggests that there is a really unmet community need for chronic pain services to children and adults. Fifty per cent of Aboriginal communities are people under the age of 24 in most places outside the urban centres, so it is a really huge need and there is a gap, and we need to really look at cultural safety. The Agency for Clinical Innovation has done a lot of work in developing a broad understanding of culturally safe communication strategies within the pain sector, and they have developed a website called "Our Mob", which helps provide community resources for people with chronic pain—adults with chronic pain, primarily—and there are some community programs that have been developed or adapted from others and then used within communities, so those things are really helpful.

Ms CATE FAEHRMANN: That was a great response. I think you said 30 per cent of Aboriginal people experience chronic pain. I assume that one of the consequences of that is using alcohol and other drugs in ways that are not great if they cannot access quality pain management. Is that something that you see quite often too, Dr Lord?

Dr LORD: We do not have data on that. There are some data that suggest that there are more people in Aboriginal communities who abstain from alcohol and that some of our preconceptions about that may be misunderstood. But I think broadly across those communities, and also others, where there is an absence of access to best-practice, multidisciplinary pain management, people end up being prescribed opioids primarily and other drugs - having a really biomedical focus. Our faculty's framework is a socio-psycho-biomedical framework. We think that the social determinants of health are incredibly important for pain and pain management, so we do think that the gap in pain services does result in community harm and some of that is through drug and alcohol use. It is not specific to Aboriginal communities, but when it occurs in those communities it adds to the disadvantage in them. I will leave space for Associate Professor Wrigley to speak also.

Associate Professor WRIGLEY: Professor Paul Wrigley here. I am a specialist pain medicine physician and, in terms of who I represent here today, I am the medical co-chair for the Agency for Clinical Innovation, Pain Management Network. I would just concur with what Dr Lord has quite eloquently said. It is not a feature just of Aboriginal health; it is across all cultures, really. I think having an interdisciplinary—in other words, not just medical but clinical psychology, physiotherapy and other allied health services—is really crucial to look at the whole person and provide useful strategies that are beyond just the medications and interventions that can be provided.

The CHAIR: Thank you, Professor. We move now to questions from Government members. Will that be the Hon. Trevor Khan or the Hon. Wes Fang?

The Hon. WES FANG: [Audio malfunction].

The CHAIR: Would a Government member like to jump in?

The Hon. WES FANG: Sorry, Chair, I was on mute. It is Wes Fang. I thank all our participants for giving your time to appear. During the hearing today we have heard already about the importance of networking. We know that where we have some difficulties in providing a full suite of care to health areas across the State, we can access networking services. Can you provide some insight as to how those networking services work in regard to palliative care? How do you think we may be able to provide some better services through that networking experience for those people who are receiving that palliative care?

Dr WENHAM: Absolutely, thank you. Networking is so important, and I think it really is the only way that we can actually provide palliative care to rural and remote areas. So, speaking from my personal experience out here in the Far West, we work very closely, as I have already mentioned, with general practitioners but also our local residential aged care facilities [RACF]; the Royal Flying Doctor Service [RFDS], which services all of

our remote facilities and areas; as well as Maari Ma, which is our local Aboriginal Medical Service. I believe all of the other LHDs will have those connected relationships and networking. A lot of it happens informally on the ground, where clinicians work very closely together for an individual patient, but I think organisations like ANZSPM and the other professional relationships also allow us to network together and to work and to provide that sort of general education and training from palliative care specialists, for example, to other specialists in other disciplines and general practitioners.

I know for our district we will support education and training for our RACF members, staff and other community-based services. I think part of the big challenge, however, is the different funding of those different models. We are all working together, but Health works under State. RFDS is Commonwealth funded, as is aged care, as is general practice. Part of the challenge is how do we, when we are all working under, I suppose, slightly different funding models, actually then all pull together, and how can that be more streamlined? And then you would throw in in-home care services and those types of things as well, which are also essential to palliative care services, and then, I suppose, the provision of medications. That is another thing. Some are available through PBS funding; others are not available on the PBS and so need to be provided either privately or through hospital pharmacy services. So, again, just not forgetting hospital pharmacists and community pharmacists in there as well.

I do not know whether I have got the answer to it. All I know is that, for us, building relationships on the ground is something that is really important. But if there is some way that that, I suppose, could be supported—for example, we have multidisciplinary team meetings, where we get everybody together, and I think within Health that is funded through one way, but if there can be some way that you can bring private practitioners into that—so general practitioners and pharmacists into that—so there can be that funding for them to be able to be part of that broader networking, both on an individual patient basis but also from an education and training perspective, that then helps local clinicians work together, both as teams but for individual patients too.

The Hon. WES FANG: Do any of the other participants have any views? Dr Lord, you look like you are waiting in anticipation to answer. I am very keen to hear your opinions as well.

Dr LORD: I think for pain medicine it is also essential. We go across acute and chronic and cancer-related pain. We are, in essence, a multidisciplinary faculty, so people train from general practice. Physicians, anaesthetists, psychiatrists, surgeons all train as pain specialists, and a growing number of GPs. In New South Wales the main network is the Agency for Clinical Innovation Pain Management Network. It includes consumers and allied health staff as well and has been a very effective instrument over time, but its sharpness has been lost by not having a connection with the ministry for health. I will hand over to Associate Professor Wrigley because he is the current chair of that network.

Associate Professor WRIGLEY: Paul Wrigley here. Thank you for your question. I think one of the key things we wanted to communicate to the Committee was that in the information you received initially you were not given the broader network that is available, and we have just three recommendations to get you to consider actioning if that was possible. One was, as Dr Lord mentioned, to reinstate a contact person within the department of health. That could help us to address the maintenance of what is there but, in fact, to be able to enhance what we can recognise is impacting on the provision of care, particularly for rural, regional and remote New South Wales. So, a voice would be great, but also to establish better full-time capacity in those part-time regional services, which are not able to attract people because it is very difficult to go out to a region and be employed part-time.

With that, one of the things we have noticed is that the ministry for health has dropped all of their service-level agreements. We would recommend that the ministry look at reintroducing a service agreement, and it can be a very general one—possibly all LHDs maintain a full-time, multidisciplinary pain management service, resourced to provide primary care or to resource an inter-LHD collaboration to achieve this. I think if there is an agreement to provide a pain service, it then puts the onus on the LHDs to actually resource what they have already got but also to look at providing something for those that do not have it. We have eight services available but at least five of them are part-time. I will stop there.

The Hon. WES FANG: Thank you for that. I was just seeing the notifications that are coming through. I have about two minutes left. Dr Wenham, you were talking about the different funding models. Obviously, we know that there are components that will fall under the Primary Health Network, which is the Feds, and then there is obviously the LHDs, which is the State. Do you have some views as to how we can better integrate the services to enable the provision to be more streamlined? I think that was the word that you were using before—"streamlining" the process. Obviously, you can see that there are those coordination issues, but I would be keen to know whether you have some views on how we might progress that forward.

Dr WENHAM: I think what we really need to be doing is getting everybody together. I really only can speak from my understanding of specialist funding. We certainly do need to be having funding of Aboriginal

health, the RFDS and also local GPs together. I think it is about making sure that we are funding everything that needs to be funded but not double funding as well. It certainly does need to be across the board. In terms of just going back to your previous question about networking, whilst I am not here representing the ACI, as with the pain network the ACI does have the End of Life and Palliative Care Network that is already set up across the State, which does have representatives from all of the State general practitioners, RACF. I think using some of those networks that are already there to actually define what needs to be done, how it needs to be funded and then look at some sort of combined funding models, or looking at what are our needs and how can we fund those out of the different pots. But I think ultimately a lot happens through the goodness of people's hearts, both in general practice and in health services. I think if you actually quantified what happens, probably there is a lot of stuff that happens that does not actually get funded, and that is rural communities for you. I think there is work to do to define it.

The Hon. WES FANG: My time has expired. Thank you again for the great work that you are all doing in this space. I commend you for appearing today.

The CHAIR: In the remaining few minutes, on behalf of the Committee I will ask a couple of questions to take us through to the end of this session. I direct my questions to Dr Lord and Professor Wrigley, specifically with regard to your submission. If you have that close by or you can access it, I am looking at the bottom of the first page, going onto the top of the second page. On the bottom of the first page, the submission states:

> Chronic pain is a major and growing public health problem throughout Australia …

After the citation, it goes on:

> Population data and extensive experience suggest that people living in rural and remote Australia—

and then it says—

> and NSW in particular, experience a higher burden of chronic pain and face more barriers to accessing best practice pain management compared with those resident in urban areas …

Can you comment on that specific reference to "and NSW in particular"? What is that based on—research, evidence or what?

Dr LORD: I believe that is in relation to population density, so the rate—so by virtue of the number of people living in New South Wales, essentially, not in relation to a differential rate of burden. We do not have that data. We hope that after the 2022 National Health Survey we will be able to report by jurisdictions the actual incidence of chronic pain in Australia and across New South Wales and different States, and have comparative data, but at this stage we do not have that. The issue is that people living in rural areas have a higher burden of socio-economic disadvantage, and that is highly correlated with experience of chronic pain.

The CHAIR: Finally, page 5 of your submission, under the heading "Planning systems used by NSW Health in relation to pain service provision (terms of reference (e))", refers to the New South Wales Pain Management Plan 2012-2016, which Dr Lord referred to earlier. Has that plan been replaced by a plan to follow that or are we in a limbo period at the moment? What is the situation?

Dr LORD: From a New South Wales perspective, we are in limbo. We have a national strategic action plan, which was endorsed by Minister Hunt at a Federal level at the end of last year, and the States have been asked to consider how they can action that plan at a State level and deliver actions that will meaningfully reach the goals that have been agreed are very valuable and important to curb this public health problem of chronic pain. I think what the State would benefit from doing is working with the ACI Pain Management Network and the Faculty of Pain Medicine on how to action the pain management plan within New South Wales most effectively for people with pain.

The CHAIR: Does that mean that it would be your submission that a new plan ought to be put in place or that the plan that expired in 2016 just needs to be implemented on a continuous basis?

Dr LORD: I will let Associate Professor Wrigley answer.

Associate Professor WRIGLEY: No, it needs to be revised. You cannot set a plan in 2012 and expect it will last forever.

The CHAIR: I would not have thought so, no.

Associate Professor WRIGLEY: We have learnt so much, but we need to then come back to the table and say what we have learnt and what needs to happen. We need to have that voice back within the ministry for health, and we have a platform for that with the most recent national strategic action plan that has been endorsed at a Commonwealth level.

The CHAIR: But it would be helpful, would it not, to have New South Wales, as a State itself, augmenting that to have its own pain management plan?

Associate Professor WRIGLEY: That is right.

Dr LORD: Absolutely.

Associate Professor WRIGLEY: A task force was developed before the New South Wales plan was made. Recommendations were made to the Minister, and then the Minister responded with that plan. That process probably needs to be redone or at least the Commonwealth plan be adapted to New South Wales.

The CHAIR: Adapted, yes. That brings this panel to a conclusion. I speak for the whole Committee [audio malfunction].

Associate Professor WRIGLEY: I think the Hon. Greg Donnelly has gone but thank you, honourable Committee members, for listening to us and inviting us today.

Ms CATE FAEHRMANN: Thank you.

Dr LORD: Thank you very much.

(The witnesses withdrew.)

(Short adjournment)

MEGAN SMITH, Executive Dean, Faculty of Science and Health, Charles Sturt University, affirmed and examined

LESLEY FORSTER, Dean, School of Rural Medicine, Charles Sturt University, sworn and examined

JENNY MAY, Director, Department of Rural Health, University of Newcastle, sworn and examined

The Hon. EMMA HURST: Wonderful. Thank you all so much. I would like to now open the opportunity for people to read out an opening statement. Professor May, did you have a short opening statement you wish to give? Please proceed.

Professor MAY: I do, Ms Hurst, thank you. Thank you, Committee. I speak to you as an academic with an interest in workforce; a practising GP who, incidentally, practises palliative care, in reference to the last hearing; and a Tamworth resident with a personal and professional investment in high-quality rural services. The last few months and the advent of COVID as a reality in rural communities has created an escalating challenge to try to maintain rural health services, with an increasing focus not only on acute services but also challenges to scale up immunisation, testing and pathology. While these challenges are new and pervasive, it is important that we use this opportunity to consider whether the gaps that we are seeing are those of a pandemic or whether there are underlying and structural concerns that need to be articulated and addressed.

In the next two minutes I make two points: Rural health services need a local, well-trained and highly valued workforce; and the systems of funding and support for rural health are incredibly interdependent and interlinked, so a movement of a lever in one sphere can have unintended consequences, especially when it comes to income autonomy, with a net loss of rural workforce and a long time to replace. I have observed the gradual loss and ongoing loss of localised capacity, with increasing reliance on locums, fly-in fly-out services and the need for rescue and retrieval. It is the result of multiple small, unconnected decisions over 20-plus years. Rural health services straddle multiple service models and funding streams, including general practice, aged care and acute services, and are delivering at a time when there is a pervasive focus on specialism above generalism. You just heard that in the last hearing.

Whilst my submission is mainly about the role of undergraduate rural health student training, that is simply the beginning. Best evidence demonstrates rural origin and positive rural exposure are both critical in attracting and encouraging medical students to careers in rural areas. Evidence nationally and in my own patch here in Tamworth with the Joint Medical Program demonstrates high levels of intent of graduating medical students as rural preferential interns in our hospital system. However, whilst I have witnessed success from both of these predictors, it is not sufficient. Even if it was doubled or trebled, it would not provide us with the workforce we need. It is clearly not the only strategy as it is not currently translating into a sufficient workforce quantum. There is pressing need to reorientate our prevocational and specialist training.

Dr Jones, during your hearing in Gunnedah, said that, despite her best efforts, junior medical officers who choose to base themselves in rural areas are provided with no assistance if they want to rotate to metro areas, yet JMOs who come out of our urban base are paid up a grade and provided with accommodation. Historically, this practice, while well meaning, is a value message: Metro-rotating doctors are worth more than those committed to rural areas, and they need to be compensated for coming to the bush. Such a small thing, such a poor message—and seemingly no avenue, including raising it in Parliament, to get it changed. Australian-trained medical graduates are consistently choosing better-paid and supported training that is urban based. Specialty training, while primarily in rural areas, is the exception not the rule—you have heard that so many times through this inquiry—with metro-based networks geared to rural rotations as opposed to rurally based training.

The solution, however, is not as simple as insisting—and I am not suggesting it—that we rurally base all specialist rotations. Any training that is perceived by our colleagues as second-rate training and occurs where resourcing is clearly constrained, and where workload for our junior trainees is far greater than their metropolitan trainees, will fail. Dr Scott clearly pointed this out in his submission in Gunnedah. Unfortunately, when we are reorientating our training system simply to promote rural training, it will not be enough unless we make it a suite of supports and manage the trends that have been well evident over the last 20 years. The challenge is instead related to the inherent valuing and messaging of generalist training, and changing that balance in our overall workforce between generalism and specialism. Whilst 20 years ago a wide scope of practice was embraced and supported, there are now significant barriers and perceptions of barriers in providing wide-scope, locally based care.

There is no doubt that this is more than a rural problem, but our rural areas are the canary in the coalmine. Clearly this requires collaborative work, which is occurring in small part as part of the National Medical Workforce Strategy. The strategy aims to improve collaboration between Federal and State, to rebalance supply

and distribution, to reform some of those training pathways and to build generalist capacity whilst understanding that growing Aboriginal and Torres Strait Islander workforce, looking after doctors' and others' mental health and wellbeing, and adapting our models of care are obviously primary. We have got to make sure that the key consideration of this strategy is the geographic maldistribution that we are so aware of. At a jurisdictional level we have a responsibility to share data, collaborate and really try to align these high-level levers.

Training a new workforce, which may take years, will not be successful if we do not clearly articulate where and how our health professionals should be working. Time and again at this inquiry you have heard about service reduction and disappearance—I call it "systematic disinvestment"—again happening incrementally over years. When services are reduced and the funding buckets change, there are no accessible general practice services and, where there are no accessible general practice areas, avoidable hospitalisations increase. There seems little flexibility or appetite to manage these high-level issues. Importantly, let's look for transparency. Even within the system our many speakers have described the challenge of getting information on what the community implications for funding and planning. The lack of support to general practice and primary care—and the importance of integration, which we feel so keenly in rural areas—must be addressed.

Virtual care has its place but, in my view, does not compensate for in-person, wide-scope, rural generalist nursing and medical skills. So, despite all of our and many of our well-meaning attempts to provide quality rural health services, we find ourselves in a situation where we are seeing reducing critical mass. If our intent and our reality is a downgrade in those services, please can we majorly ramp up retrieval services and just-in-time care, and be honest and accountable about this trade-off to our communities. Rural health has passionate, committed players and a significant direct and indirect interdependence with mainstream health services. We will achieve comparable health outcomes and high-quality care if we clearly commit, at both levels of government and as communities, to invest in an honest and accountable rural workforce and infrastructure. Thank you.

The CHAIR: Thank you, professors. It is the Chair back. I thank the Deputy Chair for holding the fort whilst I was offline for reasons that I still do not fully understand. Let us return now to the part of the hearing where we defer to members to ask questions—

The Hon. EMMA HURST: Sorry, Chair. We have only heard the opening statement from Professor May. We have not actually heard from either Professor Forster or Professor Smith.

The CHAIR: I do apologise. We will move, then, to the second opening statement.

Professor SMITH: Thank you, Chair. I am Professor Smith and I am providing a statement on behalf of both Professor Forster and myself from Charles Sturt University.

The CHAIR: Thanks, Professor. Apologies for that.

Professor SMITH: We have prepared a statement and I really would like to table that, firstly. I am not planning to read through that, but we have forwarded that through to the secretariat to become part of the minutes of the meeting.

The CHAIR: Thank you very much.

Professor SMITH: However, I think that Professor May has really outlined—and I would understand the pair of us being together in this session indicates that we have a lot of commonality between the key points that we wish to raise and represent. Certainly our main thrust of our tabling of our opening statement, and also our submission, has been the role that education plays in the future health workforce and the contribution that educating beginning practitioners in their entry to the workforce can make. We would certainly like to—rather than reiterate the issues and things that Professor May has already raised—engage in a conversation about some of the solutions and the contribution that education can make. I will hand back to you and take that as a tabled statement.

The CHAIR: Thank you very much. We look forward to receiving that statement for us to be able to read. That is great. Thank you for that. That provides us now with that opportunity to ask questions. To the witnesses, we have representatives on the Committee from the Opposition, crossbench and Government. If we are agreeable, we will rotate that across the three groups, starting with the Opposition. The Hon. Walt Secord, if you are there?

The Hon. WALT SECORD: Thank you, Chair Donnelly. I just want to alert my colleagues that the Chair and I are on the same internet service at Parliament here and I am getting the little symbol. If I disappear, be ready to resume. Professor Smith, in your statement you talked about practical solutions to work education. Can you actually spell out what you are suggesting? We as a Committee make recommendations to the Government at the end, and that is where the expert advice—what you would like to see us recommend.

Professor SMITH: Yes, certainly. The main recommendations—and this obviously comes from the lens that we have as education providers. In Professor May's statement she highlighted that the evidence base supports that if you look at the pipeline of a future health workforce, that pipeline is strengthened if you bring people into it from rural environments, educate them and allow them to have experiences in rural areas as part of their training. And then you provide them with job opportunities in rural communities at the end of that—job opportunities that are respectful of their scope of practice, that provide them with professional development opportunities and are secure employment with training associated with it. I think we know that that is the pipeline that is effective in building an effective and strong rural health workforce. I think the recommendations we have are: What can we do along that pipeline to strengthen that along the way?

One of those, for us, is actually looking at that educational experience where students have the opportunity to learn in a rural environment and to gain experience. The challenges of the workforce are such at the moment that for our rural practitioners to engage in education is difficult for them. They are stretched across service provision. But we know if they can engage in education, then we can build the next layer of workforce and strengthen that in future. Some of our recommendations are actually looking at the funding and resourcing and surrounding network that surrounds clinical placements for students—both for the student to take part in that, but more particularly for the educators who are in the sector to be able to support those students.

We do have a predominance of placements for students across the board at the moment that are in our public healthcare system. There is less participation in education from the private sector and the NGO sector. That is not necessarily a willingness; it is just the capacity of the way they deliver services to accommodate students. I think that if we are looking at the solutions, looking at how we can strengthen that education is one of the things we should be looking at. Look, I will just pause there as I am sure others would—or I can take a further question, if you like.

The Hon. WALT SECORD: Can you give a bit of context? Is it, in fact, getting rural people to remain in rural areas or is it to, in fact, get city people who come to rural areas to experience and then remain? What is the better approach to increasing workforce in rural and regional areas? Is it keeping rural people there or is it enticing city people to rural areas?

Professor SMITH: If you wanted the most impactful of those, the evidence would suggest that taking someone who has grown up in a rural area, educating them and providing them with strong education gives you the strongest return. But that is not the sole solution; there are many people who have grown up in metropolitan environments who have undertaken education in rural locations and who have become strong advocates of rural practice. To answer your question, there is neither one of those that is the perfect solution. What is important is acknowledging that a strong, meaningful and engaging experience in a rural environment can encourage people to want to work in that environment and stay there.

The Hon. WALT SECORD: Professor May, would you like to add something to that? I saw you nodding.

Professor MAY: I would love to, just to amplify what Professor Smith says. Rural origin by itself, currently 30 per cent of medical students in New South Wales are of rural origin who attend medical programs. Of those, 30 per cent of them currently go rural—so you can see our net return is 10 per cent. What we need is a workforce of at least 30 per cent—or 40 per cent probably—to get population and geographic equity. We must work not only with rural origin, who have our most positive predictors of return, but also with what I call "conversions". Positive rural exposure—providing opportunities for metropolitan students to be exposed to rural practice and to take it on.

But really the key word that Professor Smith and Professor Forster and I are working on is "positive". The difficulty is if we expose medical students to demoralised, really stretched, overworked rural clinicians, then obviously that is not going to necessarily translate to positive rural exposure. It is really building, as Professor Smith said, the environment which is conducive not only to good clinical practice but to teaching and learning as well.

The Hon. WALT SECORD: Professor Lesley Forster, is there anything that you would like to add or observe in relation to the [audio malfunction]—

Professor FORSTER: Sorry, did you finish? You seemed to disappear.

The Hon. WALT SECORD: I am sorry, I must have cut out. Is there anything you would like to add to what they have just said?

Professor FORSTER: We have all worked together for a long time and I support both Professor May and Professor Smith, obviously. But something that I assume you understand we take for granted—when Professor

May is talking about the 30 per cent of students who come from the country but only 30 per cent of them stay and set up practice, one of the big problems that exists is that, as she said earlier, they need to go away to do their training, often in Sydney. When they go, they are at that age where they have just graduated. They fall in love. They buy a house. The person that they decide to marry says, "I'm not going to the country." And so they do not come back. Whereas if we can have a situation where students from the country do their training in the country and do their postgraduate training in the country, they are the ones who probably more than anyone else are going to stay.

In our program that we are setting up we had 824 applicants for our very small number of positions, which to me indicates in the first year of a program—which always people would be a little bit anxious about—a huge unmet need in rural people who want to study medicine and are prepared to work in medicine. All of our students are of rural origin and they are all, at this stage, wanting to stay in the country when they have graduated. We are very much encouraging them, as part of our program, to look at rural generalism. We are developing a pipeline where they do their clinical placements where they come from—or, in some cases, as far away as possible from where they come from, depending on their inclinations. But we are doing that with the whole aim of maintaining those relationships and roots that they have in the country, so that they will in fact want to stay there and help this crisis.

The Hon. WALT SECORD: Are you finding that if students do come, they are going to the major regional centres? It will be quite easy to get someone to go to Tamworth, Orange, Wagga Wagga—

Professor FORSTER: Yes. Yes.

The Hon. WALT SECORD: But going to—I do not know what the actual phrase would be—smaller centres that would have major hospitals, is that the real challenge?

Professor FORSTER: I think that is what has been happening. The regional centres, as you say, are quite popular and have become quite desirable. That is why, again, we have turned it around so that our students are starting in the general practices and small towns, and they will continue, from there, to work. In the later years they will go to the regional hospital, but they will have built up those community links. We have done that deliberately to try to say to them, "General practice is really interesting and a community is really interesting if you build that up, and this is where you want to come back to."

To us, that is the way we have decided. The interesting thing has been that we have approached a lot of general practitioners who are stretched and are working hard and said, "This is what we want to do." And they have said, "I really think that's a great idea. That's going to work. Let me in; I'll teach students." So we have had a lot of remote general practitioners who have agreed to become part of our program and teach the students in the hope that they will follow on and work in their practices or near them.

The Hon. WALT SECORD: Professor Smith, I saw you raise your hand. Do you want to add something to that?

Professor SMITH: That's alright. So did Professor May, as well; she wanted to add to it. To take one of your questions about the difference in the size of the regional centres, there are a couple of comments to make about that. One of them is about where placements can occur and students gain the experience, and the second one is about where a job opportunity will exist for somebody once they have completed that training. From a placement point of view—and I would probably take my answer in the context of the wider health workforce. Clearly medical practitioners are a really integral part of our health workforce going forward, but it also applies to our nursing workforce and our allied health workforce as well.

It is easier for us to get placements for our students in the larger regional centres—that is, Wagga, Tamworth, Orange. That is a reality; there are more health practitioners, and the system is better integrated to provide a comprehensive experience for students. It becomes harder the smaller the community, most often because the health practitioners in those regions are in part-time positions or may be across multiple areas and sectors. Trying to bring that collaboration together to get a comprehensive experience for a student is more difficult the smaller the facility. I mentioned before that the predominance of placement and education is taking place in the public sector—that is, the hospital-based sector—and in smaller communities you tend not to have as big a facility, so it is harder.

To the piece about the jobs, once you have got somebody having experience, we will educate the student who will go, "Fantastic, I want to work in a rural environment." Then they will try and step into a job, but the job does not exist in a position which is well designed for someone who is new to practice. That is because someone might have funding and they would really prefer an experienced person, or it might be a fractional position, or it might be a contract position. The skill base that someone has on graduation is not well designed for them to step into a new graduate position. Here I am particularly talking about allied health and nursing as opposed to medical,

which of course has an internship-based system. They are some important parts when you get out of the bigger centres and you start looking at some of the issues around smaller centres and the capacity to provide health services in those in the future.

The Hon. WALT SECORD: Mr Chair, with the indulgence of Trevor Khan, could we have Professor May extend on the answer, please?

The CHAIR: That would be great, and then we will move to the crossbench. Thank you—and thank you, the Hon. Trevor Khan.

The Hon. WALT SECORD: Thank you, Trevor.

Professor MAY: I value that opportunity, thank you. It was simply to extend it and say that you have highlighted a really important problem, which is, for instance, when medical graduates finish their medical degree, they can only do rural preferential or internship—the PGY-1 and PGY-2 years—in a metropolitan area or in our selected regional centres. So you are exactly right: Even if you have someone who is rurally intending, the most rural they can go for internship is one of those regional centres. They do provide a little bit of a magnet, if you like, to our trainees. Now, as you have heard, from the specialists' point of view many of our rural trainees are choosing specialism over generalism. Sixty-plus per cent of our medical graduates specialise, and less than 30 per cent are now going into general practice. That is what I was alluding to: As we lose generalism and that focus of generalism in our workforce, these problems will become more and more acute.

The CHAIR: Thank you very much, Professor. The crossbench—Cate, are you kicking off?

Ms CATE FAEHRMANN: Thanks, Chair. I am happy to. Thank you for appearing and also for your submissions, which are incredibly detailed and really helpful for the inquiry. I just wanted to go—which one have I got open—Charles Sturt. I wanted to ask about particularly the cost of clinical placements and the cost on the students of clinical placements, as well. In this paragraph you have said that in relation to nurses' training, the cost of part of it is increasing at a faster rate than funding for the course. Sorry, I have lost—Charles Sturt is—

Professor SMITH: It is probably me who would be the most appropriate person to answer that question.

Ms CATE FAEHRMANN: Sometimes you can flick between all the screens and have the agenda as well. Sorry about that.

The CHAIR: And we have three professors, too.

Ms CATE FAEHRMANN: Exactly. If the professor could answer—

Professor SMITH: I am happy with Megan; trust me.

Ms CATE FAEHRMANN: Thanks, Megan.

Professor SMITH: Look, it is a really important question because the cost of placements in this particular case is the cost to the student of that experience. I think we have a particular lens on that. We have more recently look at the idea of students will do a clinical placement in a regional area from a metropolitan location. There is that idea that they get sent out to the country. One of the particular things we notice is that our students will move and do placements across a number of regional areas, and what that brings with it is a cost that relates to—I think costs are multifactorial. One of the costs is the cost of accommodation. Where are you going to live and how are you going to live there and where is that availability of it? We have had increasing ability support, particularly through the Commonwealth-funded Rural Health Multidisciplinary Training [RHMT] program, which has allowed us to start to put accommodation in locations.

But that was a major issue for us; we have had students living in caravan parks, hotels and various other environments which are not great and are expensive for them. So that is one of the costs. The costs of travel are greater. We can have a student go from the Mid North Coast to the Murray River in terms of seeking placements, and that is a long distance between them. If they are undertaking paid work, they will need to forego that paid work for the period of time that they are on clinical placement. By the time they get to their final years they are long blocks of placements, depending on it. We have had students who will drive home at the weekend to go back home to do their weekend work so they can actually earn an income to then go back to placement the next week. The nature of what is the cost to the student is quite considerable, on top of all of their living expenses and everything they have in between.

I think that is exacerbated for a rural student compared to a metropolitan student, who may be able to stay in their home base accommodation where work is down the road, travel out to a placement and come back at the end of each day. I think it is a particularly unique scenario that is worse for our students and for us in that environment. I hope that answers your question.

Ms CATE FAEHRMANN: Yes, that was really good. Thank you. Particularly for nurses, for example, who are kind of unique in terms of income generation throughout their career, that is a big sacrifice, in some ways, to make. It is all about sacrifices, really, for our nurses at the moment.

Professor SMITH: It is. I would probably add that I think what we do—and this starts to extend the cost into what they return. They make a significant contribution into the healthcare system. Absolutely, they get their education, and everyone respects that they are not fully qualified practitioners and they need support. Yet they make a difference every day to the quality of health care in our communities. I have seen hospitals that are dependent on the throughput of students to maintain the level of care that they are providing, because they are part of that workforce. You have got the cost to them—the cost of their education—and yet they are making a contribution. That is a fair sacrifice they have right up-front.

Ms CATE FAEHRMANN: Thank you. I do have one more question before my time is out which I do not think has been covered. It is in the Charles Sturt submission in relation to that health services have lobbied the Health Education and Training Institute [HETI] to upgrade the system. I do not think you have talked about that. In the submission it says that, to date, the efforts have been unsuccessful to update the HETI system. I am potentially interested in why, and to explore some of the reasons behind that. I think that is important too.

Professor SMITH: Look, I can probably only speak to our experience of working with HETI over the years. I will say that HETI does work really constructively with us, but they are facilitating placements and facilitating it across the board. The number of placements that HETI will try to administer and provide oversight with, with their ClinConnect system, is enormous. We have seen that rapidly increase. They do have a system, which is a computer-based system, but rural is small within that. For them to have the resources to be able to upgrade a system to particularly meet the needs of a rural practice, I think, is just not within the scope of all of the work they are doing. I think that is why. Rural is small. When you have the scale of some of the sizes of the metropolitan placements in there, it is just where it would sit for them. That is certainly our experience on our side, but I would think that they would have a response to that as well.

The CHAIR: Thanks, Cate. Thank you, Professor. The Deputy Chair, the Hon. Emma Hurst.

The Hon. EMMA HURST: Wonderful. Thank you, Chair. Following on from the last question around systems, I was just wondering about the ClinConnect system, Professor Smith and Professor Forster, in your submission. You said that it does not actually allow health students to indicate a preference for taking their placement in regional and rural areas, which seems like such a really obvious thing that should be able to be fixed. Why hasn't that actually changed in the system?

Professor SMITH: I think there is probably something to understand about the ClinConnect system in that it is kind of like a hotel booking system, to some extent, but it often relies on the relationships that sit at the back end of that. So what you will do is have a relationship with a healthcare provider, and then the ClinConnect system allows us to administer that. If you can think about a very busy health system that is loading placements in there, and you have a very busy education system which is trying to match the students with a placement, the rural voice can get lost in that system, well and truly. When we are looking at just trying to ensure the numbers of students we have get through, it can be hard to represent the quality of a clinical placement in a rural environment as a strength within that system. And then, out of the choice, if a provider wants to provide a placement in a rural location, then it just may not look as attractive to providers as some of the other areas, particularly from a numbers point of view.

The Hon. EMMA HURST: Thank you. Professor May, you talked about this positive rural exposure for when students are taking placements in rural areas, and we have heard about the cost and the big sacrifice financially. I was wondering if you could further unpack this idea of a positive rural exposure and what we need to be ensuring is in place to make sure that it is a positive experience.

Professor MAY: My comment relates to the thinking that any placement is a good placement, and I guess it goes also to "one rural area is just like another rural area". The difficulty is in finessing and assisting students who have exposure to what are the real benefits of working in a rural community—that is, the continuity, the integration, the community exposure and the experience of dealing with people and families, which is absolutely why I am still practising in a rural area after 30 years. It is extremely attractive, and we need to ensure that students get that experience. Professor Smith's discussion about ClinConnect is one of those little glitches that often gets in the way of us making sure that those placements are preferenced and that we can deliver those attractive placements.

I have to say really positively that as a result of the funding through the RHMT program, which employs me and has allowed us to build some very good pieces of accommodation and infrastructure in regional and rural communities, we have I think gone a long way to both validating and offering positive rural exposure. The

question is: What are the metrics? Your question is such a good one. What are the metrics of knowing that we are succeeding? As I mentioned in my opening statement, one of the dramas is that if every rural student chooses a rural preferential recruitment in a regional area, is that success when we know that we are then going to lose a large number to specialist practice? It is such a good point and I spend a lot of time trying to decide what is positive, but I think what I am trying to say is that it is a connected experience where we have engaged supervision and where we can provide a student with the support to take that on in an experimental way.

One thing I would say is that I think it is time based. A two-week taster in a rural community is just that; sometimes we call it "medical tourism". But a six- or 12-month location in a place like Tamworth, Gunnedah, Moree or Inverell, which are in my patch, I think they are the ones that will predict long-term rural return if they are positive.

The Hon. EMMA HURST: Thank you for that. If we are able to get students into these rural areas—and we talked a little bit about the data of 30 per cent and then 10 per cent of students—do we have any information about long-term retention once they are located in those areas? Do they tend to stay for a long period of time?

Professor MAY: Yes, Ms Hurst, although I think one of the things the Committee needs to think about is retention. Retention needs to be recast. The retention that I grew up with—which was one family doctor in one rural community for 25 years—I think that is yesterday's model. I do not think that our students of today are really looking at spending their whole lives in one spot, providing the sort of service that many of our clinicians in the past have spent. I think we have got to recast that and rethink that. What I want to do is train medical students to be rural doctors but they can also be urban doctors, and they can also go on Médecins Sans Frontières and they can do a lot of other things.

What I see is a great deal more mobility in our health professional student workforce. What I think is that it is equipping students with skills—and trainees with skills—that work well in rural. And if they are good in rural they are going to be good anywhere because, as your previous speakers talked about in the palliative care section, they not only need the competence to practice but in rural areas they need the confidence. That is what I call "clinical courage". If we teach them clinical courage I think they are going to be good practitioners no matter where they go, and we need to accept that a five-year retention period is probably not too bad.

The Hon. EMMA HURST: Thank you. Thanks so much for that.

The CHAIR: Thank you, Deputy Chair, and thank you, Professor. Moving now to Government members—the Hon. Trevor Khan or the Hon. Wes Fang?

The Hon. TREVOR KHAN: I think I will start with Professor May, seeing as we are probably communicating from relatively close by to each other. What I am drawing upon is the evidence that was given at Gunnedah, which plainly you have accessed—this is not only for you, Professor May; it is for the others as well but I will direct it at you—but also the evidence given at Lismore. What particularly interests me is this: When we talk about attracting somebody to work as a general practitioner in Tamworth, it seems to me we are talking about a different issue than in what I will describe as the satellite towns around the major regional centres. Obviously Gunnedah is one, but you could look at a number of others—Quirindi et cetera—in this area.

In those satellite towns it seems to me that what we have seen has been a shedding of general practitioners, for instance, and other health workforces so that now we are in, it seems to me, almost a critical phase in a number of those towns. Getting a general practitioner to come to work with you in Tamworth, I would suggest, is a bit of a snack; they have got a support structure around them. Throwing them into some of these other towns where the professional environment has been shed or the professional support has been shed is another quantum level of difficulty. What I would ask you to address, Professor May and the others, is how you deal with those centres, the satellite centres, which seem on the evidence—and, frankly, I know—to be in a really problematic stage in terms of the provision of services.

Professor MAY: First of all, can I heartily agree with your diagnosis, because I think there is a big difference. There are two things I would say. One is that we are actually better off in terms of provision to those regional centres than we were probably five to 10 years ago. You will understand and know that there was a time when you could not get a general practitioner in Tamworth.

The Hon. TREVOR KHAN: Yes.

Professor MAY: I think that is where the RHMT program and emphasis on rural origin and those sorts of programs have succeeded, so I think we need to talk that as success rather than anything else. But what you point to is absolutely right. In the appendix on my submission you will notice a table where I tried to look at Modified Monash Model [MMM] different areas. What you are alluding to is that the workforce issues in MMM 3,

which is our regional centres, are very, very different from MMM 4 to MMM 5, which are our regional procedural hubs. They have been most affected by both the loss of services and the concomitant loss of practitioners. If you are asking me about solutions, first of all, I would say: Yes, that is where the problem is. The Rural Doctors Association of Australia did mention this loss of sentinel maternity services as really the beginning of the end for many of these procedural centres. We are now in a situation of providing locums and very difficult workforce gap filling because we lack that critical mass.

That is where the rural generalist training program has to come in, but it has to come in overcoming the many barriers that say, "If we are going to support you to do obstetrics and to do anaesthetics and to provide an emergency service of a high quality, there must be numerous practitioners." So we need a critical mass. It is no good importing one or two doctors; they will burn out quicker than they arrive, and that has been what we have seen. We need to support them. How do we need to support them? We need the critical infrastructure and investment in the critical infrastructure that makes that high-quality practice, and we need to invest in the accreditation support that encourages them to have the clinical courage and to be valued to do what they do. Currently in our medical system rural generalists and those working in those MMM 4 and MMM 5 areas are not valued anything like they need to be valued for the scope of practice that they provide and the amount of care that they give.

The Hon. TREVOR KHAN: Professor or Professor, do you want to make any additional contribution?

Professor SMITH: Look, I think Professor May has captured it really well. I think the only other contribution I would say is that a doctor needs a multi-professional healthcare team wrapped around them. There is no point having a doctor in the town if there is no pharmacist. Someone has then got to drive to the regional centre to collect their medication—or there are not the nursing services and support people. I think the other thing is to think of a community as a whole and a health service as a whole—not individual practitioners—because that is the system that they need and the levels of care that are within that, that are appropriate for the community. I do not think anyone is saying that we are needing tertiary level services in these communities. What we are saying is a good primary healthcare structure that allows people to receive the services that are appropriate for the size of the community that they are in, that is a multi-professional way of thinking.

The Hon. TREVOR KHAN: That brings me to what I think is my final question, because I know the Hon. Natasha Maclaren-Jones has one, and that is this: We seem to have received a good deal of evidence, which has either hinted or been a straight-out suggestion, that we should increase the professional scope of some of the related health professions that would, in a sense, patch over some of the problems that we are facing in some communities but actually erode the base of general practice. I see the benefits of it. I also potentially see the disadvantage that it may reinforce the evacuation of general practitioners from the towns. That is my opinion. Would any of you like to express a view in regards to that? Professor May?

Professor SMITH: Professor May and I probably have a different view.

Professor MAY: I certainly would, Trevor. What makes us so sure that we are going to attract this other workforce that will not have exactly the same issues in terms of recruitment and retention? Our conversations with nurse practitioners over the time have been there are very, very few nurse practitioners who elect to have a wide scope of practice in a rural or remote area, and they are fantastic where they are but is that the intention of many? No, it is not. The workforce challenges that we talk about are actually multidisciplinary and the approach has to be, as Professor Smith said, multidisciplinary. But it needs to respect that we actually need whole clinicians in our rural communities, not part clinicians, as you have alluded to.

The undermining that has inadvertently occurred about both the income base but also the scope of practice in a negative way rather than in a complimentary and cooperative way—for instance, GP obstetrics could have been maintained if there had been arrangements and agreements between special obstetricians and GP obstetricians in a network sense. There are lots of areas where we could have retained skills in a different way by cooperating and collaborating better. But you are right: There is a risk if you undermine scope, if that is what we are trading on, and that is really what our model is predicated on.

The Hon. TREVOR KHAN: Professor Smith, do you want to—

Professor SMITH: Yes. The comment I was going to make—and I think it articulates well with Professor May's—is that our GPs do have a general skill base and they are called upon to do that. But there are often other practitioners within the community—like, if there is an allied health practitioner—who have skills that are perhaps not being used at the top of their scope of practice. They do not need to go outside their scope; they just need to be able to work fully within the scope that they have and be able to draw on those resources and practices. For example, physiotherapists do really good work in triaging and managing back pain within the primary healthcare sector. But if a person with back pain has only one option and that is to go to the emergency

department and see an emergency doctor for the treatment of their back pain, we are not using the physiotherapist at their full scope of practice to provide the appropriate health care in that community.

I think before we get to the question about starting to bleed outside of people's scope or asking people to work outside their scope, we have to ask: Have we created a system that uses people to the best of the scope that they actually have for the people who are there?

The CHAIR: Thank you very much. The Hon. Natasha Maclaren-Jones, did you have a quick question or would you like to put it on notice?

The Hon. NATASHA MACLAREN-JONES: I did. It was just in regard to nurse practitioners. We have heard at previous hearings the desire for more nurse practitioners, but some of the challenges have been the number of placements that have been available. Others have been the challenges of actually balancing their current work with undertaking study. I am interested to know about not specifically the number of placements available but whether or not the number that are available have reached full capacity. What are the challenges for people taking up those placements?

Professor MAY: Professor Smith, do you want to take that? It is a little outside my scope. I could have a go, but I would be only giving you a local observation of my visibility of placements in Hunter New England, which is probably not answering your question.

Professor SMITH: Yes. Look, it is probably a little bit outside mine. Charles Sturt had a nurse practitioner program that we were offering a number of years ago. We removed that program because the demand for the course was not there. If you think about it, Charles Sturt is a university in a regional community. If people could see a pathway through that course into practice, they would have taken it. It was a little bit before my time as a dean, but I can only say that I think we probably have not got it right for nurses to want to pursue that pathway, to see job opportunities and to have the time in their current work to make the decision to undertake that study. I think that is probably what I can offer at this point. But clearly it is not working if we were not able to see students wanting to come through that pathway. Whether it is a placement issue or whatever structure we have got right, I do not think we are quite there. Certainly the nurse practitioners themselves would have more to offer on that.

The CHAIR: Thank you very much. On behalf of the Committee, I thank you all very much. I think it is the first time we have ever had a panel with three professors. The combined experience, expertise and knowledge has been very, very impressive. You have obviously given a great deal of thought to this, not just from the academic point of view because of your respective roles in your tertiary institutions but very practical thinking about how it can be transferred into delivery of improving and enhancing health and medical services in regional, rural and remote New South Wales. We thank you very much for making your time available this afternoon.

If there are any questions on notice or supplementary questions that may arise following the reading of the transcript, the secretariat will liaise with you all. Once again, thank you very much for your submissions and your contributions this afternoon. This will now move us towards our final panel for this afternoon. It will take a few minutes to change over, so do not leave us. We will be back very shortly with our final panel.

(The witnesses withdrew.)

(Short adjournment)

BRIGID HEYWOOD, Vice Chancellor and Chief Executive Officer, University of New England, affirmed and examined

LEANNE NISBET, Project Manager, New England Virtual Health Network, University of New England, affirmed and examined

PATRICK GIDDINGS, Chief Executive Officer, Remote Vocational Training Scheme, sworn and examined

The CHAIR: This now brings us to our final panel session for today. We have three very experienced witnesses in terms of their background and knowledge about matters about health in regional, rural and remote New South Wales and beyond. I acknowledge and thank you all for your submissions to this inquiry. From the University of New England, your submission has been received, processed and stands as submission No. 466 to this inquiry and is available on the inquiry's webpage. With respect to the Remote Vocational Training Scheme, Dr Giddings, your submission is submission No. 465 to this inquiry and equally has been received, processed and stands as a submission and thus evidence to the inquiry.

Committee members had the opportunity to access and study your submissions, so in your opening statements there is no need to go into detail specifically on the content of your submissions. Perhaps through your opening statement you can open up an overall position of the issues that you think are important and that will lead to our questioning shortly. Starting with the University of New England, would it be you, Professor, who will make the opening statement?

Professor HEYWOOD: It will, Chair, thank you. Good afternoon. I am very appreciative of the opportunity to present in front of you. As indicated, the university has made a written submission about the development of an education and training program to service the needs of remote and rural communities. In the University of New England our remote and rural communities stretch from Tamworth through Armidale and through to the small villages, towns and settlements of the New England North West area. Increasingly the issue, which I think can be summarised in one clear piece of data, is the ability of the community to access health in place rather than to receive health care and support by travelling great distances. I am sure you as a committee will have received many reports and other forms of evidence which will identify the healthcare deficit and, as a result of that, the deficits in the quality of life years that result for those living in remote and rural communities.

Last year in New England alone, as I understand it, 36 positions of general practitioner were advertised. Only three could be recruited. This year it is our lived and practical experience as a university as part of that community that we are supporting and delivering, for example, vaccination programs into small remote and rural communities because there is no other provision to enable the vaccination of our communities. So we live in an environment of a modern, successful nation that has not yet resolved how to ensure equity of health care to all. For us in resolving that equation, we are proposing a new model of health education and training, which is about taking the training and the healthcare provision to the community as part of a connected networked model—the New England Virtual Hospital [NEViHN].

We are in the process of piloting this initiative with collaboration from Inverell and many other partners, and we believe that this is the model that should be investigated very clearly as a route to resolving the ongoing and increasing inequity of healthcare opportunities in our remote and rural communities. We believe, in the university addressing this issue, that we are following through on the clear recommendations of the Napthine review of 2019 about the importance of education being purposeful and linked to place-based solutions for remote, rural and regional communities.

The CHAIR: Thank you very much, Professor, for that very precise and clear opening statement. Can I move to Dr Giddings to invite him to make an opening statement.

Dr GIDDINGS: As mentioned, I lead an organisation called RVTS Ltd, which operates the Commonwealth-funded Remote Vocational Training Scheme. This organisation has been operating for more than 20 years. It is a national program and operates chiefly to retain doctors in rural and remote locations, mostly smaller locations. You will have heard, I am sure, over the course of proceedings, the Modified Monash Model classification for remoteness. RVTS eligibility is for doctors who are working in MMM 4 to MMM 7, so that is very small towns to very remote towns, and mostly in MMM 5, which is really very small towns. Over the years the Remote Vocational Training Scheme has serviced more than 400 communities across Australia and trained more than 300 doctors in remote settings, in place, to achieve their specialist qualifications in general practice. Currently in New South Wales there are more than 40 doctors in small towns across the State who are training with the program towards their specialist qualifications in general practice. Over the years there have been more than 95 communities that have had the benefit of a doctor being supported by the program.

The nature of the program is to provide a full-service postgraduate training program that would otherwise be delivered by the Australian General Practice Training Program. So our aim is to deliver training that is the equivalent of the Commonwealth-funded Australian General Practice Training Program, which is the default program for receiving general practice training and allowing doctors to become specialist general practitioners and to be able to operate in an unlimited capacity across the country. We are able to do that by taking the training to the doctors—doctors that are already working in small communities usually under workforce programs that have allowed them to fill a gap and obtain a provider number. Our organisation identifies these doctors, brings the training to them and retains the doctors in their small location for at least three or four years during their training and, in many circumstances, for years beyond their training. It has been a very, very successful program—a small program but a very successful program—with more than 90 per cent of the participants achieving their specialist qualifications in general practice.

As time has gone on it has become more and more a program where the participants are international medical graduates. These are international medical graduates, of course, who have made Australia home and for whom many rural communities are indebted. As time has gone on during the life of our program, we have seen a dramatic change in the numbers of Australian graduates working in these rural and remote settings, to the extent that now more than 50 per cent of doctors in rural and remote Australia and New South Wales are international medical graduates. So we are very, very dependent on international medical graduates and are likely to be for many years to come, despite the fact that Australian medical schools have more than tripled their output of Australian medical graduates in the last five or six years. We are not seeing that translate into doctors working in rural and remote Australia, in particular New South Wales.

This shortage of doctors, of course, has been exacerbated by border closures in the last two years with the COVID epidemic and has illustrated our dependence on international medical graduates now and the likely dependence well into the future. The importance of this is that we need to face this reality and ensure that we support these doctors who are playing a vital role and ensure that they are being supported by receiving high-quality education. In return our communities are fortunate enough to receive loyalty and commitment over years, and that has been our experience. So that is the Remote Vocational Training Scheme—a very successful program.

The CHAIR: Thank you very much, Dr Giddings. We will now move to questions from Committee members. We will start with the Opposition.

The Hon. WALT SECORD: My first question is to Professor Heywood. We have heard evidence over the last nine hearings of varying levels of support for virtual or e-health. Do you understand why there is some resistance or animosity towards telehealth in certain rural communities and from nurses who find that in fact the only doctor that they have is on the end of a video camera?

Professor HEYWOOD: I think the first level of resistance, both from our experiences here in Australia but I have also been involved in setting up telehealth programs in Europe and in Africa—telehealth is better accepted when there has been the opportunity for deep training, first of all, as opposed to it being added on to existing practice. So one of our arguments is about recognising the need for deep training both of the practitioners—the healthcare providers—but also that the community are given some support to become familiar with how to engage about discussing their health and their medical issues using a telehealth model as opposed to what they have probably experienced in other parts of their life, which is a one-to-one, in-person engagement with the healthcare environment. I think it goes back to Dr Giddings' conversation which is about the importance of placed-based training and education both for the patient but also for the practitioner—that would be number one.

Secondly, I think there does need to be an awareness that there are issues about quality of connectivity. In quite a lot of telehealth in rural communities and remote communities, the bandwidth means that it has got to be voice only rather than voice and image, and on occasion that can be quite limiting. That is not across the whole case, but that is quite often the case for some individuals. I think, finally, it is about guidance around issues of who can be present in a telehealth consultation—a support person for the patient, perhaps, without conflict of privacy, consent or confidentiality.

The Hon. WALT SECORD: How often does telehealth actually become sound-only medicine? So that is the equivalent of an old telephone call.

Professor HEYWOOD: That is quite significant and it would be my personal experience living in the region that telehealth—I have had a serious mechanical injury, skeletal injury. Almost all of the care I received following my emergency access room with telehealth was voice only. So it is in person but voice only, if that makes sense, without the support of the engagement of an image in the way that you and I are engaging now. That is a high percentage of the interactions for patients.

The Hon. WALT SECORD: You mentioned in your opening statement a virtual hospital. Can you take me through what—is that an exaggeration? When you say virtual hospital, what do you mean?

Professor HEYWOOD: Our design of it follows on from good practice that has been developed in the United States and Europe, and in fact the United States particularly now is making inquiries about following our model. We have what we call the joint operations control room. We have it at the moment in the Tablelands Clinical School in Armidale. That is a system that has the ability to provide high-fidelity engagement with the clinical practitioners out in the rural, remote communities, it allows patients to connect in and out, and if it is operating at full capacity we set it up that we could also run 290 nominal patient engagements. We would have patients technically with sensors, so they would have a pulse sensor, blood pressure sensor, heart-monitoring sensor and temperature sensor. Those kits are connected using satellite and cloud-based technologies. All of that data is aggregated real time into the flight deck and there can be a clinical practitioner and/or specialist as required at the flight deck.

At full operation we can fly in—as we do already fly in—doctors to the Armidale or Tamworth site. They can see the data and engage with the patients through the flight deck. But we also then have healthcare professionals that we have developed and are training in the community. Much like the model that Dr Giddings has described, at the moment our pilot is with Inverell. We have a relationship with the Inverell community. We have a relationship with Inverell health care and we are training our practitioners and our community to engage with the technology that we are providing but to then be able to bring specialist advice and oversight, pathology monitoring et cetera from the flight deck.

The Hon. WALT SECORD: You have said that it is a pilot. So in fact when do you think technology and the internet broadband services will be up to scratch where you could actually virtually—confidently—provide medical care and examine people? Because in fact we are sitting in State Parliament here today and two of us had connection problems in the CBD of Sydney. So, yes, I do admire your optimism, but how far off is this? How far off is a virtual hospital?

Professor HEYWOOD: We are running, we call it, a pilot because we are working out the logistics and there are partnership issues. The technology, with all due respect, already exists. We have bought the technology. We invested in the technology. We bought 3,000-odd different pieces of technology into Australia last year in anticipation of providing support hospital care in the event of COVID coming into the community because we do not have sufficient monitoring beds at our local hospital. We put this as the subsidiary medical support at the beginning of the pandemic last year, and it was active at that point and capable of patient monitoring in situ if that was required.

The cost of the ambient and ubiquitous technology that we are using has now dropped so far. The monitors, the sensors—you can basically get a hospital-in-a-box type kit that has robust, low-cost, high-fidelity sensors. You can buy the data requisition and delivery kits at relatively low cost and provided that you have got a centre equivalent to our Tablelands—all of the elements that you need to be able to do it already exist. What we need to do is have a commitment at a system level that it is a model of health care that we can support more generally. At the moment we are running it as an education facility. We set it up as a support to community care in the event of the COVID pandemic, and that was set up in agreement with the Armidale regional hospital in March of last year. So we could run a 290-bed hospital if that is what we needed to do.

The Hon. WALT SECORD: I had spoken to nurses at some of our remote hearings in western New South Wales. They said that they were called upon to use telehealth in very unusual circumstances, and they were quite uncomfortable with it. They said they had a situation where they in fact certified a death of a patient through telehealth by showing the deceased patient to a doctor at the other end of the camera. They also said that they preferred telehealth overseas—when they had overseas doctors on the receiving end or the end monitoring it—because they were more alert, because of the time change differences, than Sydney ones in the middle of the night. Can you respond to that?

Professor HEYWOOD: I personally do not have experience of that, but I have practitioner experience of that from working in other places. We ran for the United Kingdom Government a project when I was employed by The Open University which was about looking at exactly the environment that you are describing, for example, in the remote north Highlands and islands of Scotland, which is a very broad distributed area and which 10 or 15 years ago was only at the beginnings of digital and cloud-based and satellite-supported technologies. There are—and I am sure Dr Giddings can share—quite considerable issues to be resolved about moving from what we describe as conventional, in-person healthcare practices to those that are appropriate and support both the healthcare practitioner as well as the patient or, in the example that you have given, the deceased.

I am quite familiar with the fact that I have worked in environments where I would take a picture of a deceased patient, and I would do so and have that certified at the site by a witness and then we would send that

forward as part of the record of care. But that is quite a challenging thing to do if you are not used to that and you are conditioned to use what I would describe as the normal care practices upon the death of an individual within the medical care situation, or even if you were attending a home event where a death was being reported and you were attending to certify and confirm that. There are practices that we have all been brought up in which are about the analog, in-person et cetera. You need different support practices and different training to do that comfortably and respectfully if you are going to use either a digital—a fully enabled—or a telehealth model, and they are different. There are different things going on in each of those environments, but the end result is that you need slightly different training and slightly different customer practices. You cannot just bolt it on to what we all were trained to do when we were in, as I describe it, analog, abacus medicine as opposed to iPhone medicine, if I could put it that way.

The Hon. WALT SECORD: But you would concede that there are certain procedures and certain examinations for the dignity of the patient that you would not want to occur on telehealth or the patient would be reluctant to agree to?

Professor HEYWOOD: I understand the question and in the context for example of Australia I can understand that, but I have been present in Ethiopia where primary health care and digital support for the delivery of a difficult birth was conducted with a primary healthcare practitioner and the doctor sitting, as you have just described, many thousands of miles away. With the appropriate dialogue with everybody, all of that—the whole event was done using full visual in-person connected support. There are medical situations where it is almost impossible that you would consider doing that. One would hope that those "critical and emergency situations" would be those that would be managed elsewhere, but that is not the way that this occurs already and there needs to be this journey, which is what is appropriate, what is not appropriate, how do you share that consent and inform a patient?

You and I both know that patients, when in medical and healthcare stress or in a situation where they feel unsure, will respond to the authority of the medical practitioner attending and do not always feel comfortable to express or share what they understand. We hear it as a post-event survey outcome rather than it being part of the experience at the time. The pilot is about establishing what are the conditions under which this works well for the benefit of both healthcare practitioners and patient. I hope I am being clear in my response to your question.

The Hon. EMMA HURST: I think we do have the Chair back now. Chair, are you there? It looks like he has frozen again, but we will move to crossbench time. If the Opposition has any more questions, they can put it on notice. I will start with my questions now. I have a question for Dr Giddings. In your submission you mention that only 5.9 per cent of graduating domestic medical students are considering future practice in a rural or remote setting. This seems incredibly low. Why do you think that this is the case and, given it is just that they are considering, do you think that the numbers are actually much lower in reality?

Dr GIDDINGS: [Audio malfunction].

The Hon. EMMA HURST: Dr Giddings, you are on mute.

Dr GIDDINGS: I beg your pardon. Yes, it is a disturbingly low figure, but our experience suggests that that is actually the case. There are lots of reasons why medical graduates do not want to work in rural and remote practice. But what we do know are reasons for situations where doctors are more likely to work in rural and remote practice, and that is where they have rural origin, they have come from a rural background and they have had rural immersion in training so that in their training they have had exposure to rural practice either at an undergraduate or postgraduate level. I suppose an extension of that with our program—with the Remote Vocational Training Scheme—is that we have doctors that are already working in the location under a workforce program. By offering high-quality support and a high level of support and allowing them to achieve their specialist qualifications so it is not a dead-end career position, it offers career progression, we are providing that rural immersion as well and with the happy coincidence of meeting community medical workforce needs.

The Hon. EMMA HURST: You also mention in your submission that you have had quite a lot of success with targeted recruitment programs which have seen full-time doctors recruited in 15 of the most hard-to-fill positions in New South Wales. This is something that we have heard a lot about in this inquiry—the difficulty of recruiting doctors into certain areas. What did you do to actually attract people to these positions, and what can we learn from that?

Dr GIDDINGS: Our program has worked over the years as a workforce retention program. The vocational training support that we offer helps keep doctors working in their locations. But we have varied that model in recent years so that we use the training program and support that we would otherwise offer as part of the recruitment package for specific, high-workforce need locations that have been identified in conjunction with the State-based rural workforce agency, the Rural Doctors Network. More recently the Commonwealth have

enhanced that by adding salary support to that mix so that communities struggling to recruit a doctor that are identified for our program are able to receive Commonwealth-funded salary support for a period of at least two years—2½ years—into the program. We have had quite a deal of success with this. We have only been doing this for three or so years now and with a small number but we have found it very, very successful in many very, very hard-to-recruit-to locations around Australia. We have had three locations in New South Wales where we have operated on this basis. That is Lightning Ridge, Bourke and Dareton, near Wentworth, in south-west New South Wales.

The Hon. EMMA HURST: Just going quickly to Professor Heywood or Ms Nisbet, you talked in your submission a lot about longitudinal placements. Given now we are halfway through 2021, I was wondering if you had a quick update on how those placements are going and if they have been affected by the COVID lockdowns as well.

Professor HEYWOOD: We are running placements through the year four and year five of our joint medical school program with the University of Newcastle. As indicated in our submission, we have initiated a collaborative endeavour with the Inverell community both at the level of the community council as well as at the level of the community practitioners. That program is working very successfully. Following up from Dr Giddings' comments—it is our experience that, if you can give medical students and healthcare professionals an extended experience in the community and in regional healthcare training and medical training, then they both enjoy that, relish it and see a real career opportunity for themselves. We are actively engaging as a university to recruit medical school students with a focus on regional and rural medicine into the medical school program.

This year we have the highest number of Aboriginal students, so again connecting back to Dr Giddings' comment that those who work in community and live in community are more likely to be retained. We have had 12 Aboriginal medical students. That is our highest number. We normally average about six or seven a year from the community. It has now become a growing trend because we have an outreach program that actually captures them as they are coming through in the later stages of secondary school and moving forward. We also privilege and specialise in scholarship support and accommodation support for medical students who are on the joint medical school program who will do their placements and their practitioner work here in the regional community. So we create incentives to support them to be able to be part of the community and to gain the lived experience of receiving their medical training within a regional, rural or remote context.

Whilst it might be that many of those coming are, for example, drawn from large metro conurbations, the experience of our surveys is that once they are here, after the first couple of weeks, there is something that has opened up to them that they have not previously experienced. It goes back to Dr Giddings' comments about why is it a problem to move people through. If your entire medical and healthcare profession have always been trained in metro, large-system facilities, then all medical students are being trained with that medical system in mind. Part of the NEViHN concept is to be aware that quite rightly our medical system is trained to give this view and the people providing the training have experienced this version—in my language, the analog version—of medical health experience, medical health professional care and the training of medical and healthcare professionals. If you shift the model of training, both of those who will do the training and those who will be trained, into a different environment, that becomes the norm rather than something exceptional or other.

Part of the data are about what people experience and the environment in which they are trained. It is our argument that by increasing the opportunities for people to receive place-based education—training and development of their careers within the context of where those careers will then be lived—and that that is not a deficit model or some secondary option, that that is a genuine option within the totality of the healthcare and education program, that is where you start to see the real shift in numbers. Australia is not the only nation with this problem. Other nations have wrestled with this issue, and we can learn from their successes and adapt them into a model that is suitable for Australia. The NEViHN is very much based on drawing good practice from other examples where the same healthcare issues and healthcare deficits have had to be resolved.

The CHAIR: Sorry, the line dropped out again. Ms Faehrmann?

Ms CATE FAEHRMANN: I will actually give my time over because most of my questions have been asked. I know Government members will have some interest in this topic, so I am happy to cede my time.

The Hon. WES FANG: Apologies, Chair. I was just trying to bring my mouse across to get to the mute button. Thank you very much for your evidence today and your submissions, both of which are really detailed and provide a lot of clarity for us. I just wanted to delve into some of the issues that the Hon. Walt Secord was talking about with virtual medicine. It has throughout the hearing attracted some negative feedback, but I am wondering if you might be able to provide some of the positive feedback that you have experienced from being able to look at virtual medicine and the advantages to communities.

The CHAIR: Who would you like to direct that to?

Professor HEYWOOD: I think you are framing it to both of us. I have played around with the mute button faster than Dr Giddings has. The positive experiences—here in our environment the first part of it is that we engage in a collaborative discussion with the community. A lot of telehealth was the provider made that the only offer available to the patient and the patient receives it, as I said earlier, with no support. I think one of the things we are seeing very clearly from our model is the fact that there is an engagement, that we share the construct of the model, we have demonstrated the model in various ways to the community and that we have made sure that our healthcare professionals who are supporting and developing this model go out to the communities and demonstrate how it operates. You are not receiving it as de novo in the first time that you need a healthcare intervention or healthcare support.

We have operated on the basis that the education and training component has to lead out in the delivery of the whole of the rest of the model. And the data that we have clearly supports that and would make it as an outcome of our pilot work. Leanne Nisbet, who is with me as a doctoral student and mature doctoral candidate, who is looking at these data so that we can give advice on policy developments going forward—that is the object of her doctoral candidacy. She is one of the people that goes out and takes liaison, so she may wish to comment on the conversations with Inverell, for example.

I was also, as I mentioned earlier, associated with setting up a primary healthcare network using digital and virtual technologies in Africa, for example. First of all, people want health care. You know this as well as I do. They want health care in place—if you engage in a conversation with them about health care in place and how that might operate, and you do so and you outline what the opportunities and advantages of that are, rather than it being seen as a deficit model. Going back to the earlier question, some of the visible anxieties in our system about telehealth are that it has been imposed in a deficit condition—in response to a pandemic, but let's call that a deficit condition. We have gone from here to here without a great deal of guidance or education or development as to how you as a patient might have a little checklist of things that you need to walk through with your healthcare practitioner or your medical provider when you are preparing for the telehealth interview and then you are progressing through it.

We did no development work with any of our patients within the system as we moved into telehealth. That is not a criticism of our fantastic response in the middle of the pandemic, but I come from an environment where we would be supporting a quarter of a million students a day through The Open University. We would not engage with them without going through a process of induction and guidance. The work we did with the National Health Service to build their telehealth provision was about making sure there was training and guidance for both agencies—the patient and the healthcare provider, the medic. There was specific training about the process of having a telehealth interview, a telehealth care case management conference, for both parties—even as simple as just having a checklist in front of you so that you, the patient, knew how to conduct yourself in that situation and were not overwhelmed with the anxiety of both engaging with technology but listening to questions without being able to pick up the normal emotional intelligence and the emotional signals from face-to-face interactions.

The Hon. WES FANG: Did you want to expand on that, Dr Giddings? You look like you wanted to make some contribution there.

Dr GIDDINGS: I would support that. I suppose our doctors who are being supported and in training—telehealth is a great adjunct to what they are doing. It is part of the package that makes their position sustainable. I will give you an example. Drs Salma Hanif and Kumosha Abeyweera are the only two doctors in Boggabri. They are doctors in our program. They have been there for a couple of years now. They are doing a wonderful job but they are providing a seven-day-a-week, 24-hour-a-day service. It is just not sustainable, particularly when there is a community expectation that there will be 24-hour care and after-hours care. This is where telehealth is of great assistance, particularly when it is supported by other practitioners, such as nurse practitioners, advanced life support trained nurses and paramedics, who can receive telehealth support at a distance. Whether that is from Tamworth or Armidale or indeed from Sydney, New South Wales does already have some very good telehealth networks in place which provide excellent support.

Indeed, with our training, much of our training is tele-training. If you like, it is tele-education. We do tele-workplace teaching and tele-workplace assessment, taking advantage of technology that is around. I must say that internet support across New South Wales is generally pretty good. Even the smallest towns have at least a 4G Telstra tower these days. It is very uncommon not to have that. So it means that it is possible for us to be able to use technology to support doctors in this role. But there is no doubt that what our communities want is a doctor on the ground. That is their first preference. They want to have a face-to-face doctor on the ground consult. But if they cannot have that, then this is a wonderful adjunct that we can have by utilising technology. So I fully support what Professor Heywood is saying.

The Hon. NATASHA MACLAREN-JONES: Virtual health is not new. It has been talked about for close to a couple of decades in Australia. But, Professor Heywood, you did mention we have had to move forward a lot quicker with the pandemic. What I am interested to know from all of our witnesses is where can virtual health go long term, looking at particularly international experiences? Where can Australia go in the next decade or more to come, and what do we need to do to get there?

Professor HEYWOOD: If I had my way, we would recognise the value. I support Dr Giddings' conclusion. I work and I visit these communities. Each community wants its own GP but, to the point being made, one GP cannot deliver at the level that is required. So I think there is a debate about rethinking what the role of the GP and the healthcare unit is and at what level and what settlement index and what density you need people. But the virtual hospital means, significantly for a lot of the communities that we deal with, that you can talk to a consultant about a medical condition and you do not have to leave your family and go to Tamworth or go to Sydney or go to the Tweed. A lot of what we are asked to do is to travel three or four hours in order to have an appointment that might occur in eight to nine weeks' time. That is the reality. No matter what the data might be elsewhere, that will be the conversation that most commonly we are managing about the availability of health care and the frequency with which people can see it.

We all know that there is only one "pot of money" and it is never big enough. So the NEViHN is one way of looking at the solution, which is, for example, my vision of this is that Tuesday is orthopaedic day and the very best orthopaedic advisers, surgeons, whatever are all flying into the Armidale—we call it the flight deck, the mission control. They are all there on enormous connected screens, and then every community knows that this is orthopaedic day and that there will be connection at a community level to do the orthopaedic consulting et cetera. That will be a constant. That starts to do some of the things that Dr Giddings referred to, which is about the continuity and assurance of provision. And if you cannot do that by having enough people and you always have to be moved out of your home environment to go somewhere quite remote, with all of the cost that comes with that, then you will not participate. Whereas if it is provided and you make the incidence of availability lower energy—you catalyse that access—then first of all we will see an increase in healthcare outcomes, because the disability data at the moment and the disability year index for our communities do not reflect well on Australia, let's be honest, and others with fewer resources are overtaking us. But also people more actively will engage in ownership of their health care.

The Inverell model follows on from what Dr Giddings has just said, which is that the community takes responsibility for health care rather than assuming it is someone else's responsibility. It becomes a collaborative endeavour. That would be my vision for a future. It may not be our model but some version of our model, fit for purpose in an Australian context, means that in your Glen Innes, which is an hour and a bit drive from here—or two weeks ago we were up in Moree and we got the police to bus people from the mission to our open clinic, if you will. So we do that as a community. We did not wait for the health service to provide a bus to take people to the clinic. The communities say, "This is what we're going to do today", and the community came together and provided the resources to make that happen. Our job was to make sure that the clinical opportunity was sitting there waiting for people at the right level of quality and expectation when they came to that site. That is a different model. That is taking the hospital to the people rather than asking the people to come to a hospital. That is the vision of difference. That is not for everybody, but that is for rural communities.

The CHAIR: Thank you, Professor. On behalf of the Committee members, can I thank you Professor Heywood, Ms Nisbet and Dr Giddings. It has been most informative. Your submissions whetted our appetite but to be able to speak to you directly and pose questions and involve in an exchange back and forth with you has been most valuable. Once again, on behalf of the Committee, thank you very much for your participation in the inquiry with respect to both submissions and oral evidence today. That concludes our public hearing today. On behalf of the Committee, can I thank all the members of the community who may have joined us over the internet. This is an ongoing inquiry. We are getting towards the end of it, but we still have some hearing days to go. We hope that you will consider joining us again when we next come together in the not too distant future for the next public hearing. Thank you very much.

(The witnesses withdrew.)

The Committee adjourned at 15:19.