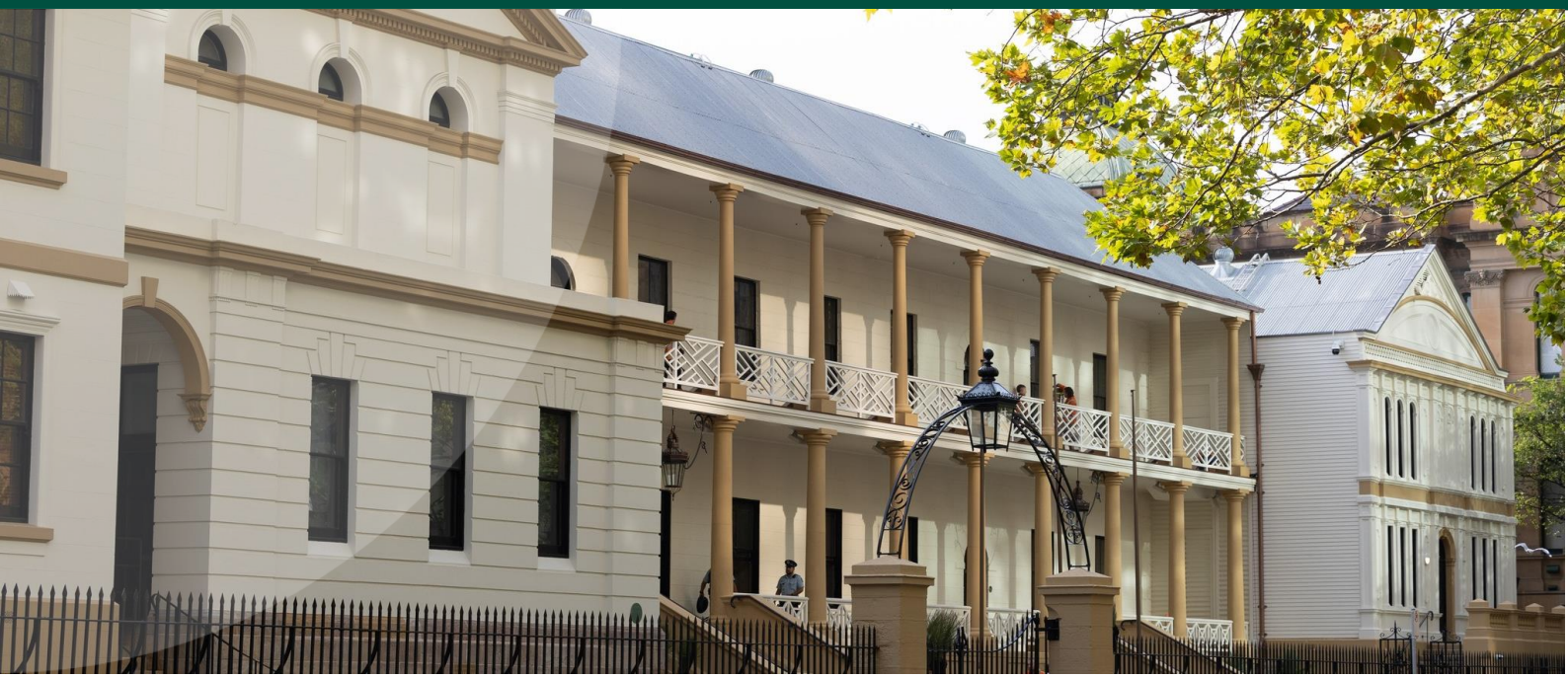
Select Committee on Remote, Rural and Regional Health

LEGISLATIVE ASSEMBLY

Report 1 - The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health



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The motto of the coat of arms for the state of New South Wales is “Orta recens quam pura nites”. It is written in Latin and means “newly risen, how brightly you shine”.

Contents

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Chair's foreword

I am pleased to table this first report of the Legislative Assembly's Select Committee on Remote, Rural and Regional Health (the Committee). The inquiry examined what progress has been made, and what challenges remain, in strengthening the rural health workforce, addressing workplace culture issues in public health facilities, and improving funding (and funding models) for particular health services and programs.

We acknowledge the work done by NSW Health in this area to address these challenges and improve health outcomes for residents in remote, rural and regional areas. However, we also found that progress has been slow in several areas and, as a result, have made a number of recommendations to support recent initiatives of NSW Health.

The Committee was established to inquire into and report on the implementation of recommendations made by the Legislative Council's Portfolio Committee No. 2's (PC2) report, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*.

The PC2 report was tabled in 2022. It painted a deeply concerning picture of the regional health system. Residents of rural, regional and remote (RRR) NSW were found to have poorer health outcomes than communities in metropolitan areas, and inferior access to health and hospital services.

The report found that there are critical worker shortages in numerous health professions, and rural hospitals are often understaffed and overwhelmed. As PC2 noted, dedicated healthcare staff working in the regional health system continue to serve their communities, despite often facing very difficult working conditions.

PC2 made 44 recommendations to improve the regional health system and health outcomes for patients in RRR communities. This included recommendations regarding the delivery of specific health services and specialist care, interactions between the NSW and Australian Governments, and engagement between the health system and local RRR communities.

In July 2023, the Committee adopted an inquiry to examine the implementation of the PC2 recommendations that related to workforce issues, workplace culture and funding considerations.

The Committee recognises that there is a genuine commitment from NSW Health to delivering reforms instigated by the PC2 report. I am grateful to The Hon. Ryan Park MP, Minister for Health, and Minister for Regional Health, for his support of the Committee's work. I would also like to thank Ms Susan Pearce, Secretary, NSW Health, Mr Luke Sloane, Deputy Secretary, Regional Health, and the Chief Executives of the regional Local Health Districts (LHDs) who have supported the Committee's site visits and made contributions to this inquiry. We heard many stories about the work that the Ministry of Health, the Office of the Deputy Secretary, Regional Health, and the regional LHDs are doing to improve the regional health system, in terms of workforce, culture and funding.

Despite these efforts, there is still much work to be done to implement the PC2 recommendations regarding workforce, culture and funding. In a number of ways, regional healthcare in NSW is the worst it's been for many years. In particular, primary health care and rural general practice are in crisis. This is an area of Commonwealth responsibility. Rural general practitioners remain in short supply, which not only affects the quality of primary care available for RRR communities but also places pressure on regional public hospitals. Public health facilities are often reliant on locum doctors, which can limit continuity of care for patients but also creates significant budget pressures for NSW Health.

There is an urgent need to explore, and expand, alternative collaborative models of primary care, with strong community input and using modern technology. There is also an urgent need to work with the Commonwealth on new approaches to funding, and supplementing existing funding for rural and remote primary care services. NSW Health has made several efforts to address the shortfall in primary care – virtual care, urgent care centres, for example. However, this is a Commonwealth responsibility, and the Australian Government needs to be held to account. This is best done with new models of primary care, funded by a joint Commonwealth and state approach. We will be exploring workforce in specific clinical areas in the next report.

The Committee heard of overstretched health workers, towns with no GPs and overwhelmed emergency departments, and even closures of birthing services in some areas. In some cases, health staff are being pushed to breaking point by poor working conditions, inadequate pay and toxic work environments. Rural and remote residents may still have to undertake lengthy and expensive travel to access much needed health care or choose not to get the health care they need.

Culture continues to be raised as an issue. While work is being done, in terms of an online portal and a refreshed framework, there appears to be a gap in leadership training in regional public health facilities. The soft skills of leadership are critical to improving culture, and these are not necessarily taught in clinical training. Managers often come from clinician ranks – they need additional training in the skills of leadership. This should be a standard requirement. There should be a comprehensive approach to ensuring this occurs, and greater accountability on the outcomes of actions taken to address culture issues where these are identified. It should not be optional for NSW Health's leadership teams to act on improving workplace culture – there must be an expectation on, and support for, rural LHDs to support their staff and address issues of leadership and culture.

In this report, the Committee aims to ensure that the PC2 recommendations are implemented effectively, and in a way that fulfills their original intention. We have made recommendations that seek to improve how key initiatives resulting from the PC2 recommendations are realised, such as by modifying the implementation of the Rural Health Workforce Incentive Scheme, expanding the rollout of the Single Employer Model for GP trainees, and ensuring that there is greater transparency and accountability of the work done by NSW Health to improve workplace culture and review health funding models.

It is very disappointing that the review of small hospital funding appears to have not really occurred. Models of funding – including population health funding – should be explored as well as new ways of working with the Commonwealth to ensure funds reach rural and remote communities. The Special Commission of Inquiry into Healthcare Funding is an avenue for this. But it is critical that appropriate funding models are designed and implemented in the regional health system with far greater urgency.

This Committee has an overarching, two-year responsibility to monitor the implementation of the PC2 recommendations. This is the Committee's first inquiry under its establishing terms of reference. We have adopted a second inquiry, into the implementation of recommendations relating to the delivery of specific health services and specialist care in RRR NSW. The outcomes of this and of future inquiries will help form a more complete picture of whether real and sustainable change is being made to improve NSW's regional health system.

Our expectation is that this report, and subsequent reports of the Committee, will ensure that the recommendations of a landmark inquiry into regional health do not become a distant memory, and lost to the cycles of inquiry recommendation and short-lived reform. The Committee understands that some of the reforms needed in RRR healthcare will not be accomplished at short notice, and that several of the recommendations discussed in this report also require the support and engagement of the Australian Government.

Yet there is too much at stake to let these issues lie. The Committee firmly believes that with the continued hard work and commitment of NSW Health, the NSW Government and collaboration with the Australian Government, better outcomes for RRR NSW communities can be delivered. This Committee will work to ensure that the voices of remote, rural and regional communities are heard clearly when key health policy decisions are made.

I thank all the participants of this inquiry who shared their knowledge and experiences with us.

I also thank the Committee members for their support and engagement, and the Committee staff for their work.

Dr Joe McGirr
Chair

Summary

This committee was established to inquire into and report on health outcomes and access to health and hospital services in remote, rural and regional New South Wales, specifically the implementation of the recommendations made by the Legislative Council Portfolio Committee No. 2 report.

Improving health outcomes and health services in remote, rural and regional (RRR) NSW requires engagement with a complex, multi-faceted and evolving policy field. Reforms to one element of the regional health system often require consideration of other critical policy and legislative challenges. Each of the four chapters in this report explore key, inter-related recommendations made by PC2 that relate to workforce, culture and funding in the regional health system.

Chapter One examines the implementation of PC2 recommendations relating to workforce planning, recruitment and retention in RRR NSW. We heard that NSW Health, and the NSW Government, more broadly, are committed to improving the recruitment and retention of healthcare workers in RRR NSW. We acknowledge a number of important developments in this area, such as the rollout of the Rural Health Workforce Incentive Scheme.

However, there are still substantial shortfalls in a number of key roles, such as general practitioners, rural generalists, emergency department staff, paramedics, nurses, midwives and staff that provide services to Aboriginal and Torres Strait Islander communities. We recognise that there are numerous challenges to successfully recruit and retain for these roles. This includes reducing the reliance on short-term locum staff and improving pay, training, employment conditions and – critically – workplace culture.

We recommend that NSW Health reviews the incentives, pay and supports for available to RRR healthcare workers. In particular, NSW Health should review the Rural Health Workforce Incentive Scheme to ensure it is operating fairly and effectively. We also recommend that NSW Health prioritise finding solutions to address the dependence on locum doctors. The Committee notes, however, that coordination between the state and federal governments is essential to address a number of these workforce issues.

In Chapter Two, we examine the implementation of PC2 recommendations relating to training, credentialing and study-career pathways. While locums have an important role to play in meeting the short-term needs of public hospitals, we heard that there is too much variance or uncertainty in the skill sets that locums offer. We recommend a credentialling framework for locum doctors, to improve continuity for both regional hospitals and patients in RRR communities.

We have also made recommendations with the aim of improving and accelerating the implementation of PC2 recommendations relating to: credentialling for Visiting Medical Officers; training opportunities for nurses; and collaboration between NSW Health and regional educators to support training. We acknowledge the work being done to rollout the Single Employer Model, which has been supported by stakeholders, and look forward to monitoring the progress of this rollout.

Chapter Three examines the implementation of PC2 recommendations relating to workplace culture. The Committee was alarmed to hear from stakeholders that burnout, fatigue, bullying, and problematic relationships between staff and managers in RRR health facilities remain a serious issue. There is a culture of fear around speaking out about problems in the regional health system.

The NSW Ombudsman has begun to establish a new Health Administration Unit, and we recommend that its establishment be expedited. This branch of the Ombudsman will promote the role of the NSW Ombudsman to public healthcare workers, and may make an important contribution to improving complaint handling and options for redress for NSW Health employees in RRR facilities.

However, more work is needed to improve workplace culture in the regional health system. NSW Health have taken a number of steps in this area, but the Committee emphasises that workplace experiences for staff need to be addressed with a greater sense of urgency. We recommend that NSW Health's new cultural framework be implemented with haste, and that this implementation work should include monitoring and accountability measures that ensure meaningful change is being realised. We have also recommended that greater efforts be made to support the cultural safety of Aboriginal and Torres Strait Islander public healthcare workers.

In Chapter Four, we examine the implementation of PC2 recommendations relating to funding for health services, programs and providers in RRR NSW. We also consider different funding models, pilots and schemes to deliver services in rural and remote communities. NSW Health told the Committee there has been an investment focus on healthcare for RRR NSW communities, and we note the numerous innovative programs that have been introduced in recent years.

It is not clear, however, if much progress has been made in the review of funding models recommended by PC2. We recommend that NSW Health publish future reviews of specific funding models, such as small hospital funding and reviews of specific programs such as the Isolated Patients Transport and Accommodation Assistance Scheme (IPTAAS), to improve transparency. We also recommend that NSW Health work with the NSW and Australian governments to explore alternative funding models that may be more appropriate for the regional health system. We note that the Committee may further examine the relationship between the NSW and Australian governments in future inquiries.

The Committee found that some local governments are playing a significant role in supporting their local health systems, and council-led initiatives have had some success in improving regional healthcare. We recommend that the NSW Government advocate for additional federal funding for local government to further support these council-led initiatives, particularly as they relate to services that fall within federal responsibilities (like primary care and aged care). We heard positive evidence about the expansion of the IPTAAS but note that some patients have difficulty accessing it. We recommend that NSW Health consult with relevant non-government health providers to identify additional areas for improvement in patient transport schemes. In particular, NSW Health should strengthen their partnerships with Aboriginal medical services and make greater effort to involve them in planning and delivering services.

The inquiry received 56 submissions from peak bodies, health services, unions, councils, research institutions and key government departments, including NSW Health. On 24 and 27

November 2023, the Committee conducted two days of public hearings in which we heard evidence from 22 organisations. In October-November 2023 we conducted site visits to the Hunter New England and Northern NSW Local Health Districts, including visiting regional hospitals in Armidale and Grafton. We discuss the conduct of the inquiry further at Appendix 2 and site visits at Appendix 4.

Findings and recommendations

Chapter One – Workforce planning, recruitment and retention

Introduction

Finding 1

The NSW Government has committed to attracting new workers to the regional health workforce, and some responses to the Portfolio Committee No. 2 recommendations have had some success.

1.1 In its 2022 report into health outcomes and access to health and hospital services in rural, regional and remote NSW, the NSW Legislative Council's Portfolio Committee No. 2 (PC2) made numerous recommendations that aimed to improve staffing levels in the regional health system.[1] This included recommendations that:

- NSW Health collaborate with the Australian Government to immediately invest in the development and roll out of a 10-Year Rural and Remote Medical and Health Workforce Recruitment and Retention Strategy (Recommendation 11)
- NSW Health expedite its review of the nursing and midwifery workforce, in order to urgently increase the number of nurses and midwives based in remote, rural and regional NSW (Recommendation 16)
- NSW Health implement the Nurse Practitioner model of care, in part by funding the recruitment and training of additional Nurse Practitioners to work in the remote, rural and regional health system (Recommendation 17)
- NSW Health and the Local Health Districts prioritise building their Indigenous workforce across all disciplines, job types and locations (Recommendation 33).[2]

1.2 Many other PC2 recommendations aimed to support the recruitment and retention of health workers, through measures such as: reviewing or improving remuneration and working conditions; expanding the Single Employer Model for trainee doctors and increasing the number of training positions for GPs and specialists; streamlining accreditation systems; and strengthening collaboration between the university sector and the health system.[3] Chapters One and Two of this report examine the progress on implementing these recommendations.

1.3 The Committee is pleased to note that some progress has been made in attracting new workers to the regional health system and keeping them there. We would like to commend the evident commitment from the NSW Government

[1] This report uses the term 'regional health system' to refer to public, private and non-government health facilities and services, across remote, rural and regional areas in New South Wales.

[2] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, pp xvi-xvii, xx.

[3] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, pp xvi-xviii.

and NSW Health to respond to the PC2 inquiry, consult with health stakeholders and deliver critical improvements for health services and facilities in remote, rural and regional NSW.

1.4 The Rural Health Workforce Incentive Scheme ('the Incentive Scheme') is a key component of the government response to the PC2 recommendations. The Incentive Scheme provides grants to recruit and retain staff in 'hard to fill roles, and assist health agencies in stabilising the supply of health workers in rural and regional locations'.[4] Through the scheme, incentive packages over and above award entitlements can be offered by health agencies, for roles such as: General Practitioners (GPs), trainee doctors and specialist training positions, nurses and midwives.[5]

1.5 The Incentive Scheme has been in place since July 2022. Incentive packages were originally available up to $10 000; however, from August 2023, this amount was doubled to $20 000 for the 'hardest to fill locations.'[6] The Committee commends the government's prioritisation of staff recruitment and retention through this initiative.

1.6 The Incentive Scheme has had some positive impacts thus far. NSW Health submitted that over 1 100 new health workers have been recruited to remote, rural and regional (RRR) locations.[7] As of 22 November 2023, the Incentive Scheme has offered recruitment incentive packages to 1 566 health workers and retention incentive packages to 9 950 health workers. Up to November 2023, a total of $61.5 million had been spent on incentives since the Scheme's introduction.[8]

1.7 In their responses to questions on notice and supplementary questions, NSW Health added that the trend of declining retention has stabilised and retention has increased following the introduction of the Incentive Scheme.[9] Some stakeholders welcomed the Incentive Scheme and commended the intention behind it.[10]

1.8 Mr Scott Beaton, Vice President, Australian Paramedics Association NSW (APA) also noted some positive developments. He told the Committee that 'the recognition that we need intensive care paramedics in regional NSW' was an improvement since the PC2 inquiry. He noted that increasing the number of intensive care paramedics is part of a four-year plan that is in its infancy.[11] The

[4] Independent Review Rural Health Inquiry (Ernst & Young), provided by NSW Health to the Committee, 16 August 2023, p 40.

[5] Independent Review Rural Health Inquiry (Ernst & Young), 16 August 2023, pp 40, 42-43; NSW Health, *Rural Health Workforce Incentive Scheme*, 11 August 2023, viewed 18 July 2024.

[6] Independent Review Rural Health Inquiry (Ernst & Young), 16 August 2023, p 40; Submission 11, NSW Health, p 10.

[7] Submission 11, p 10.

[8] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, p 18.

[9] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, p 6.

[10] For example: Submission 37, Local Government NSW, p 7; Answers to supplementary questions, Inverell Health Forum, 20 December 2023, p 1.

[11] Mr Scott Beaton, Vice President, Australian Paramedics Association (NSW), Transcript of evidence, 27 November 2023, pp 1, 3; NSW Health, *NSW Regional Health Strategic Plan 2022-2032 Priority Framework*, 21 February 2023, p 3.

Royal Australian College of General Practitioners (Rural) noted improvements more generally, such as there being 'some movement towards a greater change' in workforce sustainability.[12]

1.9 Mr Michael Whaites, Assistant General Secretary, New South Wales Nurses and Midwives' Association (NMA) highlighted the government's willingness to consult with stakeholders.[13] Dr Antony Sara, President, Australian Salaried Medical Officers' Federation NSW (ASMOF) also noted the engagement of the Minister for Health and Regional Health.

> It's been refreshing to have a Minister and his office actually say, "Tell me what's going on," and then attempt to do something about it. It's such a marked change to the last 12 years.[14]

1.10 Mr Whaites also acknowledged the government's 'commitment to implement safe staffing levels' across the five key areas of: emergency departments, resuscitation bays, Intensive Care Units, High Dependency Units and Nursing Hours Per Patient Day.[15] Mr Whaites told the Committee that, when these safe staffing levels have been implemented, it will 'provide significant improvements in regional, rural and remote New South Wales'.[16]

1.11 While the Incentive Scheme has had some success, the Committee has heard that there have not been adequate improvements in the recruitment and retention of health workers in a number of professions and sectors, more broadly. However, we commend the government on its early efforts to implement PC2 recommendations in this area. While this is a good start, the Committee is of the view that the Incentive Scheme needs to be expanded, and that it is currently having some unintended and detrimental impacts.

1.12 This chapter begins by examining the effectiveness of incentives to recruit and retain health workers to the regional health system. It pays particular attention to professions where stakeholders identified shortfalls in staffing levels, and the critical issue of the over-supply of locums in regional health facilities. The chapter also explores how providing worker accommodation and improved remuneration could further support the recruitment and retention of health workers to remote, rural and regional (RRR) communities in NSW.

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[12] Submission 45, Royal Australian College of General Practitioners (Rural), p 1.

[13] Mr Michael Whaites, Assistant General Secretary, New South Wales Nurses and Midwives' Association, Transcript of evidence, 27 November 2023, p 3.

[14] Dr Antony Sara, President, Australian Salaried Medical Officers' Federation NSW, Transcript of evidence, 27 November 2023, p 3.

[15] Mr Whaites, Evidence, 27 November 2023, p 3; New South Wales Nurses and Midwives' Association, *Ratios in the public health system*, 22 February 2024, viewed 18 July 2024.

[16] Mr Whaites, Evidence, 27 November 2023, p 3.

Incentives for new health workers

Finding 2

There are still numerous, substantial shortfalls in a number of key health professions across remote, rural and regional NSW, including in primary care, Emergency Department staff, midwives, obstetricians, GP proceduralists.

Recommendation 1

That the Rural Health Workforce Incentive Scheme be modified to broaden its scope so that it can be accessed by non-government organisations, in order to recruit workers to regional services and facilities outside of the public health system. Access to the Incentive Scheme (outside of public health agencies) should be limited to organisations that are providing important health services to remote, rural and regional communities directly or in partnership with NSW Health.

Recommendation 2

That the NSW Government provide additional funding to expand the Rural Health Workforce Incentive Scheme, to recruit for specific professions and grow the Aboriginal health workforce.

Recommendation 3

That, in the design of future incentive schemes, NSW Health should ensure that there is sufficient flexibility at a local level, to implement incentives to their best effect, and that current staff should not be unnecessarily disadvantaged when compared to new staff.

1.13 Stakeholders identified a number of health professions where there are staff shortages and subsequent impacts on health services. For example:

- General Practitioners
- the midwifery and obstetrics workforce
- Emergency department (ED) staff and intensive care paramedics (ICPs)
- GP proceduralists, Visiting Medical Officers and Rural Generalists
- the Aboriginal rural health workforce
- nurse practitioners and other specific health professions.

1.14 We recommend that the Incentive Scheme be expanded in two key areas.

1.15 Firstly, the Incentive Scheme should be modified to broaden its scope, so that it can be accessed by non-government organisations. This will assist in recruiting workers to regional services and facilities outside of the public health system.

1.16 Organisations outside of the public health system identified a key shortcoming of the Incentive Scheme: the recruitment and retention incentives are generally not

accessible by non-government agencies or by local government.[17] Non-government service providers are key pillars in the regional health system, and not being able to use government incentive payments may create additional recruitment challenges outside of the public health system.

1.17 The Royal Flying Doctors Service's (RFDS) submission highlighted the importance of allowing non-government organisations to access government incentives for staff recruitment and retention. The RFDS, for example, provides holistic emergency, preventive and primary healthcare services, and plays a vital 'complementary role to the NSW health system'.[18]

1.18 For these reasons, the RFDS recommended that incentives should be 'applied equally to all organisations providing these services as part of, or complementary to, the NSW Health system.'[19]

1.19 In their submission, Maari Ma Health Aboriginal Corporation (Maari Ma) identified that the Incentive Scheme can lead to unfair treatment for staff of non-government organisations. Many of these staff will often work in public facilities, performing the same work as government employees, but for less pay (this issue is discussed further from 1.104). Maari Ma submitted that NSW Health's

> …grand gesture will now have a flow on effect to every other service provider in the region: ourselves and other [Aboriginal medical services], aged care facilities, home care supports. Greater thought should have gone into whether or not some more generalised supports could be offered: housing support, travel/transport, other non-directly monetised incentives.[20]

1.20 The Incentive Scheme may also have unintended impacts on services provided by local government.

1.21 Coolamon Shire Council told the Committee that regional aged care is 'struggling to meet' the 24-hour and care minute requirements for registered nurses (RNs), as they 'find it difficult to compete for the same workforce.' They explained:

> For example, if an RN gets [a] $20,000 cash incentive to move to the Coolamon-Ganmain [Multi-Purpose Service], any nurses we try to attract at the Allawah Lodge Aged Care Facility either chooses to take up the job with the $20,000 incentive or asks Council to match the incentive in order for them to choose us as an employer.[21]

1.22 Regional councils often play a critical and under-acknowledged role in the provision of services such as aged care, which is discussed further in Chapter 4. Council-provided services are also suffering from the recruitment and retention challenges experienced by the public system.

1.23 In answers to supplementary questions, NSW Health told the Committee that it 'has not considered providing funding for non-government health services',

[17] Submission 32, Royal Flying Doctors Service, p 6; Submission 39, Maari Ma Health Aboriginal Corporation, p 3; Answers to supplementary questions, Coolamon Shire Council, 11 December 2023, p 1.

[18] Submission 32, p 6.

[19] Submission 32, p 6.

[20] Submission 39, p 3.

[21] Answers to supplementary questions, Coolamon Shire Council, 11 December 2023, p 1.

noting that they are 'privately funded, and have their own commercial interests.'[22] The Incentive Scheme currently applies to Affiliated Health Organisations, as per Schedule 3 of the *Health Services Act 1997*, that are engaged by NSW Health in eligible locations.[23]

1.24 However, the Committee notes that many of these Affiliated Health Organisations are not based in regional NSW. Similarly, critical services for RRR communities (such as those provided by RFDS, Maari Ma or regional aged care facilities) do not appear to be covered.[24]

1.25 The Committee recommends that the Scheme should be broadened so that non-government organisations that service RRR communities directly, or in partnership with NSW Health, are able to access the scheme. This would have the benefit of improving the capacity of organisations providing health services for Aboriginal communities, allied health services and patient transport.

1.26 Secondly, additional funding should be provided so that the Incentive Scheme can be expanded, to allow for additional capacity to recruit for specific professions and the Aboriginal health workforce. An increase in funding could mitigate and reduce staff shortages, and consideration should be given to using targeting increased incentives at the professions discussed below.

1.27 The Committee notes that there appears to be a lack of flexibility in the introduction of the Incentive Scheme at the local level. During site visits, stakeholders raised concerns with the Committee that the Scheme may preference new staff over existing staff that may already be in place. The Committee recommends that, in the design of any future schemes, there is sufficient flexibility to allow Local Health Districts to implement incentive schemes to their best effect. Furthermore, future schemes should ensure that existing staff are not disadvantaged in receiving incentive payments, when compared with new recruits.

General practitioners

1.28 The Committee is of the view that regional general practice is in crisis. The GP workforce, especially in relation to supporting hospital care, is in dire need of support.

1.29 This view was widely supported by stakeholders, with some organisations adding that the situation has deteriorated since the 2022 PC2 recommendations.[25] The Australian Medical Association NSW (AMA NSW) submitted that 'there is a dire

[22] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, p 15.

[23] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, p 15; *Health Services Act* 1997, sch 3.

[24] *Health Services Act* 1997, sch 3.

[25] Dr Christine Ahern, Academic Co-ordinator (General Practice and Community), University Centre for Rural Health, Northern Rivers, Transcript of evidence, 27 November 2023, p 20; Dr Antony Sara, President, Australian Salaried Medical Officers' Federation NSW, Transcript of evidence, 27 November 2023, p 3; Submission 45, Royal Australian College of General Practitioners, p 5; Submission 47, Australian Medical Association NSW, p 4; Submission 48, Australian Salaried Medical Officers' Federation (New South Wales), pp 4-5.

shortage of GPs in RRR areas'. The AMA NSW's submission also implied that access to GPs may be unevenly distributed across the regional health system.

> Despite the recommendations, primary healthcare access has continued to deteriorate in remote and rural areas, with 72 GPs moving from rural and remote areas to larger regional cities in the second half of 2022 alone.[26]

1.30 This problem is likely to be exacerbated by declining numbers of trainee doctors entering rural general practice. Mr Phil Minns, Deputy Secretary, People, Culture and Governance, NSW Health, told the Committee that there is a decline in the number of people entering GP training across Australia. In NSW, there was a 15 per cent decline in 2016-2023, from 519 doctors entering training in 2016 down to 440 in 2023.[27]

1.31 When patients are unable to access GPs in their community, they will often present to hospital emergency departments. The Australian Salaried Medical Officers' Federation NSW (ASMOF) submitted that:

> Patients who have difficulty accessing GPs in their practices seek services at public hospital Emergency Departments. This is evident in Western NSW, where the PHN [Primary Health Network] has the highest rates of in-hours and out-of-hours ED attendances of any PHN nationally (227 and 206 per 1,000 people, respectively), with a third of all low acuity ED presentations occurring between the hours of 9 am and 1 pm (2015-2018).[28]

1.32 Can Assist stated that GP shortages have remained acute since the time of the PC2 inquiry. Can Assist provided data from a survey of their branches: 20 per cent of respondents reported an increase in GP numbers since the PC2 inquiry, but 40 per cent had noted a decrease. Can Assist submitted that, 'It is not uncommon to find the local GP books closed to new patients'.[29]

1.33 The City of Wagga Wagga Council provided an example of the impacts of GP shortages. A local health service advised the Council that it had disbanded an out of hours service in Wagga Wagga, due to the difficulties it had in recruiting GPs to operate this service.[30]

1.34 During the public hearings, the Inverell Health Forum also described the challenges facing general practices in regional towns. Dr Cheryl McIntyre, a local GP and Member of the Inverell Health Forum, told the Committee that there were 13 GPs serving the approximately 18 000 people of Inverell. She added that five or six of these GPs would also be working in the local hospital, and this responsibility 'divides your roles in a complex sort of way'. She said that

[26] Submission 47, p 4.

[27] Mr Phil Minns, Deputy Secretary, People, Culture and Governance, NSW Health, Transcript of evidence, 27 November 2023, p 38.

[28] Submission 48, p 5; see also: Submission 25, Western Health Alliance (WNSW PHN), pp 4-5.

[29] Submission 9, Can Assist (Cancer Assistance Network), pp 4-5.

[30] Submission 10, City of Wagga Wagga Council, p 2.

> Sometimes you have to cancel a day's worth of patients if you have suddenly been called to the hospital for an emergency situation that takes hours to sort out.[31]

1.35 Dr McIntyre also described the tenuous nature of providing GP services in Inverell. She told the Committee that

> Some GPs recently retired, and so suddenly we had a reduced workforce in July this year. That was a practice that saw about 3,000 patients, so they now don't have a GP full time. They do have a little bit of cover—I think once a fortnight there's a day or two a week. But there are a lot of people without a GP at the moment. The other practices just can't suddenly take on that massive volume because we're struggling to see everybody in a timely fashion ourselves.[32]

1.36 While the Committee's recommendations above are addressed to NSW Health, we acknowledge that the Australian Government has the core responsibilities for primary care across Australia. This includes key financial supports for general practice, such as the Medicare Benefits Schedule.[33]

1.37 NSW Health is bearing the brunt of the lack of primary care, and is responding with initiatives such as virtual care and aged care facility in-reach.[34]

1.38 The Committee is of the view that alternative models for rural general practice should be explored. This includes planned and sustainable use of virtual care (rather than using virtual care as a temporary substitute for adequate staffing and access to GPs in RRR communities).

1.39 The Committee notes the NSW Health Virtual Care Strategy was developed by NSW Health's Agency for Clinical Innovation in 2022.[35] We also acknowledge the range of virtual care initiatives that NSW Health have recently invested in, including the VirtualKIDS Urgent Care Service, the Remote Patient Monitoring Initiative, Virtual Hospital in the Home, and Virtual Rural Generalist Service.[36]

1.40 NSW Health could explore adapting innovative models such as these to reduce pressure on rural general practice, provided that they are implemented with a view to supporting (rather than replacing) face-to-face care where possible. Virtual care and primary health models are discussed further in Chapter Four.

1.41 There appears to be limited progress on coordination between the state and federal governments to address shortages in the GP workforce. This is an area that requires urgent action by both levels of government to actively build up RRR general practice. Refinements to the Incentive Scheme (Recommendations 1 and 2 above) should thus include an emphasis on recruiting more GPs to the regional health workforce, to improve access to primary care in RRR communities.

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[31] Dr Cheryl McIntyre, Member, Inverell Health Forum, Transcript of evidence, 24 November 2023, p 32.

[32] Dr McIntyre, Evidence, 24 November 2023, p 33.

[33] NSW Health, *NSW Regional Health Strategic Plan for 2022-2032*, p 9.

[34] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, pp 20, 24; Ms Deborah Willcox, Acting Secretary, NSW Health, Transcript of evidence, 27 November 2023, p 38.

[35] Submission 11, NSW Health, p 26; Submission 52, Faculty of Medicine and Health, University of New England, p 4; NSW Health, *NSW Health Virtual Care Strategy*, February 2022, viewed 20 July 2024.

[36] Submission 11, NSW Health, pp 26-27.

Midwifery and obstetrics

1.42 The PC2 inquiry contained a number of recommendations that focused on workforce issues in midwifery and obstetrics (for example, Recommendations 16, 20 and 27). The *Independent Review – Rural Health Inquiry* conducted by Ernst & Young ('the EY report') reported that 352 nurses and midwives have been recruited since June 2022.[37]

1.43 However, shortages in the midwifery and obstetrics workforce remain an area of concern. The Committee notes that the situation with specialist obstetricians is dire, in some centres, and women are being required to travel unreasonable distances to get care.

1.44 Mr Luke Sloane, Deputy Secretary, Regional Health (NSW Health) told the Committee that NSW Health is working through the challenges associated with the recruitment and retention of midwives. Acknowledging the statewide shortage of midwives, Mr Sloane noted the inter-jurisdictional and 'global' shortages are also impacting the challenges faced in NSW.[38]

1.45 Dr Rod Martin, College Councillor NSW, Australian College of Rural and Remote Medicine (ACRRM) told the Committee that, since the PC2 hearings, the situation facing maternity and obstetric services 'seems to have become worse, with some locations closing and many being barely viable.' He observed that NSW has some of the 'more threatened services in the country.'[39]

1.46 Dr Martin highlighted shortages in the Rural Generalist (RG) obstetrician workforce. He told the Committee that there are 'ever decreasing numbers of RG obstetricians in the system or coming into training.'[40]

1.47 Dr Martin described the impacts that workforce shortages can have in maternity and obstetric services. NSW Health facilities that provide neonatal and maternity services are graded according to the complexity of care they can provide and the volume of mothers and infants they can admit, ranging from lower capabilities at level 1 to higher level services at level 6. Hospitals such as Coffs Harbour Hospital or Tamworth Base Hospital, for example, have level 4 maternity service capability.[41] Dr Martin stated that:

> There are even large level four services that need to go on bypass between one and three days at a time, with many patients having to travel an extra 100 to 200 kilometres, or, even worse, necessitating quite expensive retrievals so they can safely deliver in a distant centre. Our great fear is that if we have a couple of larger services that need to be on bypass sequentially with long retrieval times, sooner or later we're going to potentially see an avoidable death of a mother or baby.[42]

[37] Independent Review Rural Health Inquiry (Ernst & Young), provided by NSW Health to the Committee, 16 August 2023, p 43.

[38] Mr Luke Sloane, Deputy Secretary, Regional Health, NSW Health, Transcript of evidence, 27 November 2023, p 46.

[39] Dr Rod Martin, College Councillor NSW, Australian College of Rural and Remote Medicine, Transcript of evidence, 24 November 2023, p 6.

[40] Dr Martin, Evidence, 24 November 2023, p 6.

[41] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, pp 16-17.

[42] Dr Martin, Evidence, 24 November 2023, pp 6-7.

1.48 Bland Shire Council submitted that the midwifery service at West Wyalong District Hospital ceased in 2001. Since then, expectant mothers have 'been forced to arrange their confinement for delivery at centres which are a considerable distance from their residence'. This can increase anxiety for expectant parents and their families, and lead to a greater financial burden.[43]

1.49 The NSW Government has committed to increasing safe staffing levels through its 2023 Memorandum of Understanding with the Nurses and Midwives' Association, by hiring an additional 1200 nurses and midwives in NSW during its first term of government.[44]

1.50 While this is a positive development, the Committee notes that this is a statewide target rather than an initiative focused on the RRR health workforce. The Committee is also of the view that staffing ratios are important for workforce recruitment and retention. However, ratios should not lead to service reductions or create any risk that services are not able to operate.

1.51 The Committee acknowledges the range of scholarships and financial assistance packages that are offered to nursing and midwifery students in RRR areas. We also recognise that students in RRR communities may have difficulty accessing Bachelor of Midwifery programs close to their homes, with limited opportunities for distance education.[45]

1.52 The Committee is of the view that reliance on current training schemes or the initiatives of LHDs will not address the shortfall in the midwifery and obstetrics workforce. Additional funding for the Incentive Scheme may provide an opportunity for the targeted recruitment of midwives and obstetricians. Strengthening this critical workforce requires a direct and concerted effort at senior levels in NSW Health.

Emergency department staff and intensive care paramedics

1.53 Emergency health care is also under stress in RRR areas. Some stakeholders highlighted challenges that have endured since the time of the PC2 inquiry, such as workforce shortages in emergency departments (EDs) and a lack of intensive care paramedics in certain areas.

1.54 The Australasian College for Emergency Medicine (ACEM) submitted that the number of emergency medicine (EM) specialists has increased state-wide. However, they added that 'staffing numbers are not keeping up with the continuing growth in demand' for emergency care. EM specialists and trainees are concentrated in metropolitan areas, and there is a 'marked shortage' of ACEM Fellows, trainees and senior decision makers in regional EDs.[46]

[43] Submission 41, Bland Shire Council, p 3.

[44] Submission 11, NSW Health, p 10; NSW Government, *Minns Government signs MOU to deliver safe staffing*, media release, 31 August 2023, viewed 29 April 2024.

[45] Submission 11, pp 16-17.

[46] Submission 13, Australasian College for Emergency Medicine, pp 2-3.

1.55 ACEM added that staff shortages can have demoralising effects on emergency staff.

> Our members highlight constant staff shortages each shift, and the pressure for doctors to fill those gaps. Staff shortages were further compounded by the lack of clerical and non-clinical support staff. Our members describe feeling like they are in constant overdrive (within and outside of rostered hours) to keep the system functioning.[47]

1.56 There are also shortages in the allocation of intensive care paramedics (ICPs) across RRR areas.

1.57 Mr Scott Beaton, Vice President, Australian Paramedics Association (APA) NSW told the Committee that the regional ICP program is limited to larger urban centres. ICPs are being allocated to 'Category A' ambulance stations, such as those in Albury, Wagga Wagga, Orange, Dubbo, Tamworth and Armidale. Mr Beaton advised, 'That leaves a large portion of the state that doesn't have that distribution of intensive care paramedics'.[48]

1.58 Mr Beaton added that the distribution of ICPs can impact on the training of other paramedic staff. ICPs have the 'ability to train other staff up' and junior staff are able to upskill by learning from them. However, paramedics in regional NSW may not get these opportunities because 'there is not an equitable distribution across the state of ICPs.'[49]

1.59 Mr Gary Wilson, Delegate and former Secretary, APA NSW, told the Committee that paramedics often feel as though they 'haven't been able to provide the service that our patients need and the protection to our community because we don't have access to those skill levels.' Regional paramedics may not have clinical pathways to skill advancement. Mr Wilson said that:

> …even in their latest documents NSW Ambulance seems to be committed to limiting ICPs and ECPs [extended care paramedics] in regional areas despite the undertakings and the recommendations.[50]

1.60 Strengthening the emergency care workforce is of critical importance to the regional health system. Given the diverse roles engaged in the provision of emergency care in RRR communities – from paramedics to nurses to doctors and GP proceduralists – this may require both targeted recruitment for specific roles, in addition to addressing shortfalls across the wider health system. If NSW Health and the LHDs have access to additional funding within the Incentive Scheme, this would likely assist in strengthening emergency care in regional hospitals.

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[47] Submission 13, p 3.

[48] Mr Scott Beaton, Vice President, Australian Paramedics Association (NSW), Transcript of evidence, 27 November 2023, p 5.

[49] Mr Beaton, Evidence, 27 November 2023, p 5.

[50] Mr Gary Wilson, Delegate and former Secretary, Australian Paramedics Association (NSW), Transcript of evidence, 27 November 2023, p 6.

GP Visiting Medical Officers and rural generalists/GP proceduralists

1.61 In addition to the crisis facing rural general practice, the shortage of GPs has wider implications for healthcare in RRR areas. In particular, the supply of doctors who can fill the role of GP Visiting Medical Officers (VMOs), GP proceduralists and Rural Generalists appears to be inadequate.

1.62 The PC2 report identified VMOs and Rural Generalists as being particularly valuable to the regional health system. The need to recruit additional Rural Generalists was highlighted in recommendation 11, while providing additional supports and streamlining accreditation systems for GP VMOs was also recommended (Recommendations 12 and 13; discussed further in Chapter Two).[51]

1.63 The Rural Doctors Network (RDN) highlighted the importance of GP proceduralists, GP VMOs and rural generalists, a cohort of highly trained and multi-skilled medical professionals that 'are often central to the maintenance of public, primary care, aged care and social care (e.g. NDIS) services for remote and rural communities.' The services provided by this cohort can provide more holistic and higher quality care, and can contribute to reducing the number of hospitalisations.[52]

1.64 A VMO is a doctor that has completed training in a medical speciality, and is contracted to work at a public hospital and provide services to its patients. The VMO role can be performed by GPs also providing healthcare in communities.[53]

1.65 The GP proceduralist or rural generalist role is important for the provision of both community-based primary care and hospital-based care in a number of specialty areas. This includes the provision of anaesthetic, obstetric and general surgery services in RRR hospitals.[54] The Australian College of Rural and Remote Medicine emphasised that rural generalists have a:

> broad scope of practice which includes comprehensive primary care, public health, and advanced skills as appropriate for community need, delivered within the unique circumstances and context of rural and remote medical practice.[55]

1.66 The Royal Australasian College of Medical Administrators (RACMA) highlighted a significant issue: there are not enough medical graduates training in primary care, 'and for those who do, fewer are training as GP proceduralists who are able to contribute to hospital-based care.'[56]

1.67 The RDN acknowledged that the *NSW Regional Health Strategic Plan 2022-32* has identified the importance of increasing access to GPs.[57] The *Strategic Plan* also

[51] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, pp xvi-xvii.

[52] Submission 21, NSW Rural Doctors Network, p 3.

[53] NSW Ministry of Health, Training and working as a doctor in the NSW public health system, viewed 8 April 2024; Rural Doctors Network, Common questions, 2024, viewed 20 July 2024.

[54] Submission 51, Royal Australasian College of Medical Administrators, p 3.

[55] Submission 25, Australian College of Rural and Remote Medicine, p 5.

[56] Submission 51, p 4.

[57] Submission 21, p 3.

prioritises investment in and promotion of rural generalism for doctors, nurses and allied health professionals as a 10-year deliverable.[58]

1.68 In their submission to the PC2 inquiry in 2020, the RDN noted that there were only 177 people employed in the GP VMO, rural generalist and GP proceduralist professions. However, the RDN also warned that

> …issues such as GP VMO / Rural Generalist distribution and availability, workforce pressures following on from COVID-19 and natural disasters, general practice viability concerns, increasing 'out of region' locum payment rates and metro-friendly GP placement policies have likely exacerbated the decline trend beyond the success rates of new programs.[59]

1.69 The shortage of doctors in this cohort can be partly attributed to issues with remuneration and accreditation, in addition to other factors that limit the success of worker recruitment and retention – such as workplace culture and non-financial supports. These considerations are discussed further below.

The Aboriginal rural health workforce and staffing Aboriginal medical services

1.70 The PC2 report specifically recommended that NSW Health and the Local Health Districts (LHDs) 'prioritise building their Indigenous workforce across all disciplines, job types and locations', particularly in RRR areas (Recommendation 33).[60] The Committee notes some progress in this area. However, like most of the workforce shortages identified above, further work is needed to strengthen the Aboriginal rural health workforce and better support the Aboriginal medical services (AMS) sector.

1.71 The EY report describes work that has been completed since the PC2 inquiry. This includes $21 million that was approved for expenditure on the recruitment of 18 Full Time Equivalent (FTE) Aboriginal Care Navigators and 18 FTE Aboriginal Peer Workers.[61] The *NSW Regional Health Strategic Plan 2022-32 Priority Framework* has set the target of achieving at least four per cent, or greater, representation of Aboriginal staff by 2026 for all regional LHDs.[62] Some regional LHDs have also developed particular strategies for increasing their Aboriginal health workforce, such as Hunter New England LHD.[63]

1.72 NSW Health told the Committee that, from June 2022 to June 2023, the 'Aboriginal workforce in regional and rural areas has increased by 0.15% to 4.52% (compared to NSW Health at 3%).'[64]

1.73 Mr Michael Whaites, Assistant General Secretary, New South Wales Nurses and Midwives' Association (NMA), acknowledged that some improvements have been made in targeted recruitment for Indigenous healthcare workers, including within

[58] NSW Health, *NSW Regional Health Strategic Plan 2022-2032*, St Leonards, February 2023, p 28.

[59] Submission 21, p 3.

[60] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, p 161.

[61] Independent Review Rural Health Inquiry (Ernst & Young), 16 August 2023, p 66.

[62] NSW Health, *NSW Regional Health Strategic Plan 2022-2032 Priority Framework*, 21 February 2023, p

[63] Independent Review Rural Health Inquiry (Ernst & Young), 16 August 2023, p 66.

[64] Submission 11, p 11.

nursing and midwifery, since the PC2 inquiry. However, he told the Committee that cultural safety for patients 'is perhaps ahead of the cultural safety for staff', and that cultural safety awareness training is an area requiring improvement.[65] This issue is discussed further in Chapter Three.

1.74 Other stakeholders also identified that work needs to continue in this area – both for public health facilities, non-government organisations and Aboriginal Community-Controlled Health Organisations (ACCHOs).

1.75 Mr Richard Weston, CEO, Maari Ma Aboriginal Health Corporation, told the Committee that 'it's not an easy process to recruit general practitioners and other clinicians.' In order to attract staff to their facilities across the Central Darling, Wentworth and Balranald shires, Maari Ma have needed to employ 'a workforce consultant based in Sydney that does a hell of a lot of intensive legwork with different agencies, locum services [and] educational colleges'.[66]

1.76 The Rural Doctors Network (RDN) acknowledged the intent of the *NSW Regional Health Strategic Plan 2022-32* to strengthen the Aboriginal health workforce. They also recommended 'extending NSW Government's financial and in-kind support to ACCHOs.'[67] They added that support could be provided to other non-government organisations that engage with Aboriginal communities, 'where appropriate', and that investment could be considered for 'professional development and career pathways for Indigenous health administrative staff and future executives'.[68]

1.77 The RDN also submitted that there are Indigenous health workforce initiatives that have demonstrated success and have the potential for upscaling within NSW. They highlighted Indigenous Allied Health Australia's Academy program, which works with high school students, and the University of Newcastle's Miroma Bunbilla Program, which offers pre-medical entry pathways for Indigenous students.[69]

1.78 The Committee is of the view that strengthening the Aboriginal health workforce in RRR areas is hampered by poor working relationships between LHDs and Aboriginal medical services. Bulgarr Ngaru Medical Aboriginal Corporation submitted that, while NSW Health's strategy and planning document may emphasise collaboration with the AMS sector, the reality can be quite different.

> There is much in health department plans and vision statements about community centred and collaborative, partnership approaches. In Northern NSW there is a formal partnership agreement between the 3 AMSs, the PHN and the LHD. But in practice, our dealings with LHD management are a frequent source of disappointment and frustration. There seems a culture of arrogance, lack of listening, a propensity to make unilateral decisions that can have a significant impact

[65] Mr Michael Whaites, Assistant General Secretary, New South Wales Nurses and Midwives' Association, Transcript of evidence, 27 November 2023, p 7.

[66] Mr Richard Weston, CEO, Maari Ma Aboriginal Health Corporation, Transcript of Evidence, 27 November 2023, p 12.

[67] Submission 21, p 7.

[68] Submission 21, p 7.

[69] Submission 21, p 7.

> on primary health care services and their clients as well as a seeming failure to understand that people live in the community not the hospital and that the [primary health care] sector is where the great majority of health care actually occurs.[70]

1.79 The Committee notes these experiences of people working within this sector of the health system. We will further examine the delivery of specific health services and specialist care within the AMS sector in our second inquiry. In this report, we emphasise and recommend that this sector should be included in an expansion and refinement of the Incentive Scheme.

Nurse practitioners and other health professions

1.80 In addition to the above concerns about the size of the nursing and midwifery workforce in RRR areas, some stakeholders also pointed to the need for development of the nurse practitioner workforce. Shortages in the nurse practitioner and allied health workforces were highlighted in the PC2 inquiry (Recommendations 11 and 17).[71]

1.81 A nurse practitioner is a registered nurse who works at an advanced practice level, and possesses expert clinical knowledge and has an advanced, specialised education. [72] Nurse practitioners can request or perform selected screening and diagnostic investigations, and prescribe and implement therapeutic interventions.[73]

1.82 The Australian College of Nurse Practitioners (ACNP) submitted that nurse practitioners are 'well-positioned to provide comprehensive primary care services, including diagnosis, treatment, and management of various health conditions'. The ACNP argued that, as part of the response to PC2 recommendation 11 regarding a 10-year workforce and recruitment strategy, the role of nurse practitioners should be fully integrated in this strategy.[74]

1.83 Stakeholders also pointed to more specific professions within primary care and allied health, where greater government support could be provided.

1.84 This included pharmacy services in RRR areas. Ms Karen Carter, pharmacy owner and Fellow, Pharmaceutical Society of Australia, told the Committee that funding has recently been cut for the second year of pharmacy internships in medium rural towns (classified as MM4 under the Modified Monash Model). While pharmacies can still receive funding for a first year, and many are able to keep interns on for a second year, Ms Carter said it would be helpful to have funding to support interns staying for longer, which would support pharmacists remaining in practice in regional areas.[75]

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[70] Submission 54, Bulgarr Ngaru Medical Aboriginal Corporation, p 2.

[71] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, pp xvi-xvii.

[72] NSW Health, *Nurse practitioners in NSW*, 5 March 2021, viewed 9 April 2024

[73] Nursing and Midwifery Board, *Nurse practitioner standards for practice*, 23 March 2021, viewed 9 April 2024.

[74] Submission 24, Australian College of Nurse Practitioners, p 3.

[75] Ms Karen Carter, Fellow, Pharmaceutical Society of Australia, Transcript of evidence, 24 November 2023, p 14.

1.85 Exercise and Sports Science Australia submitted that access to exercise physiologists in RRR areas needs to be increased. In particular, positions for exercises physiologists in public facilities are limited, which 'exacerbates issues of workforce shortages and access to evidence-based clinical treatment services.'[76]

1.86 There would be benefits in ensuring that the Incentive Scheme is being used to fund the recruitment of staff to fill roles such as these, in addition to the cohorts discussed above. The regional health system is diverse and complex, and individuals seek health care from a variety of sources. Providing additional funding for the Incentive Scheme would allow for particularly in-demand roles to be targeted, which may assist in reducing pressures caused by staff shortages across the regional health system.

Retaining health workers in regional NSW

Finding 3

The challenge of recruiting and retaining health workers to regional NSW is multifaceted, and one-off financial incentives need to be supported by longer-term improvements to training, working conditions, workplace culture and remuneration.

Finding 4

NSW Health and the NSW Government have continued to work with the Australian Government on a number of workforce initiatives and strategies; however, alignment of state and federal workforce strategies must progress with greater urgency.

1.87 Retaining staff is one of the enduring challenges facing the regional health system in NSW. The PC2 inquiry found that:

> … there has been a historic failure by various NSW and Australian governments to attract, support and retain health professionals especially doctors and nurses in rural, regional and remote areas.[77]

1.88 The Committee acknowledges the government's commitment to retaining staff in regional health services and facilities. As discussed, NSW Health submitted that the retention of health workers 'has markedly improved' since the Rural Health Workforce Incentive Scheme was introduced in July 2022. NSW Health told the Committee that over 9 000 staff have been retained through the use of incentive payments.[78]

[76] Submission 23, Exercise and Sport Science Australia, p 3.

[77] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, p xviii.

[78] Submission 11, NSW Health, p 10.

1.89 However, the Committee heard that more work needs to be done to improve the retention of health workers in RRR areas.[79] Some stakeholders also told the Committee that the Incentive Scheme has not had significant impacts.[80]

1.90 The Committee also notes the multifaceted nature of supporting staff retention. We support the conclusions reached by a number of stakeholders, that one-off financial payments – on their own – may not be enough to attract health workers to RRR areas and encourage them to stay.[81]

1.91 The challenge of retaining health workers in RRR communities should be approached holistically. The Committee has heard of numerous service deficits that should be addressed in order to support the retention of healthcare workers in the regional health system. For example, several stakeholders pointed to the challenges of accessing childcare services in RRR communities and the need to improve this access to support worker recruitment and retention.[82] The New South Wales Nurses and Midwives' Association submitted that:

> Establishing extended hours childcare facilities at hospitals or ensuring places are available to the children of nurses and midwives within communities could significantly support increasing the workforce in RRR communities.[83]

1.92 During its site visits, the Committee heard about various initiatives across the state that could be deployed more consistently. For example, we are aware of some health facilities that have played a coordinating role in establishing social connections for their staff that have recently relocated to regional NSW, such as sports activities and trivia nights. There are also some workplaces that have provided flights for their staff to briefly return to their "home" cities in order to retain social connections with their families (social isolation is also discussed further in Chapter Three). Solutions such as these should be considered as critical elements in the broader efforts to retain health workers in regional NSW.

1.93 The Inverell Health Forum submitted that a broader range of incentives could be considered beyond the current format of the Incentive Scheme. This includes 'tax breaks, HECS debt relief, cash incentives [and] additional training opportunities'.[84]

1.94 Factors that could support retention include:

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[79] Dr Michael Bonning, President, Australian Medical Association (NSW), Transcript of evidence, 24 November 2023, p 4; Submission 50, New South Wales Nurses and Midwives' Association, p 8; Submission 42, National Rural Health Alliance, p 9.

[80] Mr Paul Haines, Clinical Nurse Specialist, New South Wales Nurses and Midwives' Association, Transcript of evidence, 27 November 2023, p 3; Dr Sara, Transcript of evidence, 27 November 2023, p 3; Submission 48, Australian Salaried Medical Officers Federation (New South Wales), pp 1, 5-6.

[81] Submission 48, p 5; Submission 50, pp 4, 8; Mr Gary Wilson, Transcript of evidence, 27 November 2023, p 4.

[82] Submission 9, Can Assist (Cancer Assistance Network), p 4; Submission 13, Australasian College for Emergency Medicine, p 6; Submission 37, Local Government NSW, p 9; Submission 50, p 15; Answers to supplementary questions, National Rural Health Alliance, 20 December 2023, p 10.

[83] Submission 50, p 15.

[84] Submission 31, Inverell Health Forum, p 5.

- improving pay and achieving remuneration parity between junior doctors in rural settings (and those in metropolitan settings)[85]
- providing opportunities for networking and peer support[86]
- protecting the health and wellbeing of people working in the regional health system[87]
- contracting arrangements for GM VMOs, access to transport and staff accreditation and training.[88]

1.95 Dr Michael Bonning, President, Australian Medical Association (NSW) highlighted the importance of a holistic approach to retention:

> To recruit and keep a doctor takes a community…where you actually get the different parts of that community to work together— the welcome, the engagement of partners, the education of children, the finding of services and all of that.[89]

1.96 Poor workplace culture was also identified by stakeholders as a limiting factor in the retention and recruitment of health workers.[90] The relationship between workforce retention and workplace culture is discussed further in Chapter Three.

1.97 The Committee also finds that there is still a need to strengthen partnerships with the Australian Government and build an intergovernmental approach to addressing workforce recruitment and retention challenges. While we acknowledge the work that has been completed, we note that – against the performance indicators provided in the EY Report – less progress has been made in implementing some recommendations which involve partnership with the Australian Government than in other areas (for example, Recommendations 11 and 14).[91]

1.98 The RDN submitted that, in order to build NSW's future health workforce, it is important that there be 'genuine partnering with the Australian Government's primary health workforce plans and investments'.[92] In particular, the RDN flagged the need for NSW strategies to be aligned with national plans such as the *National Medical Workforce Strategy 2021-31* and *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031*.[93]

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[85] Submission 48, p 7; Submission 21, p 6.

[86] Submission 42, p 9.

[87] Mr Richard Colbran, CEO, NSW Rural Doctors Network, Transcript of evidence, 24 November 2023, p 4.

[88] Dr Bonning, Evidence, 24 November 2023, p 4

[89] Dr Bonning, Evidence, 24 November 2023, p 9.

[90] Dr Bonning, Evidence, 24 November 2023, p 4; Dr Trevor Chan, Faculty Chair, Australasian College for Emergency Medicine, Transcript of evidence, 24 November 2023, p 11.

[91] Independent Review Rural Health Inquiry (Ernst & Young), provided by NSW Health to the Committee, 16 August 2023, pp 9-10.

[92] Submission 21, p 3.

[93] Submission 21, p 5.

1.99 Other stakeholders pointed to the need for an intergovernmental approach to addressing regional health challenges.[94] In their submission, the National Rural Health Alliance recommended that the NSW Government should be working with the Australian Government and other jurisdictions to developing a national rural health strategy.[95]

1.100 Inter-jurisdictional links between the federal and state governments are numerous and complex. They encompass diverse workforce issues ranging from recruitment and training pathways, funding models and expenditure allocations, and the provision of healthcare across state borders.

1.101 Recommendation 11 of the PC2 report was that NSW Health and the Australian Government should collaborate to develop and implement a '10-Year Rural and Remote Medical and Health Workforce Recruitment and Retention Strategy.'[96] While the Committee notes that NSW and Australian governments have commissioned independent workforce strategies, we are concerned that 'limited progress' against this recommendation was noted in the EY report.[97]

1.102 We discuss the need for greater Australian Government support for the NSW regional health system further in Chapters Two and Four. However, noting that the NSW Government's progress in implementing certain PC2 recommendations are contingent on consultation with and the initiative of the Australian Government, this is an area the Committee will likely explore in future inquiries.

Inequitable access to the Rural Health Workforce Incentive Scheme

Recommendation 4

That NSW Health review and modify the Rural Health Workforce Incentive Scheme, with the aim of ensuring it is implemented fairly and provides effective incentives for staff to remain in a facility or locality.

1.103 Further to Recommendations One and Two above, the Committee recommends that NSW Health review and modify the Rural Health Workforce Incentive Scheme. The Incentive Scheme is more likely to achieve its aim (and minimise any unintentional, negative outcomes) if it is implemented fairly. Adjusting administrative processes or modifying eligibility criteria could be one way to avoid unfair outcomes, such as pay disparity within equal roles in a facility or locality.

1.104 Stakeholders identified that eligibility for the Incentive Scheme is inconsistent and unfair. This includes situations where staff performing the same role, at the same facility, receive different rates of pay due to retention bonuses.[98]

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[94] Ms Darriea Turley, President, Local Government NSW, Transcript of evidence, 24 November 2023, p 27; Cr Wendy Wilks, Transcript of evidence, 24 November 2023, p 25.

[95] Submission 42, National Rural Health Alliance, p 9.

[96] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, p xvi.

[97] Independent Review Rural Health Inquiry (Ernst & Young), 16 August 2023, pp 9, 36.

[98] Submission 39, Maari Ma Aboriginal Health Corporation, p 3; Submission 50, New South Wales Nurses and Midwives' Association, pp 4, 14.

1.105 The inequitable implementation of the Incentive Scheme appears to be most prevalent in the nursing workforce.

1.106 Mr Paul Haines, Clinical Nurse Specialist and member, New South Wales Nurses and Midwives' Association (NMA), provided some examples from his hospital.

> At the hospital where I work, you have nurses who do exactly the same job being paid half of the bonus of the nurses they're working with. That's purely due to the cost centre the salary is costed to. To be clear, you've got two nurses doing exactly the same job receiving different amounts of the bonus to the tune of $5,000. As well as this, we've got different grades of nurses being paid different amounts of incentive bonus. All this has done is cause animosity between staff and anger towards the employer, and increase the likelihood of staff leaving our hospital, which is contrary to what I believe the scheme was originally set up for.[99]

1.107 The NMA argued that the Incentive Scheme:

> … has been poorly and inequitably applied, has caused a lot of angst and misunderstanding amongst NSW Health staff and has decreased trust and loyalty of nurses and midwives.[100]

1.108 It is also critical that the incentives are available for the right roles. For example, the Australian Paramedics Association (APA) submitted that the Incentive Scheme covers only a small percentage of paramedic roles, such as Station Officers. The APA identified that the incentives cover roles which are 'not forming the bulk of general staffing issues facing RRR NSW.'[101]

1.109 The Rural Doctors Association of NSW also submitted that the incentive payments are not available for GPs who are on contracts and working in NSW Health facilities.[102] While care should be taken that any expansion of the Incentive Scheme does not add to the costs and challenges associated with the over-reliance on locum doctors, further consideration should be given to how the Incentive Scheme can address the crisis facing rural general practice.

Supporting workforce retention through accommodation for regional health workers

Recommendation 5

That NSW Health collaborate with local government and the NSW Land and Housing Corporation to ensure that there is adequate housing for current and future health workers in remote, rural and regional NSW.

1.110 Accommodation for health workers was not an explicit recommendation from the PC2 inquiry. However, a number of stakeholders outlined the challenges of retaining staff when there is not sufficient housing in the areas they would like to work. As such, we recommend that additional efforts be made to ensure that there is adequate housing for current and future health workers in remote, rural

[99] Mr Paul Haines, Clinical Nurse Specialist and member, Nurses and Midwives' Association NSW, Transcript of evidence, 27 November 2023, p 3.

[100] Submission 50, p 4.

[101] Submission 46, Australian Paramedics Association, p 6.

[102] Submission 49, Rural Doctors Association of NSW, p 1.

and regional NSW. This will make it easier to attract and retain these crucial workers.

1.111 The Committee acknowledges that some actions outlined in the EY Report, in response to particular workforce and training recommendations, include the establishment of an Accommodation Advisory Group to explore how accommodation supports could be provided to trainee doctors (Recommendation 15) and limited funding for LHDs to support accommodation for graduate nurses appointed to small rural facilities (Recommendation 19).[103]

1.112 The Committee notes that undergraduate clinical placement grants of up to $1000 are available for nurses and midwifery students, to support their travel and accommodation costs.[104] We also acknowledge the $45.3 million investment that has been made by the NSW Government to deliver the Key Worker Accommodation project in the Far West, Murrumbidgee and Southern NSW LHDs. This accommodation is expected to be available to temporary and short-stay staff, specialists and students between late 2024 and early 2025.[105] We are pleased to see that work has commenced to boost health worker accommodation in some LHDs.

1.113 However, several stakeholders identified that limited housing and accommodation options in RRR communities remain a significant barrier to the recruitment and retention of health workers, and supporting medical and nursing students.[106]

1.114 The Australian Paramedics Association NSW (APA) told the Committee that there 'is no housing for our paramedics in some of the rural communities and this causes a great issue when we're trying to staff these small regional and rural towns'.[107] Mr Gary Wilson, Delegate and former Secretary, APA, observed that:

> With respect to recruiting to the regions, again, housing is critical. We've had instances where paramedics have been sleeping in cars and tents because there has been no accommodation.[108]

1.115 Accommodation challenges such as these are likely to have severe impacts on recruiting and retaining experienced staff. They can also limit the number of trainee or early-career doctors and nurses who decide to remain in RRR communities.

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[103] Independent Review Rural Health Inquiry (Ernst & Young), 16 August 2023, pp 41, 47.

[104] Submission 11, NSW Health, p 17.

[105] NSW Government, *Project Update – Key Worker Accommodation*, November 2023, viewed 20 April 2024; NSW Health, *Look inside $45.3 million health worker accommodation project*, 9 May 2024, viewed 10 May 2024.

[106] Mr Whaites, Transcript of evidence, 27 November 2023, p 5; Professor Vicki Flood, Director, University Centre for Rural Health, Northern Rivers, Transcript of evidence, 27 November 2023, p 21; Cr Darriea Turley AM, President, Local Government NSW, Transcript of evidence, 24 November 2023, p 12; Submission 10, City of Wagga Wagga Council, p 3.

[107] Mr Scott Beaton, Vice President, Australian Paramedics Association, Transcript of evidence, 27 November 2023, p 2.

[108] Mr Gary Wilson, Delegate and former Secretary, Australian Paramedics Association, Transcript of evidence, 27 November 2023, p 4.

1.116 Stakeholders noted that medical students in RRR areas can be forced to make the decision to cease their studies due to a lack of suitable accommodation. Professor Megan Smith, Executive Dean, Faculty of Science and Health, Charles Sturt University, told the Committee that accommodation for students can be 'really dire'. Professor Smith described how a lack of accommodation may mean that students are faced with a choice where 'if I don't have appropriate accommodation, I just don't take the placement up and I drop out.'[109]

1.117 The New South Wales Nurses and Midwives' Association (NMA) welcomed the NSW government program to build and upgrade healthcare staff accommodation in RRR areas. However, they submitted that more accommodation measures need to be introduced in RRR areas to better retain staff.[110]

1.118 The NMA drew on academic research to highlight that greater housing assistance will make workers' transition to RRR areas less challenging. The NMA's submission cited a study on early-career registered nurses in rural hospitals in Australia, which identified that key supports should include:

> …accommodation assistance, linking graduates with local real estate agencies, dedicated accommodation utilised by new people moving to the area and government funded accommodation prior to relocating from one rural area to another.[111]

1.119 In particular, they drew attention to the Attract, Connect, Stay (ACS) pilot which was successfully trialled in Glen Innes. The NMA told the Committee that this pilot 'is an example that could be utilised across NSW'.[112] This pilot was modelled on a program based in Marathon, Ontario (Canada) which has been in operation for 13 years. The ACS pilot involves the recruitment of a locally funded Healthcare Workforce Recruiter Connector (HWRC). An evaluation of the ACS pilot noted that the HWRC assisted healthcare professionals in securing housing 'in a challenging rental market'.[113]

1.120 The Committee acknowledges that some work is being done in this area. Expansion of the Key Worker Accommodation project to additional LHDs should be given serious consideration. More holistic models such as the ACS pilot trialled in Glen Innes could also be rolled out to additional RRR areas. The Committee also recognises that some local councils are active in providing housing for healthcare staff in RRR areas and commend them for this work. We discuss the role of local councils in further detail in Chapter Four.

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[109] Professor Megan Smith, Executive Dean, Faculty of Science and Health, Charles Sturt University, Transcript of evidence, 27 November 2023, p 23.

[110] Submission 50, p 8.

[111] Submission 50, p 8; H Rose, G Skaczkowski & KM Gunn, 'Addressing the challenges of early career rural nursing to improve job satisfaction and retention: Strategies new nurses think would help', *Journal of Advanced Nursing,* vol 79, 2023, p 3307, viewed 28 March 2024.

[112] Submission 50, p 8.

[113] A Moran, Attract, *Connect, Stay – Final Project Evaluation,* unplex, Wodonga, December 2022, pp 98-99.

1.121 However, the Committee is concerned that ensuring health workers have access to adequate housing is an issue that could fall through the gaps of departmental responsibilities.[114]

1.122 We recommend that the NSW Government pursue formal collaboration arrangements with both the NSW Land and Housing Corporation and local councils in RRR areas. Such a collaboration should explore locally-managed solutions such as the ACS program and broader public works projects, to guarantee that there is adequate housing for current and future health workers in RRR communities.

Reducing reliance on locum doctors

Recommendation 6

That NSW Health prioritise solutions that reduce the public health system's reliance on locum doctors as a long-term response to staff shortages. Consideration should be given to creating a statewide casual pool to fill short-term vacancies and regulating the rates paid to locums in the internal market. It is acknowledged that this requires cooperation across states, however this must be an urgent priority.

1.123 The 2022 PC2 report referred to case studies of rural, remote and regional hospitals that are over-reliant on locums to address the increasing staff shortages.[115]

1.124 The Committee is of the view that the over-reliance on locum doctors – as a longer-term response to staff shortages – should be addressed with urgent prioritisation. Locums are a costly, temporary response, and are at odds with the need to achieve sustainable workforce solutions during a period of constrained government expenditure and competing budget priorities within the public health system.

1.125 There is a clear issue of over-supply of locum doctors in RRR health facilities. Stakeholders described an 'ongoing dependence' or 'historical reliance' on locums in RRR areas.[116] The Rural Doctors Network noted the 'burgeoning locum market', while the Royal Australasian College of Medical Administrators submitted that the RRR health workforce is 'increasingly dependent' on locum medical professionals to the extent that the locum workforce model is now entrenched.[117]

[114] See, for example: Mr Beaton, Evidence, 27 November 2023, p 4.

[115] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, p 47.

[116] Submission 33, Gunnedah Community Roundtable, p 2; Submission 48, Australian Salaried Medical Officers' Federation (New South Wales), p 7.

[117] Submission 21, NSW Rural Doctors Network, p 6; Submission 51, Royal Australasian College of Medical Administrators, p 4.

1.126 The PC2 report also noted the Southern NSW LHD's regular reliance on agency nurses.[118]

1.127 In the current inquiry, the New South Wales Nurses and Midwives' Association NSW (NMA) advised that agency nurses are 'engaged to fill massive staffing gaps' despite often being 'unfamiliar with rural and remote facilities'. The NMA added that agency nurses must have senior staff members on-call, 'should they face an unfamiliar or emergent situation.'[119] However, support for agency staff may not always be available during potential emergencies. The Committee is concerned that there may be negative outcomes in RRR emergency departments if agency nurses are used at short notice and without the necessary skills, experience or supervision required to provide suitable emergency care.

1.128 The Committee thus recommends that NSW Health prioritise solutions that reduce the public health system's reliance on locum doctors and other agency staff. For example, there could be value in creating a statewide casual pool to fill short-term vacancies and regulating the rates paid to locums in the internal market.[120] We also note NSW Health's long-term objective to establish a local locum pool, which they submitted will be 'funded and driven by LHDs'.[121] This may also assist in centralising the allocation of locum workers, or facilitating greater regulation of their remuneration.

1.129 We acknowledge that addressing this issue may require cooperation across states and with the Australian Government, however this must be an urgent priority.

1.130 Locums are non-specialist medical practitioners engaged on a temporary basis to provide cover for an absent member of the permanent non-specialist medical staff.[122] While the PC2 report acknowledged locums provide critical coverage for areas experiencing staff shortages, there were also concerns about the high costs, resulting additional work for permanent staff, and 'risk to the continuity of patient care'.[123]

1.131 The Committee heard that challenges relating to locums have persisted. Stakeholders again acknowledged that the role of locums continues to be important to backfill vacant roles and meet short-term workforce needs. However, over-reliance on locums to fill critical roles in the public health system continues to be an area of concern.[124]

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[118] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 94.

[119] Submission 50, New South Wales Nurses and Midwives' Association, p 12.

[120] Associate Professor Thomas, Evidence, 24 November 2024, p 18; Submission 51, p 5.

[121] Submission 11, NSW Health, p 13.

[122] NSW Health, *Employment and Management of Locum Medical Officers by NSW Public Health Organisations*, February 2019, viewed 19 June 2024, p 2.

[123] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 48, 65-66.

[124] Submission 13, Australasian College for Emergency Medicine, p 4; Dr Shamus Shepherd, Australasian College for Emergency Medicine, Transcript of evidence, 24 November 2024, pp 16-17.

1.132 In particular, use of locums entails significant costs for the public health system, and potential variability in care or a lack of continuity for patients.[125] Issues of credentialling locums and the variability of their skill-sets is discussed further in Chapter Two.

1.133 Dr Gabriel Lau, State Councillor, Australian Salaried Medical Officers' Federation NSW (ASMOF), noted the overreliance on locums is largely due to the continued staff shortages.

> I don't think the locum problem is going to go away because there is always going to be a problem of not being able to recruit an adequate number of junior doctors or senior doctors.[126]

1.134 Stakeholders reported that the pay rates for locums are too attractive and thus create retention challenges. For example, Dr Antony Sara, President, ASMOF told the Committee that younger doctors may be more concerned with work-life balance and, as a result, might take time out of their training scheme to do locum work because 'it makes a lot of money'.[127]

1.135 The Royal Australian College of General Practitioners and Royal Australian College of Medical Administrators also submitted that locums are paid at a higher rate than rural and remote local GPs. This impacts job satisfaction in those areas and makes it less attractive for medical practitioners to commit to an ongoing role or build a practice in a rural or regional area.[128]

1.136 The Committee heard the lack of continuity of care also poses a risk. The Australian College for Emergency Medicine reported that over reliance on locums leads to a lack of continuity for patients and Emergency Department teams.[129]

1.137 Concern was also raised about issues created by the variability in locum skill sets, which can lead to a variability in care for patients and difficulties in planning for permanent staff. For example, Dr Rod Martin, College Councillor NSW, Australian College of Rural and Remote Medicine, told the Committee:

> We now get such variation in what our locums can and can't do that no one is certain about who they're going to get come in through the door. That builds uncertainty across all levels of clinical service, whether it's nursing or other doctors. We will often get locums who turn up who simply do not have the skill set that they need for… rural facilities and we end up having to call other people in to try and patch up for that.[130]

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[125] Submission 13, Australasian College for Emergency Medicine, p 4; Submission 17, Australian Lawyers Alliance, p 7; Dr Rod Martin, College Councillor NSW, Australian College of Rural and Remote Medicine, Transcript of evidence, 24 November 2023, p 8.

[126] Dr Gabriel Lau, State Councillor, Australian Salaried Medical Officers' Federation NSW, Transcript of evidence, 27 November 2024, pp 8-9.

[127] Dr Antony Sara, President, Australian Salaried Medical Officers' Federation NSW, Transcript of evidence, 27 November 2024, p 8.

[128] Submission 45, The Royal Australian College of General Practitioners (RACGP) Rural, p 5; Submission 51, Royal Australasian College of Medical Administrators (RACMA), p 4.

[129] Submission 13, p 4.

[130] Dr Rod Martin, College Councillor NSW, Australian College of Rural and Remote Medicine, Transcript of evidence, 24 November 2024, p 8.

1.138 Stakeholders called for support to address the high cost and variable skill sets of locums, and the lack of continuity of care, through measures such as:

- NSW Health reviewing the award agreements for locums and taking subsequent steps towards implementing pay equity for rural GPs[131]
- development of a credentialing framework and a set of competencies to avoid the risks of locums employed in roles beyond their skills and ensure continuity of care for patients (discussed further in Chapter Two)[132]
- creation of a casual statewide pool to 'balance internal competition'.[133]

Improving pay for health workers

Finding 4

Recent actions from the NSW Government, such as the removal of the public sector wage cap and pay increases for NSW paramedics, are positive developments and may contribute to workforce recruitment, retention and employee satisfaction.

Recommendation 7

That NSW Health review award agreements for rural GPs and local GPs, with a view to creating pay equity between the locum and permanent workforces.

Recommendation 8

That NSW Health review remuneration for health professionals more broadly, with a view to matching or bettering the rates of pay offered in other states and territories.

1.139 In its 2022 report, PC2 outlined the broad consensus that the NSW Government 'should do more to engage with rural doctors and provide contracts and packages that recognise the breadth of work they are undertaking across general practice and within hospital settings'.[134] PC2 Recommendation 12 stated:

> That NSW Health review the working conditions, contracts and incentives of GPs working as Visiting Medical Officers in public health facilities in rural, regional and remote New South Wales, to ensure that the GP/VMO model remains viable while broader innovation and reform progresses.[135]

1.140 The Committee is pleased to note that, according to the AMA NSW and RDN, NSW Health has made some progress regarding GP VMO arrangements since the

[131] Submission 45, p 5.

[132] Associate Professor Peter Thomas, Medical Workforce Policy and Advocacy Sub Committee Chair, Royal Australasian College of Medical Administrators, Transcript of evidence, 24 November 2024, pp 17-18; Submission 51, p 9

[133] Associate Professor Thomas, Evidence, 24 November 2024, p 18; Submission 51, p 5.

[134] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, p 54.

[135] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p xvi.

PC2 report.[136] This has included the formation of a working group to 'identify and implement changes to the payment arrangements for GP VMOs'.[137]

1.141 The Rural Doctors Association of NSW note the introduction of new item numbers available to rural GP VMOs working in Rural Doctors Settlement Package hospitals. Three new items were added in February 2023, which allow VMOs to be paid by Local Health Districts for additional services, such as preparing discharge summaries.[138]

1.142 The Committee also notes that the public sector wages cap was removed in the 2023-24 Budget.[139] There has also been a new agreement made between the NSW Government and the Health Service Union to award almost 5,000 paramedics 'an average wage increase of 25 per cent over four years – with increases ranging from 11 to 29 per cent'.[140]

1.143 Both of these recent actions from the NSW Government are likely to have positive impacts for essential health workers, and may contribute to workforce recruitment and retention, and employee satisfaction.

1.144 However, the Committee heard there is still a need to review award agreements and renumeration for health professionals, in order to match or better the rates of pay offered in other states and territory. Without these changes, NSW risks losing health professionals, particularly those in RRR areas, to other states.

1.145 As discussed in relation to Recommendation 5, stakeholders identified issues of unequal pay, notably between locum GP and local GPs, which is impacting job satisfaction and the ability to retain permanent GPs in rural and remote areas.[141] The AMA also reported that some doctors will choose to 'work exclusively in private practices because the difficulties and stress of working within the public hospital system is not balanced' by the current compensation available to them.[142]

1.146 The Committee heard staff are being lost due to competition from other states. Mr Whaites (NMA) told the Committee:

> I was speaking to a third-year undergraduate nurse at an awards ceremony, living and working in Port Macquarie. They had come to New South Wales from another state to do the nursing course here, very excited to be working in regional emergency care. When I said, "That's fantastic. Where are you going to work? We desperately need you," she said, "Queensland. The pay is better." Devastating. So we know that the

[136] Submission 47, Australian Medical Association NSW, p 5; Submission 49, Rural Doctors Association of NSW, p 2.

[137] Submission 47, p 5; Submission 11, NSW Health, p 12.

[138] Submission 49, p 2; Submission 11, NSW Health, p 12.

[139] Minister for Industrial Relations, Minister for Work Health and Safety, *End of former government's wages cap delivers for essential public sector workers*, media release, 19 September 2023, NSW Government, viewed 20 April 2024.

[140] NSW Health, Record pay increase for paramedics, 13 December 2023, viewed 7 March 2024.

[141] Submission 45, The Royal Australian College of General Practitioners (RACGP) Rural, p 5; Submission 51, p 4.

[142] Answers to questions on notice, Australian Medical Association NSW, 20 December 2023, p 1

> incentives can work. It is the inequitable application and the way each LHD interprets how it's applied.[143]

1.147 National Rural Health Alliance (NRHA) reported that there are differences in employment conditions in state-government funded hospitals and in the primary care system, influencing where healthcare professionals choose to work. NRHA argued that equitable pay rates and conditions across healthcare systems would help healthcare organisations attract and retain new staff especially in rural communities where resources are scarce.[144]

1.148 Review of renumeration for specific professions was also raised by stakeholders, including specifically to support trainee doctors and Aboriginal health workers and increasing Indigenous representation within the health workforce.[145]

1.149 The Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists, reported that a review of the pay and career progression opportunities offered to Aboriginal and Torres Strait Islander health workers and practitioners is 'vital to improving recruitment and retention'.[146] This is particularly key in remote and rural areas where there are significant Aboriginal populations that would benefit from receiving care from Aboriginal staff.

1.150 The Committee recommends that NSW Health review award agreements for rural GPs and local GPs, with a view to creating pay equity between the locum and permanent workforces. A focus on the highly paid locum roles is crucial to address the challenges of retaining permanent rural GP roles in the public healthcare system.

1.151 The Committee welcomes the pay increase announced for paramedics to recognise their crucial work.[147] The Committee further recommends that NSW Health review remuneration for health professionals more broadly, with a view to matching or bettering the rates of pay offered in other states and territories. A similar pay review and increase will support reduction of staff attrition, as stakeholders currently report staff seeking employment in other states with better pay conditions.

[143] Mr Michael Whaites, Assistant General Secretary, New South Wales Nurses and Midwives' Association, Transcript of evidence, 27 November 2024, p 5.

[144] Submission 42, National Rural Health Alliance, p 10; Answers to supplementary questions, National Rural Health Alliance, p 10.

[145] Submission 7, Faculty of Pain Medicine (FPM), Australian and New Zealand College of Anaesthetists (ANZCA), p 1

[146] Submission 7, p 1.

[147] NSW Health, Record pay increase for paramedics, 13 December 2023, viewed 7 March 2024.

Chapter Two – Training, credentialling, and career pathways

2.1 The Committee examined the implementation of Portfolio Committee No. 2 (PC2) recommendations that relate to other workforce issues, such as training, credentialling, and study and training pathways towards careers in the regional health system. The successful implementation of these recommendations is likely to have a significant impact on addressing staffing shortfalls across the regional health system.

2.2 This chapter explores implementing a credentialling framework for locum doctors and progress on an accreditation system for Visiting Medical Officers (VMOs). It also examines recommendations relating to training and career pathways for regional health workers, and the rollout of the Single Employer Model for GP trainees.

The need for a locum credentialing framework

Recommendation 9

That NSW Health develop a credentialling framework for locum doctors, to reduce the uncertainty for hospital services caused by the varying skills and specialties of locum doctors.

2.3 Throughout the inquiry, the Committee heard that locums are valuable in filling a short-term need for hospital staff, covering roles for staff on leave and providing support to isolated doctors.[148]

2.4 However, we were told that there is inconsistency in the skillsets of locum doctors and that the credentialing process for Visiting Medical Officers (VMOs) continues to require reform. The Committee recommends that NSW Health implements a credentialing framework for locums and a statewide VMO credentialing and registration process. This will help to reduce the risk of hospitals engaging locums without the appropriate skillset.

2.5 Similar issues were raised in the PC2 report, which discussed the impact of locums on patient care and potential for worse health outcomes to be realised through over-use of locums.[149] Locums were not explicitly mentioned in the PC2 recommendations, but an over-reliance on them is a symptom of workforce shortages and the difficulties of attracting and retaining more permanent staff to work in health facilities in remote, rural and regional (RRR) areas.

[148] Associate Professor Peter Thomas, Medical Workforce Policy and Advocacy Sub Committee Chair, Royal Australasian College of Medical Administrators, Transcript of evidence, 24 November 2023, p 18; Submission 51, Royal Australasian College of Medical Administrators (RACMA), p 4; Dr Shamus Shepherd, Australasian College for Emergency Medicine, Transcript of evidence, 24 November 2023, p 16; Dr Gabriel Lau, State Councillor, Australian Salaried Medical Officers' Federation NSW, Transcript of evidence, 27 November 2023, p 9.

[149] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of New South Wales, May 2022, pp 47 – 48.

2.6 As discussed in Chapter One, locums present a recruitment and retention challenge and we have recommended that NSW Health find solutions to reduce the regional health system's reliance on them. Locums are a costly, short-term solution to staff shortages and an over-reliance on them can lead to uncertainty in clinical environments and limit continuity of care for patients.[150] There are a number of factors to consider in addressing this issue including remuneration and pay equity, which were discussed in Chapter One.

2.7 Training and accreditation can also address the challenges posed by an over-reliance on locums. Several stakeholders noted the variable skills and specialities of locums, and also observed an increase in junior doctors filling locum positions.[151] The Committee heard that the variability in locum skillsets could be described as a 'lucky dip' and can lead to uncertainty in clinical practice and impact continuity of care for patients.[152]

2.8 Associate Professor Peter Thomas, Royal Australasian College of Medical Administrators (RACMA), stated that there is a need to consider if locums are 'safe', 'capable' and if they have a credentialing framework. To manage inconsistencies in skills he called for a locum credentialing framework to be implemented and potentially developing a core set of competencies for locums.[153]

2.9 RACMA submitted that a credentialling framework would reduce any potential risk of locums working outside of their capability and enable work to be completed within Scope of Clinical Practice.[154]

2.10 The Committee similarly recommends that NSW Health develop and implement a credentialing framework for locum doctors. The Committee is of the view that a credentialling framework will limit the likelihood of locums not having the appropriate skills for providing health care, when use of locums in unavoidable.

2.11 This framework should aim to create consistency across locum skillsets and minimise the risks presented by the use of inadequately credentialled locums in RRR health facilities.

The challenging accreditation process for Visiting Medical Officers (VMOs)

Recommendation 10

That NSW Health take urgent steps to streamline the registration and credentialling process for Visiting Medical Officers, particularly with a view to

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[150] Submission 13, Australian College for Emergency Medicine, p 4; Submission 17, Australian Lawyers Alliance, p 7; Submission 45, The Royal Australian College of General Practitioners (RACGP) Rural, p 5; Submission 51, p 4; Dr Rod Martin, College Councillor NSW, Australian College of Rural and Remote Medicine, Transcript of evidence, 24 November 2024, p 8.

[151] Dr Martin, Evidence, 24 November 2023, p 8; Dr Shepherd, Evidence, 24 November 2023, p 17; Associate Professor Thomas, Evidence, 24 November 2023, pp 17-18.

[152] Dr Shepherd, Evidence, 24 November 2023, p 17; Dr Martin, Evidence, 24 November 2023, p 8; Submission 13, p 4.

[153] Associate Professor Thomas, Evidence, 24 November 2023, p 18.

[154] Submission 51, p 5.

introducing a statewide system for Visiting Medical Officers that can be used in all Local Health Districts and general practice.

2.12 As discussed in Chapter One, a VMO is a doctor that has specialist skills, and is contracted by an LHD to work at a public hospital. VMOs also have private practices and can providing healthcare in communities as GPs and through hospital-based services.[155]

2.13 The Committee notes the efforts made by NSW Health to improve the VMO registration and accreditation process across Local Health Districts (LHDs).[156] However, we heard that there are still shortcomings in the credentialling process for VMOs.

2.14 Reiterating PC2 Recommendation 13 (discussed below), the Committee recommends that NSW Health take urgent steps to streamline the registration and credentialling process for VMOs, particularly with a view to introducing a statewide system for VMOs. This will make it easier for VMOs to work across LHDs and help to address staffing shortages.

2.15 The PC2 report highlighted the difficulties for a GP to register to work in a hospital as a VMO, and noted that the GP/VMO approval process was inconsistent across LHDs. Recommendation 13 was that:

> NSW Health establish a state-wide system of GP/VMO accreditation, which is independent of the Local Health Districts. As part of this system, NSW Health should ideally look to establish an online GP/VMO availability system where GP/VMOs can nominate dates and locations they are available to work that can be accessed by the rural and regional Local Health Districts and general practices in filling vacancies.[157]

2.16 Currently, the Medical and Dental Appointments Advisory Committee at each LHD is responsible for conducting an assessment of clinical privileges for practitioners. This assessment determines what sort of work a practitioner can perform at a hospital or health clinic in that LHD. Following this process, 'a GP's scope of practice may vary between LHDs and within facilities of LHDs based on differences in hospital role delineation.'[158]

2.17 In the *Independent Review – Rural Health Inquiry* ('the EY Report'), NSW Health's Workforce Planning and Talent Development branch reported that policy change would be needed to lift the responsibility of credentialing VMOs from individual LHDs in order to develop a consistent process.[159]

2.18 The Committee heard that some progress has been made in improving the credentialling and registration process. NSW Health has implemented an online

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[155] NSW Ministry of Health, Training and working as a doctor in the NSW public health system, viewed 8 April 2024; Rural Doctors Network, Common questions, 2024, viewed 20 July 2024.

[156] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, p 9; Submission 11, NSW Health, p 15.

[157] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of New South Wales, May 2022, p 76.

[158] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, p 9.

[159] Independent Review Rural Health Inquiry (Ernst & Young), provided by NSW Health to the Committee, 16 August 2023, p 39.

system called eCredential across most LHDs to streamline credentialing and share information between its health facilities. The platform captures clinical privileging and credentials for senior medical and dental officers, and allows clinicians to make a profile that includes information about their qualifications, employee history and training.[160]

2.19 NSW Health confirmed the following onboarding initiatives are also underway, to simplify the registration and accreditation processes:

- development of the State Scope of Clinical Practice Unit to establish model scopes of clinical practice for every medical speciality, to create consistency in determining the type of work a practitioner is authorised to do at a health facility, and also permit decision-making at the local level
- introduction of a vendor management system (VMS) to streamline recruitment processes and store credentialling records for locums, which has been rolled out to five LHDs.[161]

2.20 The Committee notes that, in 2024, NSW Health plans to review GP/VMO credentialling and onboarding systems across LHDs. The review will look at and assess eCredential and the VMS. NSW Health explained that:

> This will also include reviewing the mandatory training requirements of GP VMOs to determine if there is unnecessary duplication. The aim is to determine if further efficiencies can be introduced into the process to streamline the onboarding process further for GP VMOs, while ensuring proper due diligence is maintained for credentialling and delineation of clinical privileges.[162]

2.21 However, the Royal Australian College of General Practitioners (RACGP Rural) submitted that a state-wide GP/VMO credentialling process has not yet been established. RACGP also advocated for additional changes to simplify the process.[163]

2.22 The current credentialling process was described as 'time consuming', 'difficult' and 'costly'.[164] Credentialling challenges have also been experienced by foreign doctors seeking to work in rural areas.[165] The Committee was also told that the clinical credentialing and onboarding processes involves unnecessary duplication with doctors sharing identical information several times.[166]

2.23 Australian Medical Association NSW (AMA NSW) also raised concerns about the growing number of qualification requirements for skilled doctors to practice in remote, rural and regional health services. They told the Committee that, as a

[160] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, p 9; Submission 11, NSW Health, p 15.
[161] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, p 9.
[162] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, p 9.
[163] Submission 45, Royal Australian College of General Practitioners (Rural), p 7.
[164] Submission 45, p 7; Submission 9, Can Assist (Cancer Assistance Network), p 6.
[165] Submission 9, pp 6-7.
[166] Answers to supplementary questions, Australian College of Rural and Remote Medicine (ACRRM), p 6.

result of these requirements, some doctors feel compelled to relocate to metropolitan areas to access training to gain the required qualifications.[167]

2.24 The Committee acknowledges that NSW Health is continuing to work in this area. However, we note that a consistent, singular platform that can be used in all LHDs and in general practice has not yet been implemented.

2.25 Further work still needs to be done to make the registration and accreditation processes for VMOs more practical. The Committee recommends that a streamlined, statewide system for VMO credentialling be implemented without further delay.

Training and career pathways

Finding 5

That there has been limited progress in increasing the number and integration of rural GP and specialist training positions.

Recommendation 11

That NSW Health facilitate greater collaboration between public health facilities, medical colleges, regional universities and local primary care services, to support and encourage studying, training and working in the regional health system.

2.26 The challenges of reducing workforce shortages in the regional health system are long-term. The Committee found that there has not been adequate progress in successfully increasing the number of rural GP and specialist training positions, nor in integrating these trainees into the regional health system.

2.27 It is critical that adequate structures and processes are in place to ensure a steady progression of trainees and students transitioning into careers in RRR health and medicine. In order to achieve this, the Committee recommends that NSW Health work with medical colleges, regional universities and local primary care services, to better support existing students and trainees. Furthermore, this collaborative work should also aim to encourage more students and trainees to stay in the regional health system at the completion of their training and education.

Improving study to work pathways for medical graduates in regional communities

2.28 The PC2 report made recommendations in relation to work-study pathways for medical students entering the rural and regional health workforce. Recommendation 14 was that:

> NSW Health work with the Australian Government, the Primary Health Networks, the university sector and the specialist medical colleges to increase rural GP and specialist training positions, integrating these within the new employment and

[167] Submission 47, AMA NSW, p 6

> service delivery models recommended in Recommendations 9 and 10 [the single employer model and Rural Area Community Controlled Health Organisation pilot].[168]

2.29 Training for rural GPs and specialists is an area of particular concern. The AMA NSW reported a continuing decrease in the number of Australian medical graduates who enter general practice, despite the significant increase in the number of medical graduates overall.[169]

2.30 Stakeholders also noted that the Rural Generalist Training Program (RGTP) could be modified. The Australian College of Rural and Remote Medicine (ACRRM) acknowledged that although the RGPT has expanded in size and scale, it suffers from 'significant administrative impediments related to supervision, employment and clinical credentialling decisions.' ACRRM submitted that the RGTP 'requires state-wide cross-system support' and more centralised coordination.[170]

2.31 Dr Rod Martin, College Councillor NSW, ACRRM, told the Committee that new generations of rural generalists are looking for work-life balance and recognition. He observed that while today's rural generalists are motivated by the challenge and diversity of rural practice, like their predecessors, their stronger interest in work-life balance may require rethinking employment models and conditions.

> They will not sacrifice time, nor income, nor conditions as part of their choice to work in rural New South Wales… This could also mean a move away from the current employment models of previous generations, and a move towards some of the employment models that future RGs [rural generalists] will be looking towards.[171]

2.32 The Committee received evidence from multiple stakeholders who called for strengthening the rural study-to-career pipeline for GPs and doctors more broadly. This includes the need to increase trainees' exposure to general practice and career prospects in rural areas earlier in their studies and career.[172]

2.33 Provision of clinical placements in regional areas is essential to growing the rural and regional workforce. However, capacity to do so is scarce and places remain limited, as both rural and metropolitan students compete for regional placements. Charles Sturt University (CSU) reported that demand for placements remains a challenge for students securing clinical training placements in their preferred region. They reported that metropolitan universities seek rural

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[168] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of New South Wales, May 2022, p xvi-xvii.

[169] Dr Michael Bonning, President, Australian Medical Association (NSW), Evidence, 24 November, p 7.

[170] Submission 26, Australian College of Rural and Remote Medicine, p 2.

[171] Dr Rod Martin, College Councillor NSW, Australian College of Rural and Remote Medicine, Transcript of evidence, 24 November 2023, p 6.

[172] Dr Karin Jodlowski-Tan, National Clinical Head of Rural Pathways, Royal Australian College of General Practitioners (RACGP) Rural, Transcript of evidence, 24 November 2023, p 13; Dr Vicki Mattiazzo, Deputy Chair and NSW & ACT Representative, Royal Australian College of General Practitioners (RACGP) Rural, Transcript of evidence, 24 November 2023, p 13; Dr Christine Ahern, Academic Co-ordinator (General Practice and Community), University Centre for Rural Health, Northern Rivers, Transcript of evidence, 27 November 2023, p 24; Dr Michael Bonning, President, Australian Medical Association (NSW), Evidence, 24 November 2023, p 7; Dr Cheryl McIntyre, Inverell Health Forum, 24 November 2023, p 33

placement experiences for their students and 'may be able to offer greater incentives for regional hospitals and clinics to take on their students'.[173]

2.34 As discussed in Chapter One, there remains an overall shortage of GPs in RRR areas.[174] This can lead to a scarcity of trainers that are available to supervise junior doctors.[175] CSU also note that 'the shortage of staff (particularly specialists) in regional areas is having an impact on training the future workforce.'[176]

2.35 For regional students, local placement is a key part of their pathway to becoming rural practitioners. However, the ability to access these placements is limited. CSU called for improved system-wide oversight and coordination of regional placements. They submitted that this would ensure a steady supply of health professional graduates who are committed to working in regional areas.[177]

2.36 CSU also argued that coordination of placements also needs to better incorporate private hospitals and health care providers in regional areas, as there is an 'over-reliance' on the public sector. CSU provided their partnership with Marathon Health as an example of working with a private institution to create placements for their students. [178]

2.37 The Committee is pleased to note that the Western NSW LHD is working with CSU, Western Sydney University and the University of Sydney to assign students to clinical placements.[179]

2.38 Non-government stakeholders have also told the Committee about actions to strengthen study-to-career pathways. Inverell Health Forum and RACGP (Rural) both reported efforts to provide opportunities for junior doctors to gain exposure via rural placements and rotations into general practice.[180] However, their attempts can be limited by staff shortages and access to trainers.[181] Dr Cheryl McIntyre, Member, Inverell Health Forum also noted that it can be difficult for rural general practices to access junior doctors early in their careers, before 'they've already set roots somewhere else'.[182]

2.39 RACGP (Rural) have been working with NSW Rural Generalist coordination units and the NSW Health Education and Training Institute to enhance the effectiveness of rural placement programs.[183] They also noted that NSW Health has recently 'reopened the conversation' on a proposed Memorandum of

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[173] Submission 43, Charles Sturt University, p 4.

[174] Dr Jodlowski-Tan, Evidence, 24 November 2023, p 13; Submission 47, Australian Medical Association (NSW) p 4; Submission 9, Can Assist (Cancer Assistance Network), pp 4-5.

[175] Submission 49, p 2; Dr Jodlowski-Tan, Evidence, 24 November 2023, p 13.

[176] Submission 43, p 7.

[177] Submission 43, pp 4-5.

[178] Submission 43, p 5.

[179] Independent Review Rural Health Inquiry (Ernst & Young), provided by NSW Health to the Committee, 16 August 2023, p 85.

[180] Dr Jodlowski-Tan, Evidence, 24 November 2023, p 13; Dr Cheryl McIntyre, Inverell Health Forum, Transcript of evidence, 24 November 2023, p 33.

[181] Dr Jodlowski-Tan, Evidence, 24 November 2023, p 13.

[182] Dr McIntyre, Transcript of evidence, 24 November 2023, p 33.

[183] Dr Jodlowski-Tan, Evidence, 24 November, p 13.

Understanding with the RACGP to collaboratively support rural GP and rural generalist training.[184]

2.40 The Committee acknowledges that some collaborative work is progressing in this area, and commends those LHDs which have built relationships with the tertiary education sector.

2.41 However, it is critical that strategies to build the regional health workforce are grounded in an awareness of wider challenges presented by the study-to-work pipeline. Ensuring that long-term workforce supply meets the future demands of the regional health system will be essential to delivering adequate health outcomes for RRR communities. At present, it appears that issues with study and placement for regional doctors are likely to exacerbate staff shortages if not addressed.

2.42 The Committee recommends that NSW Health facilitate greater collaboration between public health facilities, medical colleges, regional universities and local primary care services. To help build the rural workforce, this collaborative endeavour should aim, primarily, to support rural placements for medical and health students. The Committee is of the view that universities with a significant track record of graduates practicing in rural locations should receive priority for placement positions in rural areas.

Incentives for regional students to work in the regional health system

Recommendation 12

That NSW Health work with local councils and health services to develop incentives specifically targeted at retaining health and medical students in the regional health system after they have completed their study and training.

2.43 In addition to the incentives and supports discussed in Chapter One, further measures should be introduced to help prevent health and medical students from either returning or relocating to metropolitan areas once they have completed their study and training. The Committee recommends that NSW Health work collaboratively with local councils and health services to develop additional incentives that could contribute to the retention of early career doctors and nurses in the regional health system.

2.44 To strengthen study-to-career pathways in RRR areas, additional efforts should be made to encourage regionally-based students to pursue their careers in regional areas. Dr Vicki Mattiazzo, Deputy Chair and NSW & ACT Representative, Royal Australian College of General Practitioners (RACGP) Rural, told the Committee that 'people who have lived rurally are more likely to work rurally'.[185]

2.45 NSW Health should work with local health services to ensure that the prospect of a career in the regional health system is appealing to junior doctors. This includes

[184] Submission 45, Royal Australian College of General Practitioners (RACGP) Rural, p 7.

[185] Dr Mattiazzo, Evidence, 24 November 2023, p 13.

identifying financial incentives and support that could be provided to health professionals to encourage them to take up rural roles.

2.46 The National Rural Health Alliance suggested that financial and other incentives, such as relocation allowances, housing and support to pursue further qualifications, could contribute to attracting and retaining rural health professionals.[186]

2.47 Local councils also play a key role in the provision of healthcare. They often provide housing and transport for GPs and other healthcare staff, as well as infrastructure like council-owned practices which can impact the recruitment and retention of staff.[187] The role of local government in healthcare is discussed further in Chapter 4. However, the potential role that local councils could play in supporting health and medical students in RRR areas and encouraging them to remain in those areas is worth highlighting here.

Nurses' education and training

Finding 6

That shortages in the nursing workforce are impacting the amount of training delivered by Certified Nurse Educators.

2.48 In terms of the nursing workforce, the Committee found staff shortages are still limiting the amount of training that can be delivered by Clinical Nurse Educators (CNEs). This impacts on nurses' ability to access and attend training.

2.49 The PC2 inquiry explored the difficulties experienced by rural nurses when trying to access professional training due to staff shortages. The PC2 report noted the need to improve opportunities for nurses to gain skills and experience within rural health settings, rather than require them to travel to cities to access professional development.[188] PC2 Recommendation 20 was that:

> NSW Health, as part of its review of the nursing and midwifery workforce:
>
> - develop stronger partnerships with the university sector to more proactively engage local people and support them through rurally and regionally based education, training and professional development to become qualified nurses and midwives
> - develop partnerships between rural, regional and metropolitan Local Health Districts to devise programs for nurses and midwives who are either early career, specialised or are experienced to practice in rural and remote locations

[186] Answers to supplementary questions, National Rural Health Alliance, 20 December 2023, p 10.

[187] Submission 37, Local Government NSW, pp 9-12; Councillor Darriea Turley AM, President, Local Government NSW, Transcript of Evidence, 24 November 2023, p 27; Councillor Wendy Wilks, Convenor, Inverell Health Forum, Transcript of Evidence, 24 November 2023, p 31; Submission 10, City of Wagga Wagga, p 2; Submission 8, Coolamon Shire Council, pp 1-2.

[188] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, pp 94-95.

- implement professional, financial and career enhancement incentives for nurses and midwives who work in rural and remote locations.[189]

2.50 PC2 Recommendation 19 called on rural and regional LHDs to 'increase and formalise professional development opportunities for nursing and midwives ensuring that rostering accounts' for these opportunities. Nurse practitioners can also train and/or mentor students and nurses. Recommendation 17 of the PC2 report focused on NSW Health's wider implementation of the nurse practitioner model of care.[190]

2.51 NSW Health reports that Clinical Nurse and Clinical Midwife Educator positions in NSW Health have increased by 25.7% since 2021.[191] The Committee views this as a positive development.

2.52 However, the New South Wales Nurses and Midwives' Association (NMA) advised that shortages in nursing staff is still a barrier to ensuring the availability of CNEs to deliver training, and nurses' availability to access training.[192] NSW Health acknowledged that CNEs are still called upon to provide direct patient care when the labour supply fails.[193]

2.53 Mr Paul Haines, Clinical Nurse Specialist, NSW NMA, told the Committee that CNEs are unable to deliver training due to staff shortages:

> We're supposed to be spending our time working with the junior staff, educating and upskilling these members of staff. Unfortunately, because we're just filling in gaps all the time because of lack of staffing, the education really gets put on the backburner.[194]

2.54 Where rural and regional nurses do have time for education, they are still experiencing difficulties accessing training in RRR locations. Mr Scott Beaton, Vice President, Australian Paramedics Association (NSW) reported that nurses often need to travel to a metropolitan site, such as Sydney, that has the ability to provide that education.[195]

2.55 The NMA reported that dedicated mandatory education days for nurses have ceased.[196] In addition to labour supply shortfalls limiting CNEs' ability to deliver

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[189] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p xviii.

[190] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p xvii-xviii; Nursing and Midwifery Board, 'Statement 4.2', *Nurse practitioner standards for practice*, 23 March 2021, viewed 9 April 2024.

[191] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, p 4.

[192] Answers to supplementary questions, New South Wales Nurses and Midwives' Association, 20 December 2023, p 1.

[193] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, p 4.

[194] Mr Paul Haines, Clinical Nurse Specialist, New South Wales Nurses and Midwives' Association, Transcript of evidence, 27 November 2023, p 7.

[195] Mr Scott Beaton, Vice President, Australian Paramedics Association (NSW), Transcript of evidence, 27 November 2023, p 7.

[196] Submission 50, New South Wales Nurses and Midwives' Association, p 5.

training, this is likely to make it more difficult for nurses to access training when it is available.

2.56 The Committee is of the view that improving shortages in the nursing workforce will subsequently improve access to training delivered by CNEs. Reduced access to training lessens the appeal of nursing positions and hinders recruitment. To address this, training support should be prioritised. Recommendation 10 of this report calls for improved collaboration between NSW Health and the tertiary education sector, college and health facilities. This should also improve training and education for nurses and midwives, and include access to on-site training, or at least training that is delivered in RRR areas.

Rollout of the Single Employer Model

Finding 7

That NSW Health has made progress in the rollout of the Single Employer Model into additional Local Health Districts.

Recommendation 13

That NSW Health prioritise the further expansion of the Single Employer Model, with consideration given to further sites for rollout and additional places provided for training rural generalists.

2.57 The PC2 report recognised the urgent need for reform of general practitioner workforce models, and made a recommendation:

> That NSW Health work with the Australian Government and the Primary Health Networks to expedite the implementation of a single employer model for GP trainees across rural, regional and remote New South Wales (Recommendation 9).[197]

2.58 The Committee heard that NSW Health has progressed the rollout of the Single Employer Model (SEM), which has been well received by stakeholders.[198] Under the SEM, registrars have a single employer for the duration of their fellowship training (often a Local Health District). These early career doctors are able to rotate across hospital training positions and general practices, thus providing a 'coordinated pathway to make it easier and more attractive for junior doctors to train as rural generalists.'[199]

2.59 In 2021, the Murrumbidgee LHD developed an integrated General Practitioner (GP) pathway in partnership with UNSW Sydney – the Murrumbidgee Rural

[197] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, p xvi, 73.

[198] Independent Review Rural Health Inquiry (Ernst & Young), provided by NSW Health to the Committee, 16 August 2023, p 85; Submission 11, NSW Health, p 10; Submission 21, NSW Rural Doctors Network, p 2; Submission 45, The Royal Australian College of General Practitioners Rural, p 5; Submission 48, Australian Salaried Medical Officers' Federation (New South Wales), p 6; Dr Vicki Mattiazzo, Deputy Chair and NSW & ACT Representative, Royal Australian College of General Practitioners, Transcript of evidence, 24 November 2023, p 15.

[199] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 73; Submission 11, p 10; Submission 26, Australian College of Rural and Remote Medicine (ACRRM), p 3.

Generalist Training Program.[200] PC2 noted the success of this SEM, and highlighted benefits such as its ability to provide flexibility and certainty for junior doctors about location, income and working conditions as they work across a number of healthcare settings.[201]

2.60 We recommend that further expansion is prioritised, with consideration given to adding further sites for rollout and including additional rural general practice training placements. Given the importance of the SEM, the Committee considers that there would be value in increasing the number of areas in which it operates.

2.61 The Committee heard that the SEM rollout has achieved some progress.[202] Stakeholders support the model as a way to develop a viable rural training pathway and attract and retain doctors in rural generalist and GP roles.[203] Maintaining sufficient numbers of senior staff with the capacity to supervise is an important consideration for the SEM's success, and training pathways more broadly.[204]

2.62 Early work for the wider implementation of the SEM has commenced, with the Far West LHD identified as a host site for a SEM trial. Hunter New England LHD has also been approved for the SEM, with potential training sites identified.[205] The Committee is also pleased to note that applications have opened for the 2025 intake to the NSW Rural Generalist Single Employer Pathway, which will bring more trainee doctors into regional NSW to train in RRR general practice and hospitals. [206]

2.63 Stakeholders believe the SEM will continue to create more opportunities for junior doctors. For it to succeed, however, there needs to be consistency in the implementation of the SEM across the LHDs. The Australian College of Remote and Rural Medicine (ACRRM) told the Committee that, in order to be a success, the SEM needs to be managed and implemented consistently across the state.

> It would be inappropriate for each of the LHDs to have their own SEM rules…each of which will have subtle variation in its execution. It'll just provide more uncertainty for junior doctors and they'll vote with their feet.[207]

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[200] University of NSW, *UNSW program to reduce rural doctor shortage recognised with Premier's Award*, November 2023, viewed 4 July 2024

[201] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 53, 73.

[202] Independent Review Rural Health Inquiry (Ernst & Young), 16 August 2023, p 85; Submission 11, NSW Health, p 10.

[203] Submission 45, p 6; Submission 48, p 6.

[204] Submission 48, p 4; Councillor Wendy Wilks, Member, Inverell Health Forum, Transcript of evidence, 24 November 2023, p 25.

[205] Independent Review Rural Health Inquiry (Ernst & Young), 16 August 2023, p 85; Submission 11, p 10; Submission 45, p 5.

[206] Minister for Health, Minister for Regional Health, Minister for Illawarra and the South Coast, *Innovative single employer pathway set to bring more doctors to regional NSW in 2025*, media release, 16 July 2024, viewed 18 July 2024.

[207] Dr Rod Martin, College Councillor NSW, Australian College of Rural and Remote Medicine, Transcript of evidence, 24 November 2023, p 6.

2.64 As discussed above, junior doctors in rural and regional health systems need supervision from experienced rural GPs. The Rural Doctors Association of NSW expressed concerns about the number of supervisors available to provide adequate supervision to junior doctors involved in the SEM, as well as the administrative work created for the supervisor and practice to be credentialled.[208]

2.65 The Australian Salaried Medical Officers' Federation NSW acknowledged the work done to deliver the SEM and argued that it 'must become the norm for employment arrangements for trainees'. However, they noted that administrative constraints need to be addressed and sufficient training positions made available in order for the SEM to 'meet the clinical needs of RRR communities.'[209]

2.66 NSW Health also need to consider other factors that may contribute to the successful implementation of the SEM. This includes engaging with Aboriginal Community Controlled Health Organisation, and ensuring that the SEM is sufficiently flexible for the diverse contexts in which rural generalist training takes place.[210]

2.67 The overall success of the implementation of the SEM also relies on the existing VMO model, to ensure that there are adequate GP supervisors in rural areas in order to train rural generalists. The employment conditions and incentives for VMOs are important, if an adequate supply of VMOs is to be achieved while programs like the SEM are rolled-out.

2.68 The Committee recommends that NSW Health continue to progress the rollout of the SEM, expanding it to further sites with consideration given to increasing placements for rural generalist students.

[208] Submission 49, Rural Doctors Association of NSW, p 2.

[209] Submission 48, pp 4, 6.

[210] Submission 21, p 5; Submission 26, Australian College of Rural and Remote Medicine, p 4.

Chapter Three – Addressing issues in workplace culture

3.1 The Committee examined the implementation of Portfolio Committee No. 2 (PC2) recommendations that relate to workplace culture within the regional public health system. Some positive developments were reported, such as the government's commitment to implement safe nurse-to-patient staffing ratios, reforms that may improve cultural safety for Aboriginal staff, and the development of a staff complaint and grievance portal.[211]

3.2 However, stakeholders reported that numerous issues remain, particularly in relation to staff wellbeing, poor mental health, and inadequate complaints-handling mechanisms. This is impacting staff across remote, rural and regional healthcare systems.[212]

3.3 This chapter explores workplace culture issues that have persisted since the 2022 PC2 report, and comments on progress that has been made to improve staff wellbeing, complaint handling and cultural safety. Recommendations have been made to enhance or expedite existing reforms, such as implementing the refreshed NSW Health culture framework and expediting the establishment of the new Health Administration Unit at the NSW Ombudsman.

Staff wellbeing and career satisfaction

Finding 8

The wellbeing and mental health of staff in the regional health system continues to be impacted by worker shortages, fatigue, and employment issues such as workers' relationships with management. Safety risks and moral injury have persisted in the time since the Portfolio Committee No. 2 report.

Recommendation 14

That the NSW Health Culture Framework be completed and implemented with urgency. This implementation should involve a commitment to training managers in leadership skills, and the development of accountability measures to ensure that NSW Health's workplace culture reforms are delivering tangible benefits for staff.

3.4 The Committee heard that staff in remote, rural and regional (RRR) health facilities continue to be impacted by fatigue, burnout, professional isolation, moral injury, lack of work-life balance, feeling undervalued and severe workplace

[211] Mr Michael Whaites, Assistant General Secretary, New South Wales Nurses and Midwives' Association, Transcript of Evidence, 27 November 2023, pp 3, 7; Answers to questions on notice, NSW Health, 29 January 2024, pp 7-8; Mr Phil Minns, Deputy Secretary, People, Culture and Governance, NSW Health, Transcript of evidence, 27 November 2023, p 51.

[212] Submission 46, Australian Paramedics Association (NSW), p 5; Submission 48, Australian Salaried Medical Officers' Federation (New South Wales), pp 8-9; Submission 50, New South Wales Nurses and Midwives' Association, p 7; Mr Whaites, Evidence, 27 November 2023, pp 2, 8.

culture issues, like bullying.[213] Many of these issues are made worse by pervasive staff shortages across the sector.

3.5 Recommendation 40 of the PC2 report was that NSW Health and the rural and regional Local Health Districts (LHDs):

- commission an independent review of workplace culture, including complaints management mechanisms and processes to align with a culture in which feedback from staff is encouraged, based on values of openness, continuous improvement and respect
- implement complaints management training for staff, particularly those in management positions
- commission the conduct of independent and confidential staff satisfaction surveys to measure progress and cultural improvements over time
- review and enhance whistle blower protections to ensure staff feel comfortable in speaking up, with training material to be developed and implemented across the LHDs to support this change
- develop and fund a plan to eliminate bullying and harassment within the rural and regional LHDs.[214]

3.6 The PC2 report noted that NSW Health was considering ways to enhance the rural health workforce. This included building on initiatives to support the wellbeing of the rural and regional workforce.[215]

3.7 During the current inquiry, NSW Health reported that measures to improve workplace culture and staff wellbeing are underway (discussed further from 3.32).[216] NSW Health administers the NSW People Matter Employee Survey (and additional survey instruments prior to this) and stated that it has measured a 'culture index' since 2011.[217] This culture index is based on 15 items from the People Matter Employee Survey (PMES), such as employee engagement and satisfaction.[218]

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[213] Submission 42, National Rural Health Alliance, p 10; Submission 46, pp 5-6; Submission 47, Australian Medical Association (NSW), p 7; Submission 48, pp 8-9; Submission 50, pp 7, 9; Submission 55, A Better Culture, pp 4-6; Mr Whaites, Evidence, 27 November 2023, pp 2, 5, 9; Dr Michael Bonning, President, Australian Medical Association (NSW), Transcript of evidence, 24 November 2024, p 5; Dr Shamus Shepherd, Australasian College for Emergency Medicine, Transcript of evidence, 24 November 2024, p 17.

[214] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, pp xxi, 180.

[215] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 64.

[216] Submission 11, NSW Health, pp 21-22; Mr Luke Sloane, Deputy Secretary, Regional Health, NSW Health, Transcript of evidence, 27 November 2023, pp 51-52; Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, pp 7-8.

[217] Submission 11, NSW Health, p 21.

[218] Letter and attachments from the Secretary, NSW Health, provided to the Committee 16 August 2023, 'NSW Health advice in response to Select Committee questions', p 2.

3.8 The culture index for NSW Health overall has improved from 46 to 58 per cent from 2011 to 2022.[219] NSW Health have noted that the average culture index score for regional LHDs in 2022 was 55 per cent.[220] The Committee notes that there are regional LHDs which exceed or are comparable to the NSW Health culture index average of 58 per cent: Western NSW LHD (60 per cent) and Murrumbidgee LHD (57 per cent).

3.9 However, it is concerning that the average culture index score for regional LHDs is lower than the overall average. Some LHDs with noticeably lower scores in 2022 include:

- Northern NSW LHD (49 per cent)
- Southern NSW LHD (51 per cent)
- Nepean Blue Mountains (51 per cent).[221]

3.10 The Committee notes particular areas of improvement for NSW Health more recently, in terms of PMES results that relate to workplace culture. The 2023 PMES survey was completed by 81 815 NSW Health respondents, which represents a response rate of 47 per cent.[222] Among the most improved scores reported in the 2023 PMES results:

- 49 per cent of NSW Health respondents agreed that they 'receive adequate recognition' for their contributions (an increase of 5 per cent from 2022)
- 69 per cent agreed that their organisation 'shows a commitment to ethical behaviours' (an increase of 4 per cent from 2022)
- 62 per cent agreed that they get the support they need to do their job well (an increase of 3 per cent from 2022).[223]

3.11 The Committee will continue to monitor NSW Health's PMES scores in future inquiries. The Committee will be interested to observe in greater detail how regional LHDs compare with metropolitan LHDs, in terms of this 'culture index' or more specific PMES items.

3.12 In light of commentary provided by other stakeholders, however, the Committee is concerned that progress in improving workplace culture and staff wellbeing appears to be slow. Therefore, the Committee recommends that NSW Health expedite the completion and implementation of the refreshed NSW Health

[219] Submission 11, NSW Health, p 21; Letter and attachments from the Secretary, NSW Health, 16 August 2023, 'NSW Health advice in response to Select Committee questions', p 2.

[220] Letter and attachments from the Secretary, NSW Health, 16 August 2023, 'NSW Health advice in response to Select Committee questions', p 2.

[221] Letter and attachments from the Secretary, NSW Health, 16 August 2023, 'NSW Health advice in response to Select Committee questions', p 2.

[222] Public Service Commission, People Matter NSW Public Sector Employee Survey 2023: Portfolio Report Health (report ND0100000), NSW Government, viewed 13 June 2024, p 1.

[223] Public Service Commission, People Matter NSW Public Sector Employee Survey 2023: Portfolio Report Health (report ND0100000), NSW Government, viewed 13 June 2024, p 6.

culture framework to address the significant issues impacting the wellbeing and mental health of staff in the regional health system (discussed further from 3.32).

Staff fatigue and burnout

3.13 The New South Wales Nurses and Midwives' Association (NMA) noted that the NSW Government recognises the 'extreme pressure, fatigue and burnout' its members experience.[224] However, NMA members continue to report 'feeling a strong sense of burnout', which one member noted was a factor contributing to low senior staffing numbers in maternity services.[225]

3.14 NMA reported that nurses and midwives are choosing to seek work in other states or in other professions where they believe they have better employment conditions, as they struggle to maintain a healthy work-life balance in NSW.[226]

3.15 Staff shortages have remained a serious issue for the paramedic workforce, with flow-on effects for workplace culture. The Australian Paramedics Association (APA) reported that persistent short staffing is contributing to poor workplace conditions. The attrition rate in remote, rural and regional NSW is due to employment conditions and burnout.[227]

3.16 APA also noted that there is 'limited vicarious trauma specific training, counselling, or other specific support in relation to managing exposure to vicarious trauma'. While they acknowledged that mental health supports for NSW Ambulance workers have improved, they argued that such supports are 'still wholly inadequate considering the nature of the work and daily exposure to traumatic events.'[228]

3.17 Dr Michael Bonning, President, Australian Medical Association (NSW), told the Committee that without proper support, the challenging environment of rural medicine will burn staff out. He explained:

> While we recognise that clinical practice across health care can be a hardship at times—it can be a very taxing and difficult environment—when you do that with support, you grow. When you do that without support, you burn out. That has ostensibly been the experience of junior doctors who have often very diverging experiences of regional practice.[229]

3.18 Staff wellbeing can also be impacted when professional needs are not met. The Australasian College for Emergency Medicine reported that, due to high workloads and under-staffing, emergency department (ED) doctors and senior ED nurses are often required to perform administrative tasks, like bed-making, roster management and retrieving supplies for patients.[230] This limits their ability

[224] Submission 50, p 7.
[225] Submission 50, pp 4, 16.
[226] Submission 50, p 9, Mr Whaites, Evidence, 27 November 2023, p 5.
[227] Submission 46, pp 5-6.
[228] Answer to supplementary question, Australian Paramedics Association NSW, 31 January 2023, p 1.
[229] Dr Bonning, Evidence, 24 November 2023, p 10.
[230] Submission 13, Australian College for Emergency Medicine, pp 5-6.

to practise their specialised skills and is likely to affect their career satisfaction and skill maintenance.

3.19 Inadequate staffing levels will lead to increased burnout and stress which, in turn, will contribute to low career satisfaction and poor workplace culture in RRR health facilities. If unaddressed, these factors are likely to limit the effectiveness of measures introduced to improve recruitment and retention of staff in the regional health system.

Health workers experiences of isolation and moral injury

3.20 Professional and social isolation is a challenge facing remote and rural medical practitioners. Dr Shamus Shepherd, Fellow, Australasian College for Emergency Medicine, told the Committee that 'professional and social isolation is a real problem for doctors and all medical practitioners out there' in RRR communities.[231]

3.21 Social isolation can impact junior doctors, in particular, and this may have broader effects on the rural study-to-work pipeline. A Better Culture submitted that:

> Doctors in training are uprooted and live and work away from their partner, as most couples no longer have a "trailing spouse" who can follow the doctor no matter where the state sends them. Isolation, loneliness, and fatigue imprint such doctors so that [the idea] of returning to a rural or regional post once qualified can be completely unthinkable.[232]

3.22 Telehealth may be able to alleviate this sense of professional isolation. Dr Shepherd added that, while not a 'panacea', telehealth can provide a critical support for doctors and nurses being able to access advice from clinicians when treating patients. This kind of 'scaffolding' may also contribute to successful staff recruitment efforts.[233]

3.23 Conversely, virtual supports may only go so far in addressing the impact of geographic isolation on professional development. Dr Charlotte Hall, Human Factors Consultant and Medical Educator, told the Committee:

> Healthcare workers who elect to work in regional, rural and remote areas are often isolated and have an increased need for professional development and professional support. Digital online training modules do have a place but they are no substitute for human to human interaction.[234]

3.24 In addition, some practitioners are at times unable to provide the care for their patients' needs. In some cases, a doctor may be forced to watch a patient experience avoidable poor outcomes where they cannot deliver the treatment needed, and the designated referral hospital is unable to take that patient. Dr

[231] Dr Shepherd, Evidence, 24 November 2023, p 17.

[232] Submission 55, A Better Culture, p 2.

[233] Dr Shepherd, Evidence, 24 November 2023, p 17.

[234] Submission 56, Dr Charlotte Hall, p 6.

Bonning told the Committee that this can have a negative effect on medical practitioners' wellbeing:

> That is frequently an issue if we recognise that that deterioration and that pushback from major centres also has a moral injury on doctors, who feel like they've tried to do their best, but actually someone continues to deteriorate before their very eyes.[235]

3.25 The Committee heard regional and rural doctors may feel that they are viewed as 'lesser' by their peers. A Better Culture submitted that there is a sense of 'geographic narcissism' in rural health, which can discourage doctors from working in RRR areas.[236] For example, they described the experience of a doctor that relocated from a metropolitan centre to a regional city, and 'watched his reputation drain away, as the repeated assumption was that if he was working a regional job, he must have been unable to "cut it" in the city.'[237] The Committee heard that this perception needed to change, with Dr Karin Jodlowski-Tan, National Clinical Head of Rural Pathways, Royal Australian College of General Practitioners (RACGP) Rural, discussing the need to improve the value of rural generalists and rural GPs.[238]

Bullying and harassment

3.26 Bullying and psychological injuries are increasingly reported by nurses and midwives, some of whom are leaving employment in the health system due to the negative psychological impact of their roles and workplaces.[239] Mr Michael Whaites, Assistant General Secretary, NMA, reported:

> The challenges linked to workplace culture throughout the public health system are compounded by several factors, most notably are: ongoing reports of violence and aggression towards nurses and midwives or, sadly, the growing incidences of bullying and harassment our members are experiencing.[240]

3.27 Bullying and harassment is also experienced by doctors working in RRR health facilities. A survey of the Australian Salaried Medical Officers' Federation's (ASMOF) RRR members reported that bullying and harassment are widespread:

> … 40 per cent of respondents had experienced bullying and/or harassment, 19 per cent had experienced discrimination and/or racism, and a further 42 per cent reported witnessing bullying and harassment.[241]

3.28 ASMOF argue that cultural reform and improving LHD approaches to disciplinary matters could mitigate the 'ongoing exodus of doctors' from remote, rural and regional areas. For example, an ASMOF member reported being subject to:

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[235] Dr Bonning, Evidence, 24 November 2023, p 5.

[236] Submission 55, pp 2-3.

[237] Submission 55, pp 2-3.

[238] Dr Karin Jodlowski-Tan, National Clinical Head of Rural Pathways, Royal Australian College of General Practitioners (RACGP) Rural, Transcript of evidence, 24 November 2023, p 13.

[239] Submission 50, p 9.

[240] Mr Whaites, Evidence, 27 November 2023, p 2.

[241] Submission 48, p 8.

> 'misapplications of workplace complaints policies by hospital administrators, managers and workforce teams who fail to adequately apply or comprehend the basic tenets of procedural fairness and natural justice.[242]

Widespread dissatisfaction with management of investigatory processes was reported. One RRR staff specialist described a complainant's experience with their LHD, where they allege the LHD engaged in 'collective bullying' and 'witch hunt[s]'. ASMOF reported that there is 'significant anecdotal evidence that negligible progress' has been made by NSW Health in embedding workplace culture reforms.[243]

3.29 A Better Culture reported findings from the 2023 Medical Training Survey, for doctors training in Australia. While a large majority of survey respondents in NSW believed that their workplaces did not tolerate bullying, harassment, racism and discrimination, they also reported experiencing or witnessing these negative behaviours in their workplaces. In NSW, an average of:

- 14 per cent of respondents had experienced bullying (compared with 20 per cent who had witnessed bullying)
- 9 per cent had experienced harassment (14 per cent had witnessed harassment)
- 10 per cent had experienced discrimination (13 per cent had witnessed discrimination)
- 7 per cent had experienced racism (13 per cent had witnessed racism).[244]

3.30 A Better Culture also noted that patients and carers can direct these behaviours towards health staff.[245]

3.31 Other survey research indicates that experiences of bullying in NSW Health may be slightly higher than the findings from A Better Culture indicate. In the 2023 People Matter Employee Survey, 16 per cent of NSW Health respondents reported experiencing bullying, while 26 per cent reported witnessing bullying.[246]

Improving workplace culture in the regional health system

3.32 NSW Health told the Committee that a refreshed NSW Health culture framework is currently under development to improve workplace culture. The new Culture and Staff Experience Framework intends to further embed NSW Health's workplace values of Collaboration, Openness, Respect and Empowerment (CORE).[247]

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[242] Submission 48, p 8.

[243] Submission 48, p 9.

[244] Submission 55, p 5.

[245] Submission 55, pp 5-6.

[246] Public Service Commission, People Matter NSW Public Sector Employee Survey 2023: Portfolio Report Health (report ND0100000), NSW Government, viewed 13 June 2024, p 36.

[247] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, p 7; Submission 11, p 21; Mr Phil Minns, Deputy Secretary, People, Culture and Governance, NSW Health, Transcript of evidence, 27

3.33 NSW Health stated that implementation of the Framework will be supported by measures such as metrics to track progress in workplace culture. Resources will also be developed to allow local People and Culture teams to intervene in workplaces, when necessary, with the help of a diagnostic tool and assessment process.[248]

3.34 Other beneficial measures include a refreshed eLearning module, *Respecting the Difference: Know the difference* and an 'online portal' for staff members and people leaders to access and use 'practical tools that will educate and support the culture and staff experience work being undertaken by Health organisations.'[249]

3.35 The Committee acknowledges that some work is underway to improve workplace culture within NSW Health facilities. However, we are concerned that these measures may not be enough to address the fact that there are significant mental health and wellbeing impacts on staff in the regional health system, which have persisted since the 2022 PC2 report.

3.36 In addition to expediting the implementation of the refreshed culture framework, the Committee believes that NSW Health should explore additional measures to improve staff wellbeing. In particular, we would like to highlight the range of suggestions proposed by Dr Charlotte Hall, Human Factors Consultant and Medical Educator. Consideration should be given to workplace culture changes such as:

- improving communication and safety briefing skills within hospitals and other health facilities
- improving strategies to manage workplace fatigue
- providing better support to staff who have been impacted by serious patient events
- making system-level changes that could reduce bullying, such as removing the 'single line manager model' of staff reporting.[250]

3.37 Dr Hall also proposed that both the LHD executive team and their staff receive training in 'non-technical' skills. This could include leadership skills, effective communication, and emotional intelligence as a way of 'changing thinking and thus changing behaviours'.[251]

3.38 The Committee emphasises that, in implementing its refreshed culture framework and related training initiatives, NSW Health needs to incorporate

November 2023, p 50; Ms Deborah Willcox, Acting Secretary, NSW Health, Transcript of evidence, 27 November 2023, p 36; Independent Review Rural Health Inquiry (Ernst & Young), provided by NSW Health to the Committee, 16 August 2023, p 75.

[248] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, pp 7-8.

[249] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, pp 7-8; Independent Review Rural Health Inquiry (Ernst & Young), 16 August 2023, p 75.

[250] Submission 56, Dr Charlotte Hall, pp 7-10.

[251] Submission 56, pp 2, 7.

accountability and monitoring processes that actually measure what impact – if any – these workplace culture reforms are having. Consideration should be given to external evaluation of these reforms, rather than reliance on existing survey instruments like the PMES. We also suggest greater transparency on the completion of comprehensive leadership training, including people management and soft skills training as a part of these accountability measures.

3.39 The Committee has sought additional information on the rates of completion for leadership and management development training offered in regional LHDs. At the time of writing, this documentation had not been provided to us.

3.40 We acknowledge the work that has gone into the revised culture framework, the staff portal and leadership training initiatives. However, these measures need to deliver tangible, meaningful and sustained improvements for staff, with the utmost of urgency. During its site visits, the Committee heard from health workers that NSW Health's CORE values are not always realised in RRR facilities, in a tangible and meaningful way. The Committee is of the view that frameworks, portals and refreshed organisational "values" will only go so far to address what appear to be ingrained and long-standing issues around NSW Health staff's workplace experiences. Rigorous assessment of recent workplace culture initiatives is a critical element to ensuring that greater progress can be realised in the short-term.

3.41 The Committee is also of the view that efforts to improve workplace culture should be pursued in tandem with measures to address staff shortages and working conditions. Staff wellbeing and positive workplace experiences will continue to suffer when the workload resulting from understaffed public health facilities is shifted onto health workers.

Ability of staff to make complaints

3.42 The Committee is concerned about the perception among NSW Health staff that they have limited avenues for making confidential complaints. In particular, we note that a culture of fear of speaking out is prevalent in the regional health system, with staff worried about their career prospects if they speak out on issues affecting the delivery of health services.

3.43 The Committee found that this issue has persisted since the PC2 report was tabled in 2022. We recommend that the NSW Ombudsman expedites the establishment of the new Health Administration Unit, in order to promote the Ombudsman's role to workers in the public health system.

Fear of reprisal amongst staff in the regional public health system

Finding 9

A culture of fear of speaking out has persisted in the regional public health system, with many health workers fearing reprisal for making complaints.

3.44 The PC2 report described the reluctance of staff to report workplace issues due to fear of a punitive response, retaliation, and the fear that making complaints

would put their career at risk. In addition, staff who did raise complaints were commonly met with 'silence and inaction', or 'bullying and intimidation'.[252]

3.45 The Committee found that staff in the regional public health system are still experiencing a culture of fear of speaking out following the 2022 PC2 report. Similarly, health workers still fear reprisal for making complaints about their workplace.

3.46 Stakeholders reported a culture of fear surrounding complaint making in the public health system to the Committee. The New South Wales Nurses and Midwives' Association (NMA) stated that staff who make complaints often experience retribution, in the form of bullying and unfair limitations on career progression.[253]

3.47 The cultural safety and experiences of Aboriginal and Torres Strait Islander healthcare professionals at work is discussed further below (from 3.66).

3.48 NMA described a culture of fear, with 'frequent reports' of their members being targeted for voicing concerns about 'inadequate staffing, safety and patient risk.' NMA members report having their 'career options limited without explanation' or their work 'unfairly scrutinised' when they are advocating for safe patient care, 'as they are obliged to do in line with the code of conduct and standards for practice of the nursing and midwifery professions.'[254]

3.49 Stakeholders also argued that complaint-making mechanisms are inadequate, or result in poor or minimal responses from management.[255] The Committee notes that, on the 2023 People Matter Employee Survey, 63 per cent of surveyed staff agreed that, if they experienced a grievance at work, they would be comfortable raising it with their organisation (which is 2 per cent lower than the public sector average). Conversely, only 38 per cent of surveyed staff believed that senior managers listen to employees (which is 8 per cent lower than the public sector average).[256]

3.50 Mr Whaites noted that the pathways for staff to raise concerns are not consistent and sometimes inaccessible to staff altogether with potentially severe negative results.

> Avenues for staff to escalate workplace concerns are inconsistent or, at worse, non-existent, resulting in increased workplace health and safety complaints and

[252] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, pp 172-173.

[253] Submission 9, Can Assist (Cancer Assistance Network), p 5; Submission 50, New South Wales Nurses and Midwives' Association, p 21.

[254] Submission 50, p 21.

[255] Submission 48, Australian Salaried Medical Officers' Federation (New South Wales), pp 8-9; Mr Michael Whaites, Assistant General Secretary, New South Wales Nurses and Midwives' Association, Transcript of evidence, 27 November 2023, p 7.

[256] Public Service Commission, People Matter NSW Public Sector Employee Survey 2023: Portfolio Report Health (report ND0100000), NSW Government, viewed 13 June 2024, pp 5, 23.

> increased psychological injuries. Tragically, we are aware of an increase in the number of deaths by suicide amongst our members.[257]

3.51 Australian Salaried Medical Officers' Association NSW (ASMOF) provided information on a survey of their members. The survey found that, of the respondents who had made a workplace complaint regarding bullying and harassment, discrimination, and/or racism:

- 79% were dissatisfied with the management of the workplace investigation, and
- 100% of RRR respondents said the workforce investigation process did not result in any quality and process improvement.[258]

3.52 Can Assist submitted that the fear of speaking out that was raised in the PC2 inquiry 'does not seem to have abated'.[259] However, Can Assist members were not comfortable providing more specific feedback of particular instances, due to the fear of speaking out.

> Workers are universally concerned about backlash. Public health professionals routinely ask us to leave their name and hospital out of our public feedback… Where staff members first seek "management approval" to speak with us, we are invariably met with silence.[260]

Supporting the work of the NSW Ombudsman

Recommendation 15

That the NSW Ombudsman expedites the implementation of the new Health Administration Unit, in order to promote the role of the NSW Ombudsman to workers in the public health system.

3.53 PC2 recommendation 41 was that 'the NSW Government establish an independent office of the Health Administration Ombudsman to receive and review concerns about the administrative conduct of management of Local Health Districts and NSW Health from staff, doctors, patients, carers and the public.'[261]

3.54 The Committee recognises that this recommendation was noted, rather than supported, by the previous government.[262] However, the current NSW Government has committed to supporting all 44 recommendations from the PC2 report.[263]

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[257] Mr Whaites, Transcript of evidence, 27 November 2023, p 2.

[258] Submission 48, pp 8-9.

[259] Submission 9, Can Assist (Cancer Assistance Network), p 4.

[260] Answers to questions on notice, Can Assist (Cancer Assistance Network), 13 December 2023, p 1.

[261] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, p xxii.

[262] NSW Government response, report 57, Portfolio Committee No. 2, 1 September 2022, pp 32-33.

[263] Ms Deborah Willcox, Acting Secretary, NSW Health, Transcript of evidence, 27 November 2023, p 35.

3.55 We note that the NSW Ombudsman considers that 'the statutory role, functions and powers of the NSW Ombudsman are consistent with those of the proposed health administration ombudsman.'[264] Mr Paul Miller, NSW Ombudsman, told the Committee:

> …what we have explained to government is that all of the functions and features, including the features around independence et cetera, that [PC2] had proposed of a health administration are functions and features that already exist with the NSW Ombudsman's office. That's the legal and structural position.[265]

3.56 However, the Ombudsman also reported that resource constraints have likely prevented them from investigating all matters that may warrant further scrutiny in the NSW public health system.[266]

3.57 Under recently granted functions, the NSW Ombudsman can now review and report on the complaint handling systems of public authorities. In August 2022 the *Ombudsman Legislation Amendment Act 2022* commenced. The Ombudsman now has powers to:

- review the systems of public authorities for handling complaints, and report and make recommendations to the relevant ministers
- refer a complaint made to the office of the NSW Ombudsman back to the relevant public authority for them to investigate
- 'make recommendations to, and monitor, the authority's handling of a referral, and require the authority to report to them on the outcome of its investigation.'[267]

3.58 The Ombudsman told the Committee that resource constraints may have limited their ability to investigate complaints originating in the health system. Mr Miller noted that the NSW public health system is the largest Australian healthcare system with the largest NSW government department workforce, and:

> Given that context we acknowledge that, although we may have all of the functions of a health administration ombudsman, it is likely there are matters that could warrant further scrutiny that have not always done so.[268]

3.59 The Ombudsman also told the Committee that it is likely that their role has 'not always been promoted to or accessed by public officials working across the health system.'[269]

3.60 The Government approved the NSW Ombudsman's funding proposal for a Health Administration Unit (HAU) to be established and led by a newly created Health

[264] Submission 38, NSW Ombudsman, p 2.
[265] Mr Paul Miller, NSW Ombudsman, Transcript of evidence, 24 November 2023, p 21.
[266] Submission 38, p 2; Mr Miller, Evidence, 24 November 2023, p 20.
[267] *Ombudsman Act 1974* ss 12A, 25A; NSW Ombudsman, *2021-22 Annual Report*, 2022, pp 18-19.
[268] Mr Miller, Evidence, 24 November 2023, p 20.
[269] Mr Miller, Evidence, 24 November 2023, p 20.

Administration Deputy Ombudsman role.[270] The Health Administration Unit is primarily intended to increase visibility and accessibility of the NSW Ombudsman office and help co-ordinate the work of its existing branches.[271]

3.61 The Committee is pleased to note that, as of April 2024, the Ombudsman's office planned for recruitment for all four roles within the new HAU to be completed by the third quarter of 2024. A Deputy Ombudsman Health Administration commenced in February 2024.[272] We recommend that the NSW Ombudsman take all reasonable steps to finalise recruitment and expedite the operation of this unit.

3.62 The Ombudsman noted that the establishment of this unit will not significantly increase their capacity to carry out investigatory action in response to complaints or matters that are raised. The Ombudsman clarified that, even with significant resourcing, all matters relating to conduct in the health system would not be investigated. This is because:

- their decision to formally investigate matters is 'discretionary' and dependant on 'the nature and seriousness of allegations raised'. Most complaints do not lead to formal investigations.
- their complaint handling mechanisms are deemed a 'last resort'. This provides agencies the opportunity to handle and resolve their own complaints.

However, as noted above, the Ombudsman acknowledged there may be matters that call for investigation by their office which were not investigated due to limited resources.[273]

3.63 In response to supplementary questions, the NSW Ombudsman noted that, from 2022-23, they have received a 'material enhancement' in funding to support the exercise of both their existing and new statutory functions. They advised that:

> With our additional resources we anticipate being able to carry out investigatory action in respect of more matters across the jurisdiction of the office than has been possible in recent years.[274]

3.64 The establishment of the HAU and this recent funding increase for the NSW Ombudsman are both positive developments. In particular, the work of the new Health Administration Unit will be valuable to raise awareness of the NSW Ombudsman's role and functions, including their formal investigation process.

3.65 Given the volume of issues raised by stakeholders, in relation to poor workplace culture and employee wellbeing, the Committee looks forward to hearing more

[270] Submission 38, pp 4-5.

[271] Answers to supplementary questions, NSW Ombudsman, 20 December 2023, pp 5-6; Mr Miller, Evidence, 24 November 2023, p 21

[272] NSW Ombudsman, Proposed actions by the NSW Ombudsman: Health administration – April 2024 status update, p 1, viewed 20 July 2024.

[273] Answers to supplementary questions, NSW Ombudsman, 20 December 2023, pp 4-6.

[274] Answers to supplementary questions, NSW Ombudsman, 20 December 2023, p 5.

on what impact these reforms are having in the regional health system. It may be worthwhile to establish evaluation or performance measurement processes that can ensure that the HAU is fulfilling its objectives.

Cultural safety

Finding 10

While some action has been taken to improve cultural safety in the public health system, further supports for Aboriginal health workers and cultural safety training for NSW Health staff are needed.

Recommendation 16

That NSW Health develop and provide more training to staff to improve cultural safety in the public health system.

3.66 In its 2022 report, PC2 made a recommendation aimed at improving cultural safety for Aboriginal health workers. Recommendation 32 was that:

> NSW Health and the Local Health Districts improve the cultural safety of health services and facilities by engaging with Aboriginal Elders and local communities to:
>
> - revise and incorporate local content into cultural awareness training such as *Respecting the Difference: Aboriginal Cultural Training*
> - listen to their experiences of the healthcare system and seek guidance around what cultural safety strategies should be applied in their areas
> - include prominent Acknowledgements of Country in all NSW Health facilities as a starting point.[275]

3.67 Stakeholders report that Aboriginal and Torres Strait Islander staff are still experiencing culturally unsafe workplaces in the regional health system. The Committee found that that further supports for Aboriginal and Torres Strait Islander staff are needed, and recommends that NSW Health provide more training to staff to address cultural safety at work.

3.68 The Committee acknowledges that NSW Health has undertaken several steps to improve cultural safety in the public health system. This includes:

- targeted recruitment for Aboriginal healthcare workers (as discussed in Chapter One)
- a mandatory eLearning module for staff
- grants for the co-design of culturally appropriate mental health models, with local Aboriginal community-controlled health organisations

[275] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, p 161.

- inclusion of Aboriginal health practitioners into emergency departments from 2024
- implementation of a Whole of Government Aboriginal Procurement Policy.[276]

3.69 NSW Health delivered a refreshed mandatory eLearning module, *Respecting the Difference: Know the Difference* with an optional face-to-face component in 2022. The training has been accessed by NSW Health staff, including 40 418 staff members who completed the mandatory eLearning and 13 031 staff members who completed face-to-face training.[277]

3.70 However, some stakeholders reported that there are still culturally unsafe workplaces in the regional healthcare system which could benefit from further training opportunities. Stakeholders observed challenges for Aboriginal people including bullying, culturally insensitivity and being excluded or not listened to.[278] Mr Richard Weston, CEO, Maari Ma Health Aboriginal Corporation suggested addressing the National Cultural Respect Framework as a way to tackle these issues.[279]

3.71 Mr Michael Whaites, Assistant General Secretary, New South Wales Nurses and Midwives' Association, told the Committee that Aboriginal and Torres Strait Islander members are calling for more training for staff to improve cultural safety awareness in the public healthcare system.

> Aboriginal and Torres Strait Islander members advise us that they have a significant concern around the lack of cultural safety awareness between staff and highlight the need for policy and training to address this.[280]

3.72 The Australian Lawyers Association (ALA) reported that members feeling a lack of cultural safety within healthcare workplaces is contributing to reduced availability of Aboriginal and Torres Strait Islander healthcare workers in rural, regional and remote NSW.[281]

3.73 The ALA describe this is as a symptom of the high rates of bullying, harassment and discrimination experienced by Aboriginal and Torres Strait Islander healthcare workers. The ALA recommended comprehensive training for NSW health workers as a way to address this.[282]

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[276] Independent Review Rural Health Inquiry (Ernst & Young), provided by NSW Health to the Committee, 16 August 2023, pp 64-65; Mr Michael Whaites, Assistant General Secretary, New South Wales Nurses and Midwives' Association, Transcript of evidence, 27 November 2023, p 3; Submission 11, NSW Health, p 11.

[277] Independent Review Rural Health Inquiry (Ernst & Young), 16 August 2023, p 65.

[278] Mr Richard Weston, CEO, Maari Ma Health Aboriginal Corporation, Transcript of evidence, 27 November 2023, p 13; Dr Marion Tait, Bulgarr Ngaru Medical Aboriginal Corporation, Transcript of evidence, 27 November 2023, pp 13-14.

[279] Mr Weston, Evidence, 27 November 2023, p 13.

[280] Mr Michael Whaites, Assistant General Secretary, New South Wales Nurses and Midwives' Association, Transcript of evidence, 27 November 2023, p 2.

[281] Submission 17, Australian Lawyers Association, p 8.

[282] Submission 17, p 8.

3.74 A survey of Australian Salaried Medical Officers' Association (ASMOF) remote, rural and regional members also found that 19 per cent of respondents had experienced discrimination and/or racism.[283]

3.75 Research conducted by A Better Culture similarly indicates that a significant percentage of Aboriginal and Torres Strait Islander trainees are likely to experience bullying and harassing behaviours, including racism, in their workplaces.[284]

3.76 While some action has been taken by NSW Health to improve cultural safety for Indigenous health workers, further supports for Aboriginal and Torres Strait Islander staff are required. The Committee is concerned to hear about the ongoing prevalence of discrimination, bullying, and harassment being experienced by Aboriginal and Torres Strait Island people in particular. The Committee therefore recommends that NSW Health develop and implement more training for their staff to improve cultural safety at work, and will continue to monitor progress in improving cultural safety in the regional health system.

[283] Submission 48, Australian Salaried Medical Officers' Federation (New South Wales), pp 8-9.

[284] Submission 55, A Better Culture, pp 5-6.

Chapter Four – Funding health services, programs and facilities in regional NSW

4.1 This chapter explores the implementation of certain Portfolio Committee No. 2 (PC2) recommendations related to funding for health services, programs and providers in remote, rural and regional NSW.

4.2 NSW Health report that there has been an investment focus on healthcare for people living in rural, regional and remote NSW, including funding for air transport, virtual care, palliative care and urgent care services.[285] As discussed in Chapter One, the NSW Government has also made numerous investments to build and maintain the rural and regional workforce, including recruitment and retention incentives.

4.3 This chapter focuses on the implementation of PC2 recommendations relating to funding models and funding for specific programs, such as:

- the Isolated Patients Transport and Accommodation Assistance Scheme
- virtual care
- primary care pilots.

4.4 Funding considerations related to the role of local government and Aboriginal medical services in providing regional healthcare are also discussed.

Ensuring current funding models are adequate

Recommendation 17

That NSW Health publish its reviews of specific funding models used within the regional health system, including the review of the 'small hospitals' funding model.

Recommendation 18

That NSW Health works with the New South Wales and Australian governments to explore alternative funding models to those currently used in the regional health system.

4.5 The Committee heard that there are flaws in the existing funding models used within the regional health system. Stakeholders outlined concerns that the current models do not accurately reflect the costs of services or do not incentivise small hospitals to expand their services.[286] Stakeholders were also

[285] Submission 11, NSW Health, pp 24-27.

[286] Submission 32, Royal Flying Doctor Service of Australia (South Eastern Section) p 8; Submission 49, Rural Doctors Association of NSW, p 1.

concerned about the fairness of funding allocation, and suggested allocating funding for a remote, rural and regional service model.[287]

4.6 It is not clear whether PC2 recommendation 1 has been implemented – that 'NSW review the current funding models for all rural and regional Local Health Districts in order to identify any service delivery gaps and provide any recommendations for funding increases.' For example, Professor Jason Bendall submitted that:

> There is no evidence that any review of the current funding models for rural and regional Local Health Districts has been undertaken in order to identify any service delivery gaps and provide any recommendations for funding increases. In actual fact, in many Local Health Districts there is less certainty.[288]

4.7 The Committee recommends that NSW Health publish any reviews it undertakes of specific funding models used in the regional health system. We acknowledge the ongoing work of the Special Commission of Inquiry (SCOI) into Healthcare Funding in NSW (discussed further below), and the complex inter-jurisdictional considerations of funding for regional hospitals. However, the Committee is of the view that publishing future reviews of funding models is important for ensuring that any progress in implementing this recommendation, or any challenges in doing so, are clearly and transparently communicated to the public.

4.8 In particular, the Committee is concerned that no review of small hospital funding has taken place.

4.9 The *Independent Review – Rural Health Inquiry* (the 'EY report') indicates that NSW Health considers the review of small hospital funding models to be part of 'the existing annual funding review process which is completed by NSW Health'.[289] However, a witness from NSW Health also told the Committee that no specific review of healthcare funding had commenced since the PC2 report was tabled in 2022, as NSW Health has been committed to its involvement in the SCOI.[290] In their subsequent answers to questions taken on notice, NSW Health indicated that work to review the small hospitals funding model is underway.[291]

4.10 Stakeholders also observed issues, or noted areas of opportunity, regarding the funding of rural and regional hospitals.[292] For example, the Rural Doctors Association of NSW reported concerns that the block funding model does not encourage hospitals to increase how many patients are treated or expand the services they offer.[293]

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[287] Submission 21, NSW Rural Doctors Network, p 2; Submission 36, Professor Jason Bendall, p 1.

[288] Submission 36, p 1.

[289] Independent Review – Rural Health Inquiry (Ernst & Young), provided by NSW Health to the Committee, 16 August 2023, p 21.

[290] Mr Luke Sloane, Deputy Secretary, Regional Health, NSW Health, Transcript of evidence, 27 November 2023, p 42.

[291] Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, p 5.

[292] Submission 21, p 2; Submission 49, p 1.

[293] Submission 49, p 1.

4.11 The Royal Flying Doctor Service (South Eastern Section; RFDS) submitted that the costs of providing many health services funded under the Activity Based Funding (ABF) model 'do not reflect the actual costs of providing that service.' Specifically, the RFDS incur significant costs for delivering health services in rural and regional locations, including the cost of employing doctors and nurses. The RFDS argued that these costs are not accurately captured by activity-based understandings of health services.[294]

4.12 The Rural Doctors Network (RDN) noted that the PC2 report acknowledged remote and rural health systems differ fundamentally from regional city health systems, and submitted that specific policy, initiatives and funding for a remote and rural service model and workforce strategies may improve outcomes for those communities.[295]

4.13 The *NSW Regional Health Strategic Plan 2022-32* does identify remote and rural communities as having unique community health needs.[296] This plan includes a 10-year deliverable to develop long term funding models to 'improve regional service planning and funding models to address solutions for remote hospitals, cross-border services, clinics and other services'.[297] However, there is no mention of a specific funding model that would be dedicated to remote, rural and regional communities.

4.14 Limitations of the current funding models including ABF and block funding continue to affect small rural and regional hospitals (background information on these models is provided at 4.21-26). A review of specific funding models used within the regional health system – particularly one that can assess whether the structural and systemic characteristics of funding models are appropriate – remains a priority in addressing the funding issues in the healthcare system for small regional and rural hospitals.

4.15 The Committee notes the complexity of funding services within the regional health system. The Committee has pursued the issue of funding from the Australian Government through correspondence with the relevant parties. We will continue to monitor progress on the implementation of recommendations that relate to funding arrangements with the Australian Government and the on-going work of the Special Commission of Inquiry into Healthcare Funding.

4.16 The Committee also recommends that NSW Health should work with the NSW and Australian Governments to explore alternative funding models to those currently used. For example, the NSW health system was previously funded under a population-based model, which takes into consideration the demographic characteristics of a population when allocating funding. It is more important that health funding is appropriate and flexible for delivering quality health services in RRR communities, rather than adhering to entrenched models

[294] Submission 32, p 8.

[295] Submission 21, p 2.

[296] NSW Health, *NSW Regional Health Strategic Plan 2022-2032*, February 2023, p 50.

[297] NSW Health, *NSW Regional Health Strategic Plan 2022-2032*, February 2023, p 66.

of funding (such as ABF or block funding) that may not be adequate for the specific needs of the regional health system.

Funding models for hospitals and health care

4.17 The Committee is interested in the progress of implementing the key recommendation made in the PC2 report relating to the appropriateness of funding models in the regional health system (Recommendation 1). We note that the Special Commission of Inquiry (SCOI) into Healthcare Funding is currently underway and is due to deliver its final report by March 2025.[298]

4.18 This SCOI was established to examine the 'funding models used to provide health services in NSW and whether they most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW'.[299] The Committee notes that NSW Health has committed to engaging with the SCOI.[300]

4.19 While the Committee acknowledges that the SCOI will identify opportunities to improve funding models for Local Health Districts in NSW, we are also concerned that only limited progress appears to have been made against the 2022 PC2 recommendation. The EY report describes two actions taken by NSW Health in response to this recommendation:

- Review the appropriateness of Small Hospital Funding Models to applicable hospitals as necessary
- Block funding arrangements may be in scope for the midterm review of the National Health Reform Agreement, to be completed by 2023.[301]

4.20 The EY report marks both of these actions as complete.[302] However, stakeholders told the Committee that there are still problems associated with the current funding models used within the regional health system. This includes funding and reimbursement models that do not reflect the actual costs incurred by service providers.[303] It is also unclear what reviews of the small hospital funding model have been completed to date.

Background: funding models in the NSW regional health system

4.21 Local Health Districts (LHDs) and Speciality Health Networks (SHNs), such as the Justice Health and Forensic Mental Health Network, are primarily funded through Activity Based Funding (ABF). Under the ABF model, funding is allocated to LHDs and SHNs based on the number and type of patients they treat. The ABF model

[298] Special Commission of Inquiry into Healthcare Funding, *Letters patent dated 21 February 2024*, entered into Register of Patents no. 93, p 430, viewed 25 May 2024; Special Commission of Inquiry into Healthcare Funding, *Letters patent dated 23 August 2023*, entered into Register of Patents no. 93, p 392, viewed 23 July 2024.

[299] Special Commission of Inquiry into Healthcare Funding, *Letters patent dated 21 February 2024*, entered into Register of Patents no. 93, p 430, viewed 25 May 2024, p 1.

[300] Mr Sloane, Evidence, 27 November 2023, p 42; Answers to questions on notice and supplementary questions, NSW Health, 29 January 2024, p 5.

[301] Independent Review – Rural Health Inquiry (Ernst & Young), 16 August 2023, p 7.

[302] Independent Review – Rural Health Inquiry (Ernst & Young), 16 August 2023, p 7.

[303] Submission 32, p 8.

allocates funding to the place where the treatment occurs, rather than the area in which a patient resides.[304]

4.22 In ABF, health services are funded at a unit price determined by the clinical complexity of the service provided (a National Weighted Activity Unit).[305] NSW Health submitted that regional hospitals received additional loadings to recognise the costs of delivering care in regional areas. The funding received by service providers is based on 'activity agreed in service agreements' between LHDs/SHNs and the Secretary, NSW Health.[306]

4.23 Activity targets are developed for each health service in a LHD or SHN according to certain activity level drivers. Consideration is also given to 'the size and health needs of a district/network's population and provision of services to residents outside the local area'.[307] In 2022-23 services funded through ABF included:

- emergency department services
- acute admitted services
- admitted mental health services
- sub-acute and non-acute services
- non-admitted services.[308]

4.24 A block funding model is used to fund services that are not suitable for ABF. Block funded amounts are 'guided by the latest full year clinical costing data submission'.[309] Specific hospital services are block funded, and this type of funding can also be provided for:

- non-admitted services, such as some mental health services and chronic disease management
- highly specialised therapies, such as CAR-T cell therapy for cancer treatment
- teaching, training and research.[310]

4.25 Small rural hospitals, Multipurpose Services and certain speciality hospitals receive block funding. NSW Health explained that a block funding variation applies to small rural hospitals to permit funding for additional activity growth.[311]

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[304] Submission 11, p 24.

[305] National Heath Funding Body, Calculation of National Weighed Activity Unit, viewed 22 April 2024; Submission 11, p 24.

[306] Submission 11, p 24;National Health Funding Body, New South Wales basis for National Health Reform payments 2022-2023, viewed 15 November 2023.

[307] National Health Funding Body, New South Wales basis for National Health Reform payments 2022-2023, viewed 15 November 2023.

[308] National Health Funding Body, Funding Types, viewed 15 November 2023.

[309] Submission 11, p 24.

[310] National Health Funding Body, Funding Types, viewed 15 November 2023.

[311] Submission 11, p 24.

4.26 Both of these models – block funding and ABF – are derived from the National Health Reform Agreement (NHRA). The NHRA outlines the shared contributions that are made by the Australian Government and states and territories for the funding of public hospitals in Australia.[312]

Supporting the role of local government

Finding 11

That local governments in remote, rural and regional areas often play a significant role in supporting the local health system, and council-led community ownership models have had some success in regional NSW.

Recommendation 19

That the NSW Government work with the Australian Government to improve support to local councils, including ensuring more funding is available for local governments that provide services that fall within Australian Government responsibilities, such as aged care and primary care support.

4.27 Local government often plays an under-acknowledged role in the provision of healthcare in remote, rural and regional (RRR) communities. The Committee found that local councils can be important supports in the regional health system and are complementary to the core functions and responsibilities of state and federal governments.

4.28 The role of local government as a healthcare provider was not explicitly addressed in the PC2 recommendations.[313] However, the Committee is of the view that local governments should be better supported by the NSW and Commonwealth governments, in order to provide quality community-based care outside of the public health system where required.

4.29 The Committee recommends that the NSW Government undertake to provide more support to local government in their efforts to deliver health services and projects. In particular, the NSW Government should advocate for more Commonwealth funding to be made available for local governments that provide services that fall within Australian Government responsibilities, such as aged care and primary care support. Among a range of possible applications, this funding could be provided for assistance in recruiting health workers to council-operated facilities or for developing community-owned health facilities.

4.30 Local Government NSW (LGNSW) and several local councils participated in the inquiry. These stakeholders reported that rural and regional councils provide and subsidise critical services and healthcare facilities in their communities.[314] In

[312] Department of Health and Aged Care, 2020–25 National Health Reform Agreement (NHRA) | Australian Government Department of Health and Aged Care, viewed 23 July 2024.

[313] Local government was noted in relation to recommendations involving community consultation (e.g. Recommendations 11, 30 and 43). The Committee will examine recommendations relating to community consultation in future inquiries.

[314] Submission 37, Local Government NSW, p 9; Cr Darriea Turley, President, Local Government NSW, Transcript of evidence, 24 November 2023, p 27; Cr Wendy Wilks, Convenor, Inverell Health Forum, Transcript of evidence, 24 November 2023, p 31; Submission 8, Coolamon Shire Council, pp 1-2.

doing so, LGNSW argued that healthcare costs are being shifted to local councils, impacting their overall budgets.[315]

4.31 LGNSW reported that councils often incur costs relating to housing and transport for medical practitioners, supplying critical health infrastructure, scholarships for medical students and subsidising the running costs of medical facilities. The financial impact of this on council budgets can impact their ability to invest in other essential services and revenue producing facilities.[316]

4.32 Councillor Wendy Wilks, Convenor, Inverell Health Forum, described how Inverell Shire Council supports medical practitioners in the community. The Council has a policy which helps doctors find accommodation or a car, in addition to supporting medical student accommodation through private billet arrangements.[317]

4.33 The City of Wagga Wagga submitted that development of the Wagga Wagga Housing Strategy is underway and contributing to the implementation of PC2 workforce recommendations. The council has also set up an accommodation working group, with members including the NSW Government, the Murrumbidgee LHD, the University of NSW and private developers. This working group is focused on initiatives to address the lack of housing for the local health workforce,[318]and was established under the auspices from the Murrumbidgee Health and Knowledge Precinct initiative.

4.34 Community-led health service models have had some success in NSW and elsewhere in remote, rural and regional Australia. Some inquiry participants noted their support for these community-led programs, and provided evidence of the positive outcomes achieved in the communities they operate in. Specific case studies are discussed further below.

4.35 We encourage the NSW Government to continue exploring the models through which community-led and/or community owned health services could be supported.

4.36 This includes the 'hub-and-spoke' model, which has been used in the Murrumbidgee LHD. In this model, one site acts as a central base for activity and plays a support and coordination role to the spokes or 'satellite' services. Providers in the satellite services may also provide services from the hub.[319] The hub-and-spoke model in RRR NSW would involve health workers from a larger regional facility providing services to smaller facilities based in outlying towns. This model was endorsed by Coolamon Shire Council, who argued that it establishes 'a level of health service facilities in local communities that can be sustained' by larger centres.[320]

[315] Submission 37, p 9; Cr Turley, Evidence, 24 November 2023, p 27.

[316] Submission 37, pp 9-12; Cr Turley, Evidence, 24 November 2023, p 27.

[317] Cr Wilks, Evidence, 24 November 2023, p 31.

[318] Submission 10, City of Wagga Wagga, p 2.

[319] NSW Health, HealthOne NSW Service Models, viewed 23 July 2024.

[320] Mr David McCann, Mayor, Coolamon Shire Council, Evidence, 24 November 2023, pp 29-30.

4.37 A hub-and-spoke style model has also shown success in providing services to Aboriginal patients. The model has been implemented by Bulgarr Ngaru Medical Aboriginal Corporation, where visiting medical specialists from the LHD attend clinics at their Aboriginal medical service (AMS) and provide services for their patients that are unable to travel, or 'don't feel comfortable attending' the larger LHD facility. Using this model, clinicians attend a trusted health service where patients will engage.[321]

4.38 Another potential model is the National Rural Health Alliance's Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS) model. Under this model, block funding is provided to a community to allow them to design and establish a non-for-profit practice that is centred on community needs.[322] The PRIM-HS model is discussed further at 4.58.

Case study: Coolamon Shire Council

4.39 Coolamon Shire Council have demonstrated success in supporting their community's healthcare needs via council-led services and projects. Mr Tony Donoghue, General Manager, Coolamon Shire Council, told the Committee that the Council's work in supporting community healthcare began in 1993.[323]

4.40 Coolamon Shire Council provide a range of services, facilities, subsidies and financial supports for healthcare in the area. This includes accommodation for their healthcare staff and supporting international healthcare staff to move and work in Australia.[324]

4.41 The Council has developed a portfolio of health care service infrastructure, many of which they own and/or operate. This includes:

- a 33-bed residential aged-care service at Allawah Lodge
- building homes for a local doctor and aged care staff
- the Coolamon doctor and dentist surgery, and the Ganmain doctors' surgery
- 24 self-care units in Coolamon
- providing free rooms at the community centre for allied health professionals.[325]

4.42 In addition to providing health services and facilities, Coolamon Shire Council also subsidises rent for health facilities. The Council has provided land for the Coolamon Multipurpose Service and for local community health services. Mr

[321] Dr Marion Tait, Bulgarr Ngaru Medical Aboriginal Corporation, Transcript of evidence, 27 November 2023, p 16.

[322] National Rural Health Alliance, *Primary care Rural Integrated Multidisciplinary Services (PRIM-HS)*, 2023, viewed 5 July 2024, pp 3-4; Answers to supplementary questions, National Rural Health Alliance, 20 December 2023, p 6.

[323] Mr Tony Donoghue, General Manager, Coolamon Shire Council, Transcript of evidence, 24 November 2023, p 34.

[324] Submission 8, pp 1-2.

[325] Mr Donoghue, Evidence, 24 November 2023, p 26; Submission 8, pp 1-2, 9.

Donoghue told the Committee that the Council has also provided land and funding for the local ambulance station.[326]

4.43 Coolamon Shire Council has implemented an international recruitment strategy to address the shortfalls in workforce supply in rural and regional NSW. They supported ten aged care workers from the Philippines, and have built housing in Coolamon for them to live in. Several of the new staff members were nurses qualified under the US system in the Philippines, and the Council engaged a local provider in Wagga to train them to a registered nurse level. Mr David McCann, Mayor, Coolamon Shire Council, said that it is the Council's 'hope and intention' that, once the nurses have fulfilled their contracts as aged care workers in Coolamon, they may continue working in New South Wales.[327]

4.44 Coolamon Shire has been able to provide specific health services required by the local community, through council funding and leadership. The NSW Government should work with the Commonwealth and advocate for additional funding to local councils, for the specific purposes of providing healthcare services. Doing so could mean that the successes of councils such as Coolamon could potentially be emulated elsewhere in NSW.

Case study: Bogan Shire Council

4.45 The National Rural Health Alliance (NRHA) described a number of small regional towns in Australia that have achieved positive outcomes from community-led practices, including in Bogan Shire Council in NSW.

4.46 In their answers to supplementary questions, the NRHA report on the Bogan Shire Medical Centre which was supported with council funds. The Council identified a market failure to supply a local GP service and purchased land in Nyngan to build a medical centre in 2015. In 2017, they opened an accredited practice for the Bogan Shire community, that is operated by the Council.[328]

4.47 The Bogan Shire Medical Centre works with the nearby Multipurpose Service to handle patient care between each service, where required. This bulk-billed practice has been successful and grown in size since its opening in 2017, although there is a $600,000 to $900,000 shortfall per year that is subsidised by Council funds.[329]

Funding the development of innovative primary care models

Recommendation 20

That NSW Health accelerate the implementation of primary care pilots, and allocate additional funding to existing primary care programs and initiatives.

4.48 In its 2022 report, PC2 made several recommendations that related to supporting and developing the primary care sector in regional NSW. For example, Recommendation 8 was that the 'NSW Government investigate ways to support

[326] Mr Donoghue, Evidence, 24 November 2023, p 26.

[327] Mr McCann, Evidence, 24 November 2023.

[328] Answers to supplementary questions, National Rural Health Alliance, 20 December 2023, p 12

[329] Answers to supplementary questions, National Rural Health Alliance, 20 December 2023, pp 12-13.

the growth and development of the primary health sector' in RRR communities.[330] The PC2 report discussed the need for innovative, flexible and localised models of care that are tailored to local communities. Recommendation 10 was that:

> The NSW Government work with the Australian Government to establish a Rural Area Community Controlled Health Organisation pilot, with a view to evaluating and refining it for rollout in all areas of New South Wales where existing rural health services do not meet community needs.[331]

4.49 The Rural Area Community Controlled Health Organisation (RACCHO) model was developed by the NRHA. The NRHA noted that, since the PC2 inquiry, the RACCHO model has evolved and been renamed the Primary care Rural Integrated Multidisciplinary Health Services (PRIMS-HS) model, which is discussed further below.[332]

4.50 The EY report outlines a range of proposed actions in relation to PC2 Recommendation 10. This includes exploring the adaptation of existing models, such as HealthOne and a rural pilot of the Urgent Care Centre model, and working with the Australian Government to develop and trial additional models that 'support communities where existing rural health services do not meet community needs.' The EY report noted that progress against these actions was on track.[333]

4.51 However, stakeholders told the Committee that primary care services in regional NSW remain a significant issue. The Committee recommends that NSW Health accelerate the implementation of pilots to improve access to primary care, with additional funding to be provided to the primary care services and initiatives currently available. Increasing funding for existing primary care in regional NSW represents a valuable opportunity to improve early intervention and preventative health services.

4.52 The AMA argued that 'primary healthcare access has continued to deteriorate in remote and rural areas'.[334] NSW Health also acknowledged that 'primary care is under significant strain across various parts of the state.'[335] The NRHA released a report in 2023 that identifies that in the healthcare system, general practitioners (GPs) are commonly the referral pathway for service access. Therefore, scarce access to GPs has resulting impacts on the accessibility of allied health and specialist services.[336]

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[330] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, p xvi.

[331] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p xvi.

[332] Submission 42, National Rural Health Alliance, p 7.

[333] Independent Review – Rural Health Inquiry (Ernst & Young), provided by NSW Health to the Committee, 16 August 2023, pp 34-35.

[334] Submission 47, Australian Medical Association NSW, p 4.

[335] Ms Deborah Willcox, Acting Secretary, NSW Health, Transcript of evidence, 27 November 2023, p 38.

[336] Submission 42, p 4.

4.53 As discussed in Chapter One, lack of access to primary healthcare leads to an increased reliance on emergency departments.[337] The Committee heard that access to primary care 'prevents avoidable hospitals admissions and reduces hospital stays.[338] As Dr Vicki Mattiazzo, Deputy Chair and NSW & ACT Representative, Royal Australian College of General Practitioners Rural, told the Committee, 'Healthy general practice primary care takes pressure off hospitals.'[339]

4.54 Remote communities also have a lower uptake of preventative health services such as screening programs.[340] An Australian Salaried Medical Officers' Federation (ASMOF) member reported that over time limited access to specialist care, 'worsening chronic conditions' and diminishing preventative care services could lead to longer admission times.[341]

4.55 The Committee is of the view that access to primary and specialist healthcare services will greatly improve health outcomes for RRR communities by enabling early intervention and prevention. We are also of the view that access to general practice will alleviate pressures on emergency departments by reducing the number of patients that present with unaddressed complex and multi-layered health needs. The Committee will explore specialist care services and their interactions with the primary care sector in greater detail in its second inquiry.

4.56 There are several place-based primary care programs and pilots that could be considered by NSW Health, for expansion and funding, such as PRIM-HS; the Collaborative Care Program; and rural pilots of the Urgent Care Services, which are discussed further below.

4.57 The Committee also recognises the central role that the Australian Government plays in supporting the primary care sector. The Committee notes the complexity of funding services within the regional health system and will continue to monitor progress on recommendations that relate to funding arrangements with the Australian Government. We acknowledge that the issue of inter-jurisdictional funding arrangements should be addressed by the Special Commission of Inquiry into Healthcare Funding. However, the NSW Government, should not delay in monitoring the Commonwealth, and holding them to account, in providing funding to RRR NSW communities.

Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS)

4.58 The NRHA has developed the Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS) model. PRIM-HS is a model of care and funding for health care in rural areas, designed with the local community to address the specific challenges of providing health services in that area. NRHA argued that, if

[337] Submission 42, p 4.

[338] Submission 42, p 5.

[339] Dr Vicki Mattiazzo, Deputy Chair and NSW & ACT Representative, Royal Australian College of General Practitioners Rural, Transcript of evidence, 24 November 2023, p 12.

[340] Submission 42, p 5.

[341] Submission 48, Australian Salaried Medical Officers' Federation (New South Wales), p 5.

supported, this model would provide a 'comprehensive and affordable range of primary healthcare services' in local communities.[342]

4.59 The PRIM-HS model involves government funding being provided to establish not-for-profit, community-based organisations that offer healthcare services. PRIM-HS organisations will recruit rural generalists, nurses and midwives, dentists and allied health professionals.[343]

4.60 PRIM-HS would support staff by encouraging professional development opportunities and reducing social and professional isolation through peer support. Under the model, practitioners could work in rural areas without committing to setting up their own practice.[344]

4.61 The PRIM-HS model is based on evidence from the Aboriginal Community Controlled Health Organisation (ACCHO) sector. The NRHA noted that ACCHOs have had a positive impact on experiences and health outcomes for Aboriginal and Torres Strait Islander people.[345] The evidence suggests that these positive outcomes derive from 'community designed and governed organisations providing comprehensive primary healthcare in alignment with local population health needs, with a component of block funding and the ability to employ staff in a flexible manner to meet these needs'.[346]

4.62 The PRIM-HS model also draws on the principles of a Victorian model, the Community Health Program (CHP). Under the CHP model health services and/or not-for-profit organisations can request CHP funding to offer primary healthcare services. Independent community health services are delivered in line with local needs and may use several funding streams. NRHA noted:

> This model acknowledges the social, environmental and economic factors that affect health, in addition to the biological and medical, and enables the provision of holistic care and wrap-around services by multidisciplinary teams, with a focus on vulnerable populations.[347]

4.63 The NRHA argued that there are several 'shovel-ready' organisations that would benefit from funding to implement PRIM-HS.[348]

4.64 The Committee is pleased to note that the Mareeba and Communities Family Healthcare service (MCFHC; Queensland), was recently announced as a recipient of funding from the Australian Government. The $1.57 million Commonwealth

[342] Submission 42, p 7.

[343] Submission 42, p 7.

[344] Submission 42, p 8.

[345] KS Panaretto, M Wnitong, S Button, IT Ring, Aboriginal community controlled health services: leading the way in primary care, Medical Journal of Australia, 16 June 2014, vol 200, issue 11, pp 611-679, viewed 23 July 2024.

[346] Answers to supplementary questions, National Rural Health Alliance, 20 December 2023, p 6.

[347] Answers to supplementary questions, National Rural Health Alliance, 20 December 2023, p 6.

[348] Answers to supplementary questions, National Rural Health Alliance, 20 December 2023, p 7.

funding grant will allow the PRIM-HS model to be trialled for the first time at the MCFHC.[349]

4.65 The Committee will monitor any developments in this area, in the hope that similar funding will be provided for trialling innovative primary care models in New South Wales.

Collaborative Care Program

4.66 The Collaborative Care Program (CCP) is a place-based planning approach led by the Rural Doctors Network in collaboration with the LHDs, Primary Health Networks, Aboriginal Community Controlled Health Organisations (ACCHOS) and local stakeholders.[350]

4.67 The CCP has been implemented in five trial sites in sub-regions across Murrumbidgee, Western NSW and Far West LHDs. It is now part of the Australian Government Innovative Models of Care program and is ready to be implemented in other areas.[351]

4.68 The Committee will explore this model in closer detail in its future inquiries.

Urgent Care Services

4.69 Urgent Care Services (UCSs) have been introduced in NSW to help decrease demand on emergency departments. UCSs provide treatment needed quickly for an illness or injury that is not an emergency, such as sports injuries, minor burns, insect or animal bites and mild asthma attacks.[352]

4.70 As of May 2024, 16 UCSs have been established by NSW Health. This includes the Tweed Valley urgent care response team in Northern NSW LHD. The NSW Government is investing funding to roll out 25 UCSs by mid-2025.[353] The Committee commends NSW Health for their action in this area.

Funding for patient transport

Recommendation 21

That NSW Health publish its future reviews of patient transport schemes, such as air transport and the Isolated Patient Travel and Accommodation Assistance Scheme, and consult with non-government health providers to identify any additional areas for improvement in these schemes.

[349] National Rural Health Alliance, *Community-led innovation to revolutionise healthcare access in rural Australia*, media release, 24 June 2024, viewed 8 July 2024; Minister for Health and Aged Care (Cth), *$16 million to support innovative healthcare delivery in rural and remote Australia*, media release, 24 June 2024, viewed 8 July 2024.

[350] Submission 11, NSW Health, p 25.

[351] Submission 11, p 25; Submission 21, NSW Rural Doctors Network, pp 10-11.

[352] NSW Health, Urgent Care Services, viewed 1 May 2024.

[353] Submission 11, p 25; NSW Health, *More than 55,000 visits to Urgent Care Services*, media release, 23 May 2024, viewed 8 July 2024.

Recommendation 22

That NSW Health seek greater involvement of Aboriginal medical services in the planning and delivery of local health services, and formalise and strengthen the existing partnerships between NSW Health and Aboriginal medical services.

4.71 In its 2022 report, Portfolio Committee No. 2 (PC2) made several recommendations regarding funding for patient transport in RRR NSW. This included recommending that the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) be reviewed, with an aim of increasing reimbursement rates and expanding eligibility criteria (Recommendation 2).[354]

4.72 More broadly, PC2 also recommended that NSW Health work with the regional LHDs and Transport for NSW to ensure frequent and affordable transport services are available, for people in RRR NSW to attend medical appointments (Recommendation 3), and that NSW Health 'review the funding available for air transport' (Recommendation 4).[355]

4.73 The Committee heard that NSW Health have expanded eligibility for IPTAAS and will continue to review the scheme periodically.[356] Ms Majella Gallagher, Advocacy and External Relations, Can Assist, told the Committee that IPTAAS reforms have 'been rolled out swiftly and are creating better patient outcomes.'[357]

4.74 The Committee is concerned that limited progress may have been made against PC2 Recommendation 4, in relation to the review of available funding for air transport. In the EY report, it was reported that this review 'is scheduled to be delivered by June 2023'.[358] NSW Health indicated that they have 'committed to conduct a review of the funding available for air transport'. This review will include consideration of costings data for non-emergency patient air transport, and 'will inform future funding, delivery and outcomes for non-emergency air patient transport.'[359]

4.75 While this review will be valuable, the June 2023 date specified in the EY report appears to have been missed. The Committee is concerned that no significant action on this recommendation has taken place.

4.76 As a result, we recommend that NSW Health publish its future reviews of patient transport schemes, particularly for air transport and also for subsequent reviews of IPTAAS. Publishing reviews of patient transport schemes will add a greater degree of transparency and accountability to the implementation of these

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[354] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, p xv.

[355] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p xv.

[356] Submission 11, NSW Health, p 24; Mr Luke Sloane, Deputy Secretary, Regional Health, NSW Health, Transcript of evidence, 27 November 2023, p 37.

[357] Ms Majella Gallagher, Advocacy and External Relations, Can Assist, Transcript of evidence, 27 November 2023, pp 27-28.

[358] Independent Review – Rural Health Inquiry (Ernst & Young), provided by NSW Health to the Committee, 16 August 2023, p 28.

[359] Submission 11, pp 24-25.

recommendations. Moreover, NSW Health should ensure that it consults with relevant non-government health providers to identify any additional areas for improvement in these schemes. The issues raised by inquiry participants should inform the future reviews planned by NSW Health.

4.77 The Committee also recommends that NSW Health seek greater involvement of Aboriginal medical services in the planning and delivery of local health services and formalise and strengthen the existing partnerships between NSW Health and Aboriginal medical services. While there are numerous areas in which this is important, effective transport services are vital for delivering Aboriginal health programs and services. This is particularly important in remote areas where community members must travel to access particular health services.

4.78 The provision of Aboriginal health services and patient transport are areas of critical need for RRR communities in NSW. The Committee will examine progress in patient transport and Indigenous health services in future inquiries.

The Isolated Patients Travel and Accommodation Assistance Scheme

4.79 IPTAAS is a scheme that provides financial assistance towards travel and accommodation costs when NSW residents need to travel over 100km one way or 200km in a week for medical care that is not provided locally. This care must be for specialised medical appointments with the same practitioner or health service.[360]

4.80 Stakeholders told the Committee about challenges in accessing the IPTAAS, such as the process being 'time-consuming and quite complicated'.[361] Local health providers reported having to supplement patient transport costs out of their own budgets.[362] For example, Maari Ma Health Aboriginal Corporation (Maari Ma) reported covering travel costs to support longer-term treatment away from home..[363]

4.81 NSW Health recently increased funding and expanded eligibility for the IPTAAS. NSW Health reported that following additional investment, there has been an increase of more than 40 per cent in the use of IPTAAS. NSW Health acknowledged that funding is not the only barrier to accessing IPTAAS and noted they will continually review the scheme, including evaluating its user experience. NSW Health is also working to enhance parts of the IPTAAS form including GP validation of IPTAAS applications.[364]

4.82 Transport is a key aspect of delivering Aboriginal health services, particularly in remote and regional areas. Mr Richard Weston, CEO of Maari Ma, told the

[360] NSW Health, Isolated Patients Travel and Accommodation Scheme (IPTAAS), viewed 18 April 2024.

[361] Dr Marion Tait, Bulgarr Ngaru Aboriginal Medical Corporation, Transcript of evidence, 27 November 2023, p 15; Submission 39, Maari Ma Health Aboriginal Corporation, p 2.

[362] Mr Richard Weston, CEO, Maari Ma Health Aboriginal Corporation, Transcript of evidence, 27 November 2023, pp 12-13; Submission 39, pp 1-2; Answers to questions on notice, Bulgarr Ngaru Medical Aboriginal Corporation, 20 December 2023, p 2.

[363] Mr Weston, Evidence, 27 November 2023, pp 12-13.

[364] Mr Luke Sloane, Evidence, 27 November 2023, pp 37, 41.

committee that 'transport is a critical part of helping our people access services'.[365]

4.83 Maari Ma reported covering the travel costs for their clients in remote areas like Broken Hill where patients and their families have to travel long distance to access care, including end-of-life care. They access the available IPTAAS support, however, have continued to run at a deficit with travel costs.[366]

4.84 Bulgarr Ngaru Medical Aboriginal Corporation also reported that the process to access IPTAAS is time-consuming and complicated. As a result, their organisation supports their clients with additional funding and uses earnings from Medicare to employ drivers to assist patients in getting to appointments.[367]

Other patient transport services in remote, rural and regional NSW

4.85 There is also a need for funding for other programs to support NSW residents accessing the healthcare they need when it is not available in their local area, specifically funding for non-emergency community transport.

4.86 The Australian Paramedics Association (NSW) told the Committee there has been no increase in non-emergency patient transport, which leads to paramedics having to complete non-emergency work. This places paramedics at risk for unsafe fatigue and takes 'emergency response resources away from the community.'[368]

4.87 In small communities this can take the emergency ambulance out of that community for several hours, for example, to take someone from a nursing home to an imaging service for a CT or X-ray.[369]

4.88 Bland Shire Council described an example where an ambulance had to travel from Wagga Wagga to a hospital in Wyalong to retrieve a patient, due to locally based ambulances being unavailable.[370]

4.89 Community transport has also been excluded from the reform process. For patients who are ineligible for IPTAAS, transport remains costly. Ms Gallagher told the Committee:

> Patients who use [community transport] are ineligible for IPTAAS. In opposition to the philosophy of IPTAAS, patients travelling for non-emergency treatment via community transport are subsidised less per kilometre the longer they need to travel and [are] charged the same rate as a passenger travelling for a shopping trip.[371]

[365] Mr Weston, Evidence, 27 November 2023, p 13.

[366] Mr Weston, Evidence, 27 November 2023, p 13; Submission 39, pp 1-2.

[367] Dr Tait, Evidence, 27 November 2023, p 15.

[368] Submission 46, Australian Paramedics Association (NSW), p 6; Mr Scott Beaton, Vice President, Australian Paramedics Association (NSW), Transcript of evidence, 27 November 2023, p 2.

[369] Mr Beaton, Evidence, 27 November 2023, p 2.

[370] Submission 41, Bland Shire Council, p 2.

[371] Ms Gallagher, Evidence, 27 November 2023, pp 27-28.

4.90 Ms Gallagher added that travelling for radiotherapy is 'uniquely expensive for patients not living close to treatment.'[372]

4.91 The Committee is of the view that expanding non-emergency patient transport is a valuable opportunity to improve health services in RRR communities. The Committee is also of the view that a more coordinated and flexible approach to current non-emergency patient transport services would improve health outcomes in RRR communities. Both of these approaches would provide patients in these areas with more options for accessing health services in a timely and convenient manner. Expanding non-emergency patient transport will also benefit the regional health system more broadly, particularly in those areas with extremely limited patient transport. Crucially, this will reduce reliance on the use of emergency vehicles and deployment of paramedic staff for cases where community transport is more appropriate. Furthermore, by providing greater support for community transport services, the NSW Government may realise cost savings through reduced non-emergency uses of ambulances and other paramedic services.

Funding for virtual care and telehealth infrastructure

4.92 Recommendation 30 of the PC2 report focused on virtual care. The report recommended, among other considerations, that NSW Health offer effective virtual care in regional areas while also committing to a model of virtual care that supplements (rather than replaces) face-to-face services.[373]

4.93 Stakeholders reported that further support and funding for telehealth infrastructure is required. The Royal Australian College of General Practitioner (RACGP) Rural reported that the removal of telehealth allowances has resulted in consumers having to pay outright for services that were previously bulk billed.[374]

4.94 RACGP (Rural) recommended that additional funding be considered to upgrade infrastructure for telehealth in rural and remote communities. RACGP (Rural) members reported that despite virtual care being established across NSW, there are challenges with the infrastructure and the availability of clinical support for telehealth appointments.[375]

4.95 University of New England (UNE) have developed the New England Virtual Health Network (NEViHN), a 'digitally-enabled model of healthcare practice'. The multi-disciplinary NEViHN pilot would involve collaboration between UNE, the LHD and PHN. If funded the model could establish a 'digital approach' to supplement existing in-person care.[376]

4.96 Digital solutions such as telehealth have the potential to significantly improve access to healthcare services for people living in remote, rural and regional communities. This includes by augmenting existing services, where it is clinically

[372] Ms Gallagher, Evidence, 27 November 2023, p 28.

[373] Portfolio Committee No. 2, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, report 57, Parliament of NSW, May 2022, p xx.

[374] Submission 45, The Royal Australian College of General Practitioner (RACGP) Rural, p 6.

[375] Submission 45, pp 5-6.

[376] Submission 52, Faculty of Medicine and Health - University of New England, pp 6-8.

appropriate to do so.[377] However, telehealth should not be used to compensate for staff shortages in remote, rural and regional areas.

4.97 ACRRM report that rural healthcare facilities are increasingly experiencing periods without doctors onsite. Dr Rod Martin, College Councillor NSW, Australian College for Rural and Remote Medicine told the Committee:

> Increasingly, rural facilities are running without an onsite doctor for periods of up to 12 to 24 hours, instead needing to rely on a videoconference doctor, often sitting in a distant office. This puts everyone involved with the care of patients, especially those critically unwell or as a result of trauma, at substantial personal and professional risk. It also puts patients at avoidable risk.[378]

4.98 The Committee will explore the role of telehealth in more detail in subsequent inquiries, particularly as it relates to the delivery of specific types of health services and specialist care.

[377] Submission 52, p 1.

[378] Dr Rod Martin, College Councillor NSW, Australian College of Rural and Remote Medicine, Transcript of evidence, 24 November 2023, p 7.

Appendix One – Terms of reference

This inquiry was self-referred on 6 July 2023.

That the Select Committee on Remote, Rural and Regional Health inquire into and report on the progress of and issues relating to the implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding for remote, rural and regional health services and programs, including:

a) any challenges or opportunities relating to the implementation of recommendations relating to workforce issues, workplace culture and funding for remote, rural and regional health services and programs

b) staffing numbers, recruitment and retention, and related workforce management and planning issues (including Recommendations 8, 9, 11, 12, 15, 16, 17, 18, 30 and 33)

c) staff accreditation and training (including Recommendations 13, 14, 19, 20, 23, and 29)

d) workplace culture, including forthcoming reviews of workplace culture and complaint handling mechanisms (including Recommendations 40 and 41)

e) funding for agencies, programs and incentives (including Recommendations 1, 4, 10, 23, 24,30 and 38), and any funding issues relating to the above recommendations.

Appendix Two – Conduct of inquiry

Establishment of the Committee

On 11 May 2023, the Legislative Assembly resolved, on the motion of the Hon. Ron Hoenig MP (Leader of the House and Minister for Local Government), to appoint a Legislative Assembly Select Committee on Remote, Rural and Regional Health. The House required the Committee to report on the implementation of recommendations made by the Legislative Council Portfolio Committee No. 2 in its 'Health outcomes and access to health and hospital services in rural, regional and remote New South Wales' report (the Portfolio Committee No.2 report).

Adoption of the inquiry

On 6 July 2023, the Committee resolved to conduct an inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health.

Call for submissions

The Committee issued a media release on 3 August 2023 and wrote to key stakeholders inviting them to make a submission to the inquiry. The Committee also advertised the call for submissions on social media. On 20 September, the Committee informed stakeholders that it had extended the submissions deadline on 13 October 2023.

A total of 56 submissions were received from local councils, community health care providers, peak bodies, professional colleges, NSW Health and members of the public. A list of submissions is at Appendix Three. Submissions are available on the Committee webpage.

Site visits and stakeholder consultation

On 30 October 2023, the Committee received a private briefing from the NSW Health Secretary, Regional Health Deputy Secretary and from the Chief Executives of Local Health Districts.

The Committee conducted site visits in the Northern NSW and Hunter New England regions in 2023. On 31 October, the Committee visited the Bulgarr Ngaru Medical Aboriginal Corporation and Grafton Base Hospital, and met with local hospital staff, health practitioners, patients and carers. On 1 November 2023, the Committee toured Armidale Hospital and had discussions with local hospital staff and health practitioners.

The Committee also held a virtual consultation with health stakeholders from Tenterfield on 9 February 2024, due to the cancellation of the Committee's visit to Tenterfield in November 2023.

The Committee and secretariat visited NSW Health's office in St Leonards, Sydney on 15 March 2024 , for a demonstration of their staff portal. The Chair also conducted a follow-up visit to NSW Health's office on 3 April 2024.

Further information on the site visits is provided in Appendix Four (Site visit report).

Public hearings

The Committee held two public hearings at Parliament House on 24 and 27 November 2023. Representatives from not for profit and Indigenous healthcare providers, professional colleges, peak bodies, local councils, unions, academics and NSW Health appeared as witnesses in person and via videoconference.

A list of witnesses is at Appendix Four. Transcripts of evidence taken at the hearings are available on the Committee's webpage.

Appendix Three – Submissions

No.	Author
1	Name suppressed
2	Confidential
3	Confidential
4	Mr Allan Fredericks
5	Confidential
6	Professor Kate Curtis
7	Faculty of Pain Medicine (FPM), Australian and New Zealand College of Anaesthetists (ANZCA)
8	Coolamon Shire Council
9	Can Assist (Cancer Assistance Network)
10	City of Wagga Wagga
11	NSW Health
12	Cancer Council NSW
13	Australasian College for Emergency Medicine
14	Royal Far West
15	Australasian College of Paramedicine
16	Confidential
17	Australian Lawyers Alliance
18	Confidential
19	Wollondilly Shire Council
20	Central NSW Joint Organisation (CNSWJO)
21	Rural Doctors Network (RDN)
22	Pharmacy Guild of Australia (NSW Branch)
23	Exercise and Sports Science Australia (ESSA)
24	Australian College of Nurse Practitioners
25	Western Health Alliance Limited, trading as the Western NSW Primary Health Network (WNSW PHN)
26	Australian College of Rural and Remote Medicine (ACRRM)
27	Pharmaceutical Society of Australia
28	Confidential
29	Mrs Trisha Dawson
30	Gunnedah Shire Council
31	Inverell Health Forum

No.	Author
32	Royal Flying Doctor Service of Australia (South Eastern Section)
33	Gunnedah Community Roundtable
34	The Society of Hospital Pharmacists of Australia (SHPA)
35	University Centre for Rural Health, Northern Rivers
36	Professor Jason Bendall
37	Local Government NSW
38	NSW Ombudsman
39	Maari Ma Health Aboriginal Corporation
40	The Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
41	Bland Shire Council
42	National Rural Health Alliance
43	Charles Sturt University, Faculty of Science and Health
44	Varian
45	The Royal Australian College of General Practitioners (RACGP) Rural
46	Australian Paramedics Association (NSW)
47	AMA NSW
48	Australian Salaried Medical Officers' Federation (New South Wales)
49	Rural Doctors Association of NSW
50	New South Wales Nurses and Midwives' Association
51	Royal Australasian College of Medical Administrators (RACMA)
52	Faculty of Medicine and Health - University of New England
53	Ms Vanessa Landenberger
54	Bulgarr Ngaru Medical Aboriginal Corporation
55	A Better Culture
56	Dr Charlotte Hall

Appendix Four – Site visit report

In October-November 2023 and March-April 2024, members of the Select Committee on Remote, Rural and Regional Health undertook site visits and roundtable discussions to support the inquiry. We visited:

- Bulgarr Ngaru Medical Aboriginal Corporation, Grafton
- Grafton Base Hospital
- Armidale Hospital
- NSW Health head office, St Leonards

The Committee would like to thank the staff and management of Bulgarr Ngaru Medical Aboriginal Corporation (BNMAC) for hosting the Committee in the BNMAC Grafton office. In particular, we would like to thank Mr Scott Monaghan, CEO, and BNMAC's general practitioners, Visiting Medical Officers and psychologists for sharing their expertise on the issues affecting Aboriginal medical services (AMS) in the region. The prevalence of treatable diseases in Indigenous communities in the region is deeply concerning, as are some of the interactions between the AMS sector and public health system. We acknowledge the commitment and innovation of organisations like BNMAC in meeting these challenges.

The Committee is very grateful to NSW Health for their assistance in organising the visits to St Leonards and hospitals in Grafton and Armidale. In particular, we would like to thank Ms Susan Pearce, Secretary, Mr Luke Sloane, Deputy Secretary, Regional Health, the staff of the Office of the Deputy Secretary, Regional Health, and the staff and senior management of the Northern NSW and Hunter New England Local Health Districts for facilitating the Committee's visits. We would also like to acknowledge the contributions of the NSW Health and Local Health District executive teams that have participated in public hearings and private briefings with the Committee.

The Committee had also planned to visit Tenterfield during the regional site visits, but was unable to due to bushfire risk in the region. We are grateful to those local health stakeholders for finding the time to participate in subsequent virtual discussions with the Committee.

Staff and management at each of the sites were open with the Committee and generous with their time. The visits gave the Committee an opportunity to see firsthand the operation of health facilities in regional areas, and meet with local health practitioners. The Committee received tours of facilities and gained a better understanding of how they operate. We saw and heard about the challenges and also the important work being done in these facilities.

Through detailed and often very personal accounts, we learned about the impacts of primary care shortages in the regions, and the problems that arise when public health facilities are over-reliant on locum doctors and agency nurses. We heard about the breadth of recruitment and retention challenges that regional hospitals are facing, particularly the deficits in obstetrics and nursing staff in a number of locations. We learned that efforts to address poor workplace culture and staff wellbeing are underway, but the sense of a 'disconnect' between frontline staff and senior management was also clearly apparent.

The Committee has also had the opportunity to meet privately with health stakeholders, who each engage with the regional health system in different ways and in different capacities. The Committee thanks you for your courage in meeting with us, and telling us your stories of how the regional health system continues to affect your lives. We are immensely grateful to you for your contributions to this inquiry.

Appendix Five – Witnesses

24 November 2023
Parliament House, Macquarie Room, Sydney

Witness	Position and Organisation
Mr Richard Colbran	CEO, NSW Rural Doctors Network (RDN)
Dr Tom Douch	Deputy Chair, NSW Rural Doctors Network (RDN)
Dr Michael Bonning	President, Australian Medical Association (NSW)
Ms Fiona Davies	CEO, Australian Medical Association (NSW)
Ms Margaret Deerain	Director, Policy and Strategy Development, National Rural Health Alliance
Ms Clare Fitzmaurice	Policy and Data Analytics Officer, National Rural Health Alliance
Dr Rod Martin	College Councillor NSW, Australian College of Rural and Remote Medicine (ACRRM)
Dr Trevor Chan	Faculty Chair, Australasian College for Emergency Medicine
Dr Shamus Shepherd	Australasian College for Emergency Medicine
Dr Vicki Mattiazzo	The Royal Australian College of General Practitioners (RACGP) Rural
Dr Karin Jodlowski Tan	The Royal Australian College of General Practitioners (RACGP) Rural
Mr Luke Kelly	Pharmaceutical Society of Australia
Ms Karen Carter	Pharmaceutical Society of Australia
A/Prof Peter Thomas	Medical Workforce Policy and Advocacy Sub Committee Chair, Royal Australasian College of Medical Administrators (RACMA)
Mr Paul Miller	NSW Ombudsman
Ms Monica Wolf	Chief Deputy Ombudsman, NSW Ombudsman
Mr David McCann	Mayor, Coolamon Shire Council
Mr Tony Donoghue	General Manager, Coolamon Shire Council
Cr Darriea Turley AM	President, Local Government NSW
Cr Wendy Wilks	Convenor, Inverell Health Forum

Cr Joanne Williams	Inverell Health Forum
Dr Cheryl McIntyre	Inverell Health Forum
Mr Andrew McIntyre	Inverell Health Forum

27 November 2023
Parliament House, Macquarie Room, Sydney

Witness	Position and Organisation
Mr Scott Beaton	Vice President, Australian Paramedics Association (NSW)
Mr Gary Wilson	Delegate and former Secretary, Australian Paramedics Association (NSW)
Dr Antony Sara	President, Australian Salaried Medical Officers' Federation NSW (ASMOF)
Dr Choong-Siew Yong	Vice President, Australian Salaried Medical Officers' Federation NSW (ASMOF)
Dr Gabriel Lau	State Councillor, Australian Salaried Medical Officers' Federation NSW (ASMOF)
Mr Michael Whaites	Assistant General Secretary, New South Wales Nurses and Midwives' Association
Mr Paul Haines	Clinical Nurse Specialist, New South Wales Nurses and Midwives' Association
Mr Richard Weston	CEO, Maari Ma Health Aboriginal Corporation
Dr Marion Tait	Bulgarr Ngaru Medical Aboriginal Corporation
Dr Steven Skov	Bulgarr Ngaru Medical Aboriginal Corporation
Professor Vicki Flood	Director, University Centre for Rural Health, Northern Rivers
Dr Christine Ahern	University Centre for Rural Health, Northern Rivers
Professor Megan Smith	Executive Dean, Faculty of Science and Health, Charles Sturt University
Professor Julian Grant	Acting Head of School, School of Nursing, Paramedicine and Healthcare Sciences/ Professor of Nursing, Charles Sturt University
A/Prof Michael Curtin	Head of School, School of Allied Health, Exercise and Sports Sciences, Charles Sturt University
Ms Majella Gallagher	Advocacy and External Relations, Can Assist (Cancer Assistance Network)
Emma Phillips	Executive Director, Can Assist (Cancer Assistance Network)
Ms Jacqui Emery	CEO, Royal Far West

Ms Claire Taylor	Head of Strategy and Partnerships – Child and Family Services, Royal Far West
Dr Marcel Zimmet	Chief Medical Officer, Royal Far West
Ms Deborah Wilcox	Acting Secretary, NSW Health
Mr Phil Minns	Deputy Secretary, People, Culture and Governance, NSW Health, NSW Health
Mr Alfa D'Amato	Deputy Secretary, Financial Services and Asset Management and Chief Financial Officer, NSW Health
Mr Luke Sloane	Deputy Secretary, Regional Health, NSW Health

Appendix Six – Extracts from minutes

MINUTES OF MEETING NO. 1
2:05pm, 24 May 2023
Jubilee Room, Parliament House

Members present
Dr Joe McGirr (Chair), Ms Janelle Saffin (Deputy Chair), Ms Liza Butler, Ms Tanya Thompson, Mr Steve Whan, Mrs Leslie Williams.

Officers present
Leon Last, Matt Johnson, Jacqueline Linnane.

Apologies
Mr Clayton Barr.

Agenda Item

1. Appointment of committee
The Chair opened the meeting.
The Committee noted the following extracts from the Legislative Assembly Votes and Proceedings:

Legislative Assembly Votes and Proceedings no 3, Thursday 11 May 2023, entry no 13:
Mr Ron Hoenig moved, Notwithstanding anything to the contrary in the standing orders:

1) A select committee, to be known as the Legislative Assembly Select Committee on Remote, Rural and Regional Health be appointed

Terms of Reference

2) The committee will inquire into and report on health outcomes and access to health and hospital services in rural, regional and remote New South Wales, specifically:
    a) The implementation of the recommendations made by the Legislative Council Portfolio Committee No. 2 report Health outcomes and access to health and hospital services in rural, regional and remote New South Wales (the Portfolio Committee No.2 report);
    b) any matters relating to the report on progress and developments referred to in Recommendation 6 of the Portfolio Committee No. 2 report (Recommendation 6 report).
3) In undertaking (2), the committee can examine and report on the following matters relevant to the effective implementation of the recommendations of the Portfolio Committee No.2 report, or the Recommendation 6 report, relevant to the effective implementation of the recommendations including but not limited to:
    a) any matter referred to it by the House

b) any relevant legislation, policy, bill or subordinate legislation;
c) any relevant financial matter;
d) any relevant portfolio issue.

4) Legislative scrutiny - The committee, in undertaking (2), will have a legislative scrutiny function that shall include evaluating the policy impact and consequences for each portfolio of any bill relevant to implementation of the Portfolio Committee No.2 report or Recommendation 6 report introduced in Parliament, and any item of subordinate legislation.
5) Financial matters - The examination of financial matters by the committee in undertaking (2) includes the review of government financial management, as relevant to the implementation of the Portfolio Committee No. 2 Inquiry report and Recommendation 6 report, by considering the financial documents, expenditure, performance and effectiveness of any relevant government department, agency, statutory body or state-owned corporation.
6) Examination of annual and other reports – In undertaking (2), the committee may examine any matter in the annual report or other reports of any public body, including the adequacy and accuracy of all financial and operational information and any matter arising from the annual report or other report concerning the efficient and effective achievement of the agency's objectives.

Initiation of inquiries

7) The committee may be referred an inquiry by resolution of the House or in writing from a Minister.
8) Except in the case of bills, the committee also may initiate an inquiry on its own motion and report on any proposal, matter or thing relevant to its functions, including an annual report, other report or petition. The Committee can only consider a bill on referral from the House in accordance with standing order 323 (Legislation Committees).
9) The committee must take care not to duplicate an inquiry into any matters under examination by another portfolio or standing committee of the House, and any question arising in this connection may be referred to the House for determination.

Membership

10) The Committee is to consist of seven members, comprising:
    a) four government members,
    b) two opposition members; and
    c) one crossbench member.
11) Dr Joe McGirr shall be the Chair of the committee.
12) The Members shall be Dr Joe McGirr, Ms Janelle Saffin, Mr Clayton Barr, Ms Liza Butler, Mrs Tanya Thompson, Mrs Leslie Williams, and Mr Steve Whan.

Sub-committees

13) The Committee have the power to appoint sub-committees, consisting of 3 members, and to refer to a sub-committee any of the matters which the Committee is

empowered to consider. In this regard, the sub-committee may be responsible for conducting hearings, briefings, visits of inspections and other activities but cannot make decisions concerning the conduct of an inquiry, such as the selection of witnesses, and the Committee's reports.

14) A sub-committee have at least one member supporting the Government and one member not supporting the Government, and a quorum for a sub-committee shall be at least two members, one of whom must be a government member and one of whom must be an opposition member.

Visits of inspection

15) The committee have leave to make visits of inspection within the State of New South Wales, and other States and Territories of Australia and relevant international jurisdictions.

Other matters

16) The committee will have leave to sit during the sitting or any adjournment of the House.
17) That at any meeting of the committee three members shall constitute a quorum, one of whom must be a government member and one of whom must be an opposition member.
18) The committee will deliver a final report by no later than two years from its first meeting and may report to the House, at any stage, pending its final report.

Debate ensued.
Question put and passed.

2. Election of Deputy Chair

Resolved, on the motion of Mr Whan, seconded Mrs Williams:
That Ms Saffin be elected Deputy Chair of the Committee.

3. Administrative and staffing arrangements

The Chair introduced the Committee Director, Committee Manager and Legislative Assembly Engagement Manager.

4. Standard motions

Resolved, on the motion of Mrs Williams, seconded Mr Whan:
That unless the Committee resolves otherwise:

Conduct of proceedings

1. During any committee meeting, if a division or quorum is called in the Legislative Assembly, or either House in the case of joint committees, the meeting will be suspended until the committee regains quorum.
2. Conditions for the broadcasting, filming or photography of the committee's public proceedings will be determined by the committee on a case-by-case basis. Those

conditions shall be consistent with the Legislative Assembly's resolution of 9 May 2023; and the Assembly's guidelines for coverage of proceedings for parliamentary committees administered by the Legislative Assembly.

3. Witnesses appearing before the committee will not be represented by a member of the legal profession or other advocate.
4. Committee members can only use electronic devices unobtrusively during committee proceedings, so that they do not interfere with, or disrupt, the conduct of those proceedings.
5. Supplementary questions for witnesses, following a public hearing, shall be determined by the committee.
6. Media releases on behalf of the committee can only be made by the Chair; and where practicable, following consultation with the committee.

Administrative arrangements

7. Arrangements that facilitate or support committee proceedings and activities be delegated to the chair and the committee staff, to undertake in accordance with the committee's decisions.
8. Members nominated by the committee to undertake site visits are expected, where practicable, to participate in the full itinerary.
9. The Chair and the Committee Director, through the Clerk of the Legislative Assembly, be authorised to liaise with the Speaker on approvals for committee expenditure.

Communications and engagement

10. The Legislative Assembly's Engagement Team will support and promote the work of the committee. The Team will implement any agreed media and engagement strategy and coordinate the production of media and other promotional activity with the Chair.

5. Method and timeline of the Committee's work programme

The Chair outlined some options for the Committee's initial work programme.
Discussion ensued.
The Committee agreed that the secretariat will draft a research paper on issues relating to the Committee's terms of reference.

6. Private briefing

The Committee considered holding a private briefing with Government stakeholders as an initial step in the inquiry process.
Resolved, on the motion of Ms Butler, seconded Ms Saffin, that the Committee write to the Minister of Health and Secretary, NSW Health, requesting a private briefing with representatives of NSW Health.

7. Next Meeting

The meeting adjourned at 2:27pm until a time and date to be determined.

MEETING NO. 2
2.02 pm, 26 June 2023
Preston Stanley Room

Members present
Dr Joe McGirr MP (Chair), Ms Janelle Saffin MP (Deputy Chair), Mr Clayton Barr MP, Ms Liza Butler MP, Mrs Tanya Thompson MP, Mr Steve Whan MP, Mrs Leslie Williams MP.

Officers present
Leon Last, Matt Johnson, Alison Buskens, Ilana Chaffey, Caitlin Bailey.

Agenda Item

1. Confirmation of minutes
Resolved, on the motion of Ms Butler, seconded by Mr Whan: That the minutes of the meeting of 24 May 2023 be confirmed.

2. Briefing
Resolved, on the motion of Mr Whan, seconded by Mrs Thompson: That the Committee admit the following representatives of NSW Health and the Ministry of Health to the meeting for a briefing on issues related to the Committee's inquiry:

- Susan Pearce AM – Secretary, NSW Health
- Luke Sloane – Coordinator General Regional Health
- Deb Willcox AM – Deputy Secretary, Health System Strategy and Patient Experience
- Matthew Daly - Deputy Secretary, System Sustainability and Performance
- Phil Minns - Deputy Secretary, People, Culture and Governance
- Jenelle Rimmer – Deputy Chief of Staff, Director of Policy, Office of the Minister for Health, Regional Health, Illawarra and South Coast

Ms Pearce, Mr Sloane, Ms Willcox, Mr Daly, Mr Minns, and Ms Rimmer entered the room at 2.11 pm.
Ms Pearce, Mr Sloane, Ms Willcox, Mr Daly, Mr Minns, and Ms Rimmer briefed the Committee and answered questions from members.
The briefing concluded and Ms Pearce, Mr Sloane, Ms Willcox, Mr Daly, Mr Minns, and Ms Rimmer the left the room at 3.40 pm.

3. Conduct of inquiry
The Committee discussed areas of interest and options for conducting its inquiry.

4. Next meeting
The meeting adjourned at 3.59 pm until 10 am, Thursday 6 July 2023.

MINUTES OF MEETING NO. 3
10.03 AM, 6 July 2023
Room 1254, Parliament House and via Webex

Members present
Dr Joe McGirr MP (Chair), Ms Janelle Saffin MP (Deputy Chair), Mr Clayton Barr MP, Ms Liza Butler MP, Mr Steve Whan MP, The Hon Leslie Williams MP.

Apologies
Mrs Tanya Thompson MP

Officers present
Leon Last, Matt Johnson, Alison Buskens and Nicolle Gill.

Agenda item
The Chair opened the meeting and acknowledged the traditional owners of the land, thanking them for their custodianship of country.

1. Forward work plan

1.1 Further information from NSW Health and Ministers
Committee discussed information to request from NSW Health, following the private briefing held on 26 June.

Resolved, on the motion of Mr Barr, seconded by Mrs Williams: That the Chair write to NSW Health requesting information to be provided to the Committee by 31 July 2023, including:

- A copy of the independent review of progress implementing actions from the PC2 inquiry, prepared by Ernst & Young
- Information on the key performance indicators related to the delivery of the NSW Regional Health Strategic Plan 2022-2032
- Background information on how NSW Health funding models work, particularly in relation to remote, rural and regional health
- Commentary on the results of the two most recent People Matter Employee Surveys, in relation to workplace culture, and how NSW Health has responded to these results
- Information that identifies what mental health inquiries have been done in the past 5 years, any recommendations these inquiries have made, and NSW Health's response to any recommendations made.

***

1.2 Inquiry into the implementation of recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health.
The Committee discussed its forward work plan, and considered draft terms of reference for an inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health.

Resolved on the motion of Mr Whan, seconded Mrs Williams, that:

- That the Committee conduct an inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding for remote, rural and regional health services and programs, in accordance with the draft terms of reference, as amended.
- That the secretariat circulate a list of stakeholders to members, and that members have 3 business days after receiving that list to provide further input.
- That the Committee call for submissions and advertise the inquiry on the Committee's webpage.
- That the closing date for submissions be Friday, 22 September 2023.
- That key stakeholders identified by the Committee be informed of the inquiry and invited to make a submission.
- That the Chair issue a media release and promotional video announcing the inquiry.

The Committee agreed that the secretariat will draft and publish material to provide guidance for stakeholders when preparing submissions.

2. ***

3. Confirmation of minutes

Resolved, on the motion of Mrs Williams, seconded by Ms Butler: That the minutes of the meeting of 26 June 2023 be confirmed.

4. Next Meeting

Committee discussed the timing of the next meeting.

The meeting adjourned at 10.49 am.

MINUTES OF MEETING NO. 4

2.04 PM, 18 September 2023

Room 1254, Parliament House and via Webex

Members present

Dr Joe McGirr MP (Chair), Ms Janelle Saffin MP (Deputy Chair), Mr Clayton Barr MP, Ms Liza Butler MP, Mr Steve Whan MP and Mrs Tanya Thompson.

Apologies

The Hon Leslie Williams MP.

Officers present

Leon Last, Matt Johnson, Alex Read and Nicolle Gill

Agenda Item

1. Confirmation of minutes

Resolved, on the motion of Mr Whan, seconded Ms Butler:
That the minutes of the meeting of 6 July 2023 be confirmed.

2. Briefing note on the confidentiality of Committee proceedings and documents

Resolved, on the motion of Mrs Thompson, seconded Ms Butler: That the Committee notes the circulated briefing note on the confidentiality of Committee proceedings and documents.

3. Response and additional information from Secretary, NSW Health

The Committee considered the letter and attachments from Ms Susan Pearce, Secretary, NSW Health, received 16 August 2023, responding to the Committee's request for additional information, following the private briefing with NSW Health on 26 June 2023.

Resolved, on the motion of Ms Saffin, seconded Ms Butler: That the Chair write to the Secretary, NSW Health, thanking her for the information provided and noting that the Committee may request further information at a later time.

Resolved, on the motion of Mrs Thompson, seconded Mr Barr: That the letter and attachments received from the Secretary be published on the Committee's website.

4. Inquiry into PC2 recommendations relating to workforce issues, workplace culture, and funding considerations for remote, rural and regional health

4.1 Submissions received

The Committee considered the 7 submissions received to date.

Resolved, on the motion of Mr Whan, seconded Mr Barr:

- That submission 1 be accepted by the Committee and published with redactions and name withheld on the Committee's webpage;
- That submissions 2, 3 and 5 be accepted and kept confidential to the Committee; and
- That submissions 4, 6 and 7 be accepted by the Committee and published in full on the Committees webpage.

4.2 Extension of submission deadline

The Committee considered extending the deadline for submissions.

Resolved, on the motion of Mrs Thompson, seconded by Mr Barr: That the Committee extend the deadline for submissions until 13 October 2023 and write to any stakeholders previously notified, advising them of the extension.

Resolved, on the motion of Mr Barr, seconded by Ms Saffin:

- That the Chair issue a media release announcing the extension of the deadline for submissions; and
- That the relevant details be updated on the Committee's webpage.

4.3 Inquiry timeline

The Committee discussed its plans for the inquiry, including site visits, public hearings and additional private briefings with health stakeholders.

The Committee considered conducting site visits in the Grafton-Tenterfield region.
***

Resolved, on the motion of Mrs Thompson, seconded Mr Whan: That the Committee, subject to funding approval from the Speaker, undertake up to four days of site visits in relation to the inquiry into PC2 recommendations relating to workforce issues, workplace culture and funding considerations.

Resolved, on the motion of Ms Butler, seconded Ms Saffin: That the Committee undertake a public hearing in November or December.

Resolved, on the motion of Ms Saffin, seconded Mrs Thompson: That the Committee requests the secretariat to prepare a research paper and if required, commission research on different health funding models.

5. *

6. *

7. Next meeting

The meeting adjourned at 3:00pm until a time and date to be determined.

MINUTES OF MEETING NO. 5
3.58 PM, 30 October 2023
McKell Room, Parliament House and via teleconference

Members present
Dr Joe McGirr MP (Chair), Ms Janelle Saffin MP (Deputy Chair; Webex), Mr Clayton Barr MP (Webex), Ms Liza Butler MP, Mrs Tanya Thompson MP, and The Hon. Leslie Williams MP (Webex).

Apologies
Ms Trish Doyle MP.

Officers present
Leon Last, Matt Johnson, Alex Read and Nicolle Gill

Agenda Item

1. Confirmation of minutes

Resolved, on the motion of Ms Butler, seconded Mrs Thompson:
That the minutes of the meeting of 18 September 2023 be confirmed.

2. Membership changes

The Committee noted the extract from the Legislative Assembly Votes and Proceedings, no 32, entry no 12:

12 PARLIAMENTARY COMMITTEE MEMBERSHIP

2) Trisha Lee Doyle be appointed to serve on the Legislative Assembly Committee on Remote, Rural and Regional Health in place of Steven James Robert Whan, discharged.

3. Submissions received for the inquiry into PC2 recommendations relating to workforce issues, workplace culture, and funding considerations for remote, rural and regional health

The Committee considered the 43 submissions received since the previous meeting.
Resolved, on the motion of Mrs Thompson, seconded Mr Barr:

- That submission 29 be accepted and published with redactions and name withheld on the Committee's webpage;
- That submissions 16, 18 and 28 be accepted and kept confidential to the Committee; and
- That submissions 8-15, 17, 19-27 and 29-51 be accepted by the Committee and published in full on the Committee's webpage.

***

4. Briefing with the Chief Executives of Local Health Districts and the Secretary, NSW Health

Resolved, on the motion of Ms Butler, seconded Ms Saffin:
That the Committee admit the following representatives of NSW Health and the Ministry of Health to brief the Committee on issues related to the Committee's inquiry:

- Susan Pearce AM – Secretary, NSW Health
- Luke Sloane – Deputy Secretary, Regional health
- Brad Astill – Chief Executive, Far West LHD
- Tracey McCosker – Chief Executive, Hunter New England LHD
- Stewart Dowrick – Chief Executive, Mid North Coast LHD
- Jill Ludford – Chief Executive, Murrumbidgee LHD
- Tracey Maisey – Chief Executive – Northern NSW LHD
- Margaret Bennett – Chief Executive, Southern NSW LHD
- Mark Spittal – Chief Executive, Western NSW LHD
- Lee Gregory – A/Chief Executive, Nepean Blue Mountains

- Sonia Marshall – A/Chief Executive, South Western Sydney
- Scott McLachlan – Chief Executive, Central Coast LHD

Ms Pearce and Mr Sloane entered the room, and Mr Astill, Ms McCosker, Mr Dowrick, Ms Ludford, Ms Maisey, Ms Bennett, Mr Spittal, Mr Gregory, Ms Marshall and Mr McLachlan joined via teleconference at 4.04pm.

The representatives from NSW Health and the Ministry of Health briefed the Committee.

The briefing concluded and the representatives from NSW Health and the Ministry of Health left the meeting at 5.19pm.

5. Site visits for current inquiry

5.1 Travel arrangements

The Committee discussed arrangements for its upcoming site visits in Grafton, Tenterfield and Armidale, from 31 October to 2 November.

5.2 Correspondence

The Committee noted letters from the Chair to the Minister for Health and Regional Health, and to the Secretary, NSW Health, in relation to the upcoming site visits, sent on 20 October 2023.

Committee noted reply letter from the Secretary, NSW Health, received 25 October 2023.

Resolved, on the motion of Ms Butler, seconded Mrs Thompson:

That, following the conclusion of the site visits, the Committee write to the Secretary, NSW Health, and Minister for Health and Regional Health, to thank them for their assistance organising the site visits.

6. Next meeting

The Committee adjourned the meeting at 5:28pm until 31 October 2023.

MINUTES OF MEETING NO. 6

12:52pm, 24 November 2023
Macquarie Room, Parliament House, and videoconference

Member present
Dr Joe McGirr (Chair), Mr Clayton Barr, Ms Liza Butler, Mrs Tanya Thomson, Ms Trish Doyle, Mrs Leslie Williams

Apologies
Ms Janelle Saffin (Deputy Chair).

Officers present
Leon Last, Rohan Tyler, Matt Johnson, Madelaine Winkler, Sukhraj Goraya, Nicolle Gill.

Agenda Item

1. Confirmation of minutes
Resolved, on the motion of Ms Butler, seconded by Mrs Thompson: That the minutes of the meeting of 30 October 2023 be confirmed.

2. Correspondence
The Committee noted the letter from Ms Susan Pearce, Secretary, NSW Health, received 31 October 2023, providing further information on the progress of actions relating to recommendations 41 and 44 of the Portfolio Committee No 2 inquiry.

3. Pre-hearing procedural resolutions
The Committee considered the notice of hearing and witnesses.

Resolved, on the motion of Mrs Williams, seconded by Ms Doyle:

- That the Committee invites the witnesses listed in the notice of the public hearing for Friday, 24 November 2023 to give evidence in relation to the inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health.
- That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 24 November 2023, in accordance with the Legislative Assembly's resolution of 9 May 2023; and the Assembly's guidelines for coverage of proceedings for parliamentary committees administered by the Legislative Assembly.
- That the Committee adopt the following process in relation to supplementary questions:
    - Members to email any proposed supplementary questions for witnesses to the secretariat by 5pm, Friday 1 December 2023;
    - Secretariat to then circulate all proposed supplementary questions to Committee, with members to lodge any objections to the questions by 5pm, Monday 4 December 2023.
- That witnesses be requested to return answers to questions taken on notice and any supplementary questions within 14 days of the date on which the questions are forwarded to witnesses.

The Chair adjourned the meeting at 1:01pm.

4. Public hearing

Witnesses and the public were admitted. The Chair opened the public hearing at 1:02 pm and made a short opening statement.

Mr Richard Colbran, CEO, and Dr Tom Douch, Deputy Chair, NSW Rural Doctors Network, were sworn and examined.
Dr Michael Bonning, President, and Ms Fiona Davies, CEO, Australian Medical Association (NSW), were affirmed and examined.
Ms Margaret Deerain, Director, Policy and Strategy Development, and Ms Clare Fitzmaurice, Policy and Data Analytics Officer, National Rural Health Alliance, before the Committee via videoconference, were sworn and examined.,
Dr Rod Martin, College Councillor NSW, Australian College of Rural and Remote Medicine, before the Committee via videoconference, was sworn and examined.

Ms Deerain, Dr Douch, Mr Colbran, and Dr Bonning each made an opening statement. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

Dr Trevor Chan, Faculty Chair, and Dr Shamus Shepherd, Australasian College for Emergency Medicine, were sworn and examined.,
Dr Vicki Mattiazzo, Royal Australian College of General Practitioners, Rural, before the Committee via videoconference, was affirmed and examined. Dr Karin Jodlowski-Tan, Royal Australian College of General Practitioners, Rural, before the Committee via videoconference, was sworn and examined.
Ms Karen Carter, and Mr Luke Kelly, Pharmaceutical Society of Australia, before the Committee via videoconference, were affirmed and examined.
Associate Professor Peter Thomas, Medical Workforce Policy and Advocacy Sub Committee Chair, Royal Australasian College of Medical Administrators, before the Committee via videoconference, was affirmed and examined.

The Chair noted that he and A/Prof. Thomas both serve as members of the policy advisory committee at the Royal Australasian College of Medical Administrators in a voluntary capacity.

The Chair noted he is a retired fellow of the Australasian College for Emergency Medicine.

Dr Chan, Dr Mattiazzo, Mr Kelly, and A/Prof. Thomas each made an opening statement. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair adjourned the hearing at 3:00 pm.

The Chair resumed the hearing at 3:30 pm.

Mr Paul Miller, NSW Ombudsman, was affirmed and examined. Ms Monica Wolf, Chief Deputy Ombudsman, NSW Ombudsman, was affirmed and examined.

Mr Miller made an opening statement. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

Mr David McCann, Mayor, and Mr Tony Donoghue, General Manager, Coolamon Shire Council, were sworn and examined.
Councillor Darriea Turley, AM, President, Local Government NSW, before the Committee via videoconference, was affirmed and examined.
Councillor Wendy Wilks, Convenor, Inverell Health Forum, was affirmed and examined.
Councillor Joanne Williams, Dr Cheryl McIntyre, and Mr Andrew McIntyre, Inverell Health Forum, were sworn and examined.

Cr Wilks, Dr McIntyre, Mr McCann, Mr Donoghue and Cr Turley each made an opening statement. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair adjourned the meeting at 5:01 pm.

5. Post-hearing deliberative meeting
The Committee commenced a deliberative meeting at 5:03 pm.

5.1 Publication orders
Resolved, on the motion of Mr Barr, seconded by Ms Williams that the corrected transcript of public evidence today be authorised for publication and uploaded on the Committee's webpage.

6. General business
The Committee requested that advice be given to witnesses regarding the length of their opening statements.
The Committee also noted a virtual consultation with Tenterfield stakeholders will be arranged for early 2024, following the cancelled site visit in November.

7. Next meeting
The meeting adjourned at 5:07 pm, until 8:50 am on 27 November 2023

MINUTES OF MEETING NO. 7
8:53AM, 27 November 2023
Macquarie Room, Parliament House, and Teleconference

Member present
Dr Joe McGirr (Chair), Ms Janelle Saffin (Deputy Chair), Mr Clayton Barr, Ms Liza Butler, Mrs Tanya Thomson, Ms Trish Doyle, Mrs Leslie Williams.

Apologies
Nil.

Officers present
Leon Last, Matt Johnson, Madelaine Winkler, Sukhraj Goraya, Nicolle Gill.

Agenda Item

1. Late submissions received for inquiry into PC2 recommendations relating to workforce issues, workplace culture, and funding considerations for remote, rural and regional health

1.1 Submission from Faculty of Medicine and Health, University of New England (UNE)
A late submission was received from the Faculty of Medicine and Health, UNE, on 20 November 2023.
Resolved, on the motion of Mr Barr, seconded by Ms Doyle, that the submission from the Faculty of Medicine and Health, University of New England, be accepted as a late submission (52) and published on the Committee's website.

1.2 Submission from Ms Vanessa Landenberger
Ms Landenberger provided a statement and related correspondence from NSW Health during the Committee's site visit to Grafton Base Hospital, on 31 October 2023, which she subsequently asked to be treated as a submission.
Resolved, on the motion of Ms Doyle, seconded by Mrs Williams, that Ms Landenberger's statement and attached letter from NSW Health be accepted as a late submission (53) and published with redactions on the Committee's website.

2. Pre-hearing procedural resolutions
Committee considered the notice of hearing and witnesses.

Resolved, on the motion of Mrs Williams, seconded by Mr Barr:

- That the Committee invites the witnesses listed in the notice of the public hearing for Monday, 27 November 2023 to give evidence in relation to the inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health.
- That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 27 November 2023, in accordance with the Legislative Assembly's resolution of 9 May 2023; and the Assembly's guidelines for

coverage of proceedings for parliamentary committees administered by the Legislative Assembly.

- That the Committee adopt the process for supplementary questions for the hearing of 27 November 2023, as agreed to during the meeting of 24 November 2023.

The Chair adjourned the meeting at 9:01am.

3. Public hearing

Witnesses and the public were admitted. The Chair opened the public hearing at 9:03 am and made a short opening statement.

Mr Scott Beaton, Vice President, Australian Paramedics Association (NSW), before the Committee via videoconference, was affirmed and examined. Mr Gary Wilson, Delegate and former Secretary, Australian Paramedics Association (NSW), before the Committee via videoconference, was sworn and examined.
Dr Antony Sara, President, and Dr Choong-Siew Yong, Vice President Australian Salaried Medical Officers' Federation NSW, were sworn and examined., Dr Gabriel Lau, State Councillor, Australian Salaried Medical Officers' Federation NSW, was affirmed and examined.
Mr Michael Whaites, Assistant General Secretary, and Mr Paul Haines, Clinical Nurse Specialist, before the Committee via videoconference, New South Wales Nurses and Midwives' Association, were affirmed and examined.

Mr Beaton, Mr Whaites, Dr Sara, Dr Yong and Dr Lau each made opening statements. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

Mr Richard Weston CEO, Maari Ma Health Aboriginal Corporation, was sworn and examined. Dr Marion Tait, and Dr Steven Skov Bulgarr Ngaru Medical Aboriginal Corporation, before the Committee via videoconference, were affirmed and examined.

Dr Skov and Mr Weston each made opening statements. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair adjourned the hearing at 10:47am.

The Chair resumed the hearing at 11:01am.

Professor Vicki Flood, Director, University Centre for Rural Health, Northern Rivers, before the Committee via videoconference, was affirmed and examined. Dr Christine Ahern, University Centre for Rural Health, was affirmed and examined.
Professor Megan Smith, Executive Dean, Faculty of Science and Health, Professor Julian Grant, Acting Head of School, School of Nursing, Paramedicine and Healthcare Sciences, and Associate Professor Michael Curtin, Head of School, School of Allied Health, Exercise and Sports Sciences, Charles Sturt University, before the Committee via videoconference, were affirmed and examined.

Professor Flood and Professor Smith each made opening statements. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

Ms Majella Gallagher, Advocacy and External Relations, Can Assist, was sworn and examined.
Ms Emma Phillips, Executive Director, Can Assist, was affirmed and examined.
Ms Jacqui Emery, Chief Executive Officer, Royal Far West, was affirmed and examined. Ms Claire Taylor, Head of Strategy and Partnerships Child and Family Services, and Dr Marcel Zimmet, Chief Medical Officer, Royal Far West, were sworn and examined.

Ms Emery and Ms Gallagher each made opening statements. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair adjourned the hearing at 12:31pm.

The Chair resumed the hearing at 1:06pm.

Ms Deborah Wilcox, Acting Secretary, and Mr Luke Sloane, Deputy Secretary, Regional Health, NSW Health, were affirmed and examined. Mr Phil Minns, Deputy Secretary, People, Culture and Governance, and Mr Alfa D'Amato, Deputy Secretary, Financial Services and Asset Management and Chief Financial Officer, NSW Health, were sworn and examined.

Ms Wilcox and Mr Sloane each made opening statements. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair closed the hearing at 3:00pm.

4. Post-hearing deliberative meeting

The Chair resumed the meeting at 3:03pm.

4.1 Publication orders

Resolved, on the motion of Ms Saffin, seconded by Mrs Doyle that the corrected transcript of public evidence given today be authorised for publication and uploaded on the Committee's webpage.

4.2 Acceptance and publication of tendered documents

Resolved, on the motion of Mrs Thompson, seconded by Ms Butler, that the Committee accept and publish the following documents:

- Letter from New South Wales Nurses and Midwives' Association to the Chair, dated 27 November 2023

4.3 Written questions to Royal Flying Doctors Service

Resolved, on the motion of Ms Doyle, seconded by Ms Saffin, that the Committee provide written questions to the Royal Flying Doctor Service (South Eastern Section) due to their inability to appear at the public hearing.

5. ***

6. General business

***

7. Next meeting

The meeting adjourned at 3:12pm until a time and date to be determined.

MINUTES OF MEETING NO. 8

9:01 AM 9 February 2024
Room 1254, Parliament House and via Webex

Members present

Dr Joe McGirr (Chair) (videoconference), Mr Clayton Barr, Ms Liza Butler, Ms Trish Doyle, Mrs Tanya Thompson, and Mrs Leslie Williams

Apologies

Ms Janelle Saffin (Deputy Chair)

Officers present

Leon Last, Matt Johnson, Madelaine Winkler, Nicolle Gill, and Mohini Mehta

Agenda item

1. Confirmation of minutes

Resolved on the motion of Ms Doyle, seconded Mr Barr, that the minutes of the meetings of 24 November and 27 November 2023 be confirmed.

2. Inquiry into Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations

2.1 Documents tendered during public hearings

The Committee considered documents tendered by the NSW Ombudsman on 24 November 2023.

Resolved on the motion of Mrs Williams, seconded Ms Butler that the Committee accept and publish the following documents tendered by the NSW Ombudsman during the public hearing on 24 November 2023:

- Letter from the NSW Ombudsman to the Minister for Regional Health, dated 31 May 2022
- Letter from the NSW Ombudsman to the Chair of the Committee on the Ombudsman, the Law Enforcement Conduct Commission and the Crime Commission, dated 9 December 2022.

2.2 Late submissions

A late submission was received from Bulgarr Ngaru Medical Aboriginal Corporation, on 29 November 2023.

Resolved on the motion of Ms Thompson, seconded Ms Doyle that the submission from Bulgarr Ngaru Medical Aboriginal Corporation be accepted as a late submission (54) and published on the Committee's website.

The Committee noted that Dr Charlotte Hall, Human Factors Consultancy and Dr Jillian Farmer, CEO, A Better Culture had also indicated that they would provide late submissions. The Committee agreed that the Secretariat should circulate these submissions when they are received.

2.3 Answers to questions on notice and supplementary questions

The Committee considered answers to questions on notice and supplementary questions received from the following organisations:

- Bulgarr Ngaru Medical Aboriginal Corporation, received 29 November 2023 and 20 December 2023
- Coolamon Shire Council, received 11 December 2023
- Local Government NSW, received 14 December 2023
- NSW Ombudsman, received 14 December 2023 and 20 December 2023
- Royal Australian College of General Practitioners Rural, received 14 December and 20 December 2023
- Charles Sturt University, received 15 December 2023
- Royal Far West, received 18 December 2023
- Royal Australasian College of Medical Administrators, received 19 December 2023
- Can Assist (Cancer Assistance Network), received 19 December 2023 and 15 January 2024
- Australian Medical Association (NSW), received 20 December 2023National Rural Health Alliance, received 20 December 2023
- Australasian College for Emergency Medicine, received 20 December 2023
- Inverell Health Forum, received 20 December 2023
- New South Wales Nurses and Midwives' Association, received 20 December 2023
- Pharmaceutical Society of Australia, received 20 December 2023
- Royal Flying Doctors Service (South Eastern Division), received 21 December 2023

    - Questions were sent to the Royal Flying Doctors Service as correspondence, after they were unable to attend the public hearings.
- Australian College of Rural and Remote Medicine, received 21 December 2023
- Rural Doctors Network, received 22 December 2023 and 24 January 2024
- Australian Salaried Medical Officers' Federation NSW, received 5 January 2024
- NSW Health, received 29 January 2024
- Australian Paramedics Association (NSW), received 31 January 2024
- University Centre for Rural Health, Northern Rivers, received 31 January 2024.

***

Resolved on the motion of Ms Doyle, seconded Mrs Williams that the Committee:

- Accept the responses to questions on notice from the Australian Medical Association (NSW) and Local Government NSW, and publish them on its website with attached correspondence removed and contact details redacted.
- Accept all other answers to questions on notice and supplementary questions, as listed in the agenda, and publish them on its website, with contact details redacted.

2.4 Briefing paper on funding models

The Committee noted the briefing paper on funding models in the NSW health system, which was previously circulated.

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2.5 Committee visit to NSW Health, St Leonards

The Committee noted that it has been invited to attend NSW Health's St Leonards office, for a demonstration of their staff complaints portal on Friday, 15 March.

***

3. *

4. *

5. Private meeting with Tenterfield stakeholders

The Committee held two private consultation sessions with health stakeholders based in Tenterfield.

Resolved on the motion of Ms Doyle, second Mrs Thompson:

That the Committee admit the following representatives of NSW Health to discuss issues relating to the Committee's current inquiry:

- Ms Susan Heyman, Executive Director, Rural and Regional Health Services, Hunter New England Local Health District
- Ms Lisa Ramsland, Health Service Manager, Tablelands Sector, and General Manager, Armidale Hospital
- Mr Tony Roberts, Health Service Manager, Tenterfield Hospital
- Ms Michelle Whiteley, Director of Nursing & Midwifery, Armidale Hospital

***

6. Next meeting

The meeting adjourned at 12:39pm until a time and date to be determined.

MINUTES OF MEETING NO. 9
2.32 pm, 8 April 2024
Videoconference via Webex

Members present
Dr Joe McGirr (Chair), Ms Janelle Saffin (Deputy Chair), Mr Clayton Barr, Ms Liza Butler, Ms Trish Doyle, Mrs Tanya Thompson, and Mrs Leslie Williams

Apologies
None

Officers present
Leon Last, Matt Johnson, Madelaine Winkler, Sukhraj Goraya, Nicolle Gill

Agenda item

1. Confirmation of minutes
Resolved on the motion of Mrs Thompson, seconded Ms Doyle, that the minutes of the meetings of 24 November and 9 February 2023 be confirmed.
The Committee agreed to redact certain confidential information from previous meetings' minutes when those minutes are published in tabled reports.

2. Committee's first inquiry (PC2 recommendations relating to workforce issues, workplace culture, and funding considerations for remote, rural and regional health)

2.1 Late submissions
The Committee considered late submissions from Dr Jillann Farmer, A Better Culture and Dr Charlotte Hall, Consultant, Human Factors Consultancy, received on 9 and 16 February 2024, respectively.

Resolved on the motion of Mr Barr, seconded Mrs Williams:
That the Committee accept and publish the submissions from A Better Culture (Submission 55) and Dr Charlotte Hall (Submission 56).

2.2 Answers to supplementary questions
Resolved on the motion of Ms Saffin, seconded Ms Doyle, that the Committee accept the response to supplementary questions and questions on notice from Australian Salaried Medical Officers' Federation NSW (ASMOF) and publish them on its website with the attachments kept confidential to the Committee.

2.3 Consultations and meetings

The Committee considered the following documents following the Committee's virtual consultation with Tenterfield stakeholders on 9 February 2024:

- ***

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***

The Chair provided an update on a second session he attended at NSW Health, St Leonards on 3 April 2024, for further discussions regarding the complaints portal.

3. ***

4. Correspondence

4.1 ***

4.2 Outgoing correspondence to Treasurer and Minister for Health, Regional Health

The Committee discussed the findings of the Nous report titled 'Evidence base for additional investment in rural health in Australia'.

Resolved on the motion of Mr Barr, seconded by Mrs Thompson, that the Committee write to the NSW Treasurer and Minister for Health and Regional Health, noting the current expenditure gap in health care between urban and non-urban populations due to a significant degree of workforce shortages and market constraints, and urging them to work with the Commonwealth to develop models that would allow additional Commonwealth expenditure to be provided via the state government, with a view to providing better health services in rural and remote communities.

5. Next meeting

The meeting adjourned at 3:20pm until the site visit on 15 April 2024.

MINUTES OF MEETING NO. 10

2.33 pm, 20 May 2024
Room 1254 and Webex videoconference

Members Present

Dr Joe McGirr (Chair, via Webex), Mr Clayton Barr, Ms Liza Butler (via teleconference), Ms Trish Doyle (via Webex), and The Hon Leslie Williams (via Webex)

Apologies

Ms Janelle Saffin (Deputy Chair), Mrs Tanya Thompson

Officers Present
Leon Last, Matt Johnson, Madelaine Winkler, Sukhraj Goraya, Nicolle Gill, Karena Li

Agenda Item

1. Confirmation of minutes
Resolved on the motion of Ms Doyle, seconded Mr Barr, that the minutes of the meeting of 8 April 2024 be confirmed.

2. ***

3. ***

4. Additional information requested from NSW Health
The Committee noted information provided by NSW Health ***

The Committee noted additional information ***has not been received yet.

5. Next meeting
The meeting adjourned at 2:48pm until the site visit on Monday, 27 May 2024.

UNCONFIRMED MINUTES OF MEETING NO. 14
2:03 pm, 2 August 2024
Room 1136 and Webex videoconference

Members Present
Dr Joe McGirr (Chair), Ms Janelle Saffin (Deputy Chair) (via Webex), Mr Clayton Barr, Ms Liza Butler (via Webex), Mrs Tanya Thompson (via Webex) and The Hon Leslie Williams (via Webex).

Apologies
Ms Trish Doyle

Officers Present
Leon Last, Matthew Johnson, Sukhraj Goraya, Madelaine Winkler, Nicolle Gill, and Karena Li.

Agenda Item
1. Confirmation of minutes

Resolved, on the motion of Ms Butler, seconded by Mrs Thompson: That the minutes of the meetings of 31 May and 3 June 2024 be confirmed.

2. Inquiry into the implementation of PC2 recommendations relating to the workforce issues, workplace culture and funding considerations

2.1. Recording of meeting

Resolved, on the motion of Mrs Williams, seconded by Ms Butler: That the Committee agrees to record the meeting for the purposes of committee staff preparing the minutes and report amendments, and that the recording be deleted when the report is tabled.

2.2. Consideration of the Chair's draft report

Resolved on the motion of Mr Barr, seconded by Mrs Williams: That the draft report be considered chapter by chapter.

2.2.1. Amendments

The Committee considered the report summary.
Resolved on the motion of Mrs Williams, seconded by Mr Barr: That the summary stand part of the report.

The Committee considered Chapter One of the report.
Resolved on the motion of Ms Saffin, seconded Mr Barr:

- That a new recommendation, Recommendation 3, be inserted after Recommendation 2 that reads: 'That, in the design of future incentive schemes, NSW Health should ensure that there is sufficient flexibility at a local level, to implement incentives to their best effect, and that current staff should not be unnecessarily disadvantaged when compared to new staff.'

- That a new paragraph be inserted after 1.26 that reads: 'The Committee notes that there appears to be a lack of flexibility in the introduction of the Incentive Scheme at the local level. During site visits, stakeholders raised concerns with the Committee that the Scheme may preference new staff over existing staff that may already be in place. The Committee recommends that, in the design of any future schemes, there is sufficient flexibility to allow Local Health Districts to implement incentive schemes to their best effect. Furthermore, future schemes should ensure that existing staff are not disadvantaged in receiving incentive payments, when compared with new recruits.'

  Motion carried.

Resolved on the motion of Mr Barr: That the words 'remuneration, training, working conditions and workplace culture' are omitted from Finding 3, and replaced with the words 'training, working conditions, workplace culture and remuneration' so that the finding reads 'The challenge of recruiting and retaining health workers to regional NSW is multifaceted, and one-off financial incentives need to be supported by longer-term improvements to training, working conditions, workplace culture and remuneration'.
Motion carried.

Resolved, on the motion of Mr Barr: That the word 'is' be omitted following 'virtual care' from paragraph 1.39, and the words 'and primary health models are' are

inserted, so that the sentence reads 'Virtual care and primary health models are discussed further in Chapter 4'. Motion carried.

Resolved on the motion of Mr Barr: That two new paragraphs be inserted after paragraph 1.89:

- A new paragraph 1.90 be inserted that reads, 'The challenge of retaining health workers in RRR communities should be approached holistically. The Committee has heard of numerous service deficits that should be addressed in order to support the retention of healthcare workers in the regional health system. For example, several stakeholders pointed to the challenges of accessing childcare services in RRR communities and the need to improve this access to support worker recruitment and retention. [Insert footnote: Submission 9, Can Assist (Cancer Assistance Network), p 4; Submission 13, Australasian College for Emergency Medicine, p 6; Submission 37, Local Government NSW, p 9; Submission 50, p 15; Answers to supplementary questions, National Rural Health Alliance, 20 December 2023, p 10.] The New South Wales Nurses and Midwives' Association submitted that:

  > Establishing extended hours childcare facilities at hospitals or ensuring places are available to the children of nurses and midwives within communities could significantly support increasing the workforce in RRR communities. [Insert footnote: Submission 50, p 15]

- A new paragraph 1.91 be inserted that reads, 'During its site visits, the Committee heard about various initiatives across the state that could be deployed more consistently. For example, we are aware of some health facilities that have played a coordinating role in establishing social connections for their staff that have recently relocated to regional NSW, such as sports activities and trivia nights. There are also some workplaces that have provided flights for their staff to briefly return to their "home" cities in order to retain social connections with their families (social isolation is also discussed further in Chapter Three). Solutions such as these should be considered as critical elements in the broader efforts to retain health workers in regional NSW.

Motion carried.

Resolved on the motion of Mr Barr: That two new sentences, be inserted at the end of paragraph 1.117 after the words 'additional RRR areas', that read, 'The Committee also recognises that some local councils are active in providing housing for healthcare staff in RRR areas and commend them for this work. We discuss the role of local councils in further detail in Chapter Four.' Motion carried.

Resolved on the motion of Mr Barr, seconded by Mrs Thompson: that a new sentence be inserted at the end of paragraph 1.124 that reads, 'The Committee is concerned that there may be negative outcomes in RRR emergency departments if agency nurses are used at short notice and without the necessary skills, experience or supervision required to provide suitable emergency care.'

Resolved, on the motion of Mrs Williams, seconded by Mr Barr: That Chapter One, as amended, stand part of the report.

The Committee considered Chapter Two of the report.

Resolved, on the motion of Ms Saffin, seconded by Mrs Thompson: That Chapter Two stand part of the report.

The Committee considered Chapter Three of the report.

Resolved on the motion of Mr Barr, seconded by Mrs Williams: That a new paragraph 3.25 be inserted after paragraph 3.24 that reads,

- 'The Committee heard regional and rural doctors may feel that they are viewed as 'lesser' by their peers. A Better Culture submitted that there is a sense of 'geographic narcissism' in rural health, which can discourage doctors from working in RRR areas [Insert footnote: Submission 55, pp 2-3.]. For example, they describe the experience of a doctor that relocated from a metropolitan centre to a regional city, and 'watched his reputation drain away, as the repeated assumption was that if he was working a regional job, he must have been unable to "cut it" in the city.' [Insert footnote: Submission 55, pp 2-3] The Committee heard that this perception needed to change, with Dr Karin Jodlowski-Tan, National Clinical Head of Rural Pathways, Royal Australian College of General Practitioners (RACGP) Rural, discussing the need to improve the value of rural generalists and rural GPs. [Insert footnote: Dr Karin Jodlowski-Tan, National Clinical Head of Rural Pathways, Royal Australian College of General Practitioners (RACGP) Rural, Transcript of evidence, 24 November 2023, p 13.]'

Resolved on the motion of Mr Barr, seconded by Ms Saffin: That a new sentence be inserted in paragraph 3.37 after the words 'instruments like the PMES' that reads, 'We also suggest greater transparency on the completion of comprehensive leadership training, including people management and soft skills training as a part of these accountability measures.'

Resolved on the motion of Mr Barr, seconded by Mrs Thompson: That in paragraph 3.40,

- A new sentence be inserted after the words 'utmost of urgency' that reads: 'During its site visits, the Committee heard from health workers that NSW Health's CORE values are not always realised in RRR facilities, in a tangible and meaningful way.'
- The words 'frameworks and portals' to be replaced with 'frameworks, portals and refreshed organisational "values"'.

Resolved, on the motion of Mr Barr, seconded by Ms Saffin: That Chapter Three, as amended, stand part of the report.

The Committee considered Chapter Four of the report.

Resolved on the motion of Mr Barr, seconded by Mrs Williams: That in paragraph 4.53,

- The words 'As discussed in Chapter One,' be inserted before 'Lack of access'

- A new sentence be inserted after the words 'reliance on emergency departments' that reads: 'The Committee heard that access to primary care 'prevents avoidable hospitals admissions and reduces hospital stays. [Insert footnote: Submission 42, p 5.]'

Resolved on the motion of Mr Barr, seconded by Mrs Thompson: That two new paragraphs be inserted after paragraph 4.53,

- A new paragraph 4.54 be inserted that reads: 'Remote communities also have a lower uptake of preventative health services such as screening programs. [Insert footnote: Submission 42, p 5.] An Australian Salaried Medical Officers' Federation (ASMOF) member reported that over time limited access to specialist care, 'worsening chronic conditions' and diminishing preventative care services could lead to longer admission times.' [Insert footnote: Submission 48, Australian Salaried Medical Officers' Federation (New South Wales), p 5.]

- A new paragraph 4.55 be inserted that reads: 'The Committee is of the view that access to primary and specialist healthcare services will greatly improve health outcomes for RRR communities by enabling early intervention and prevention. We are also of the view that access to general practice will alleviate pressures on emergency departments by reducing the number of patients that present with unaddressed complex and multi-layered health needs. The Committee will explore specialist care services and their interactions with the primary care sector in greater detail in its second inquiry.'

Resolved on the motion of Mr Barr, seconded by Mrs Thompson: That a new paragraph be inserted after paragraph 4.88 that reads,

- 'The Committee is of the view that expanding non-emergency patient transport is a valuable opportunity to improve health services in RRR communities. The Committee is also of the view that a more coordinated and flexible approach to current non-emergency patient transport services would improve health outcomes in RRR communities. Both of these approaches would provide patients in these areas with more options for accessing health services in a timely and convenient manner. Expanding non-emergency patient transport will also benefit the regional health system more broadly, particularly in those areas with extremely limited patient transport. Crucially, this will reduce reliance on the use of emergency vehicles and deployment of paramedic staff for cases where community transport is more appropriate. Furthermore, by providing greater support for community transport services, the NSW Government may realise cost savings through reduced non-emergency uses of ambulances and other paramedic services.'

Resolved on the motion of Ms Butler, seconded by Mrs Williams: That Chapter Four, as amended, stand part of the report.

Resolved, on the motion of Mrs Thompson, seconded by Ms Butler:

1. That the draft report, as amended, be the report of the Committee, and that it be signed by the Chair and presented to the House.

2. That the Chair and committee staff be permitted to correct stylistic, typographical, and grammatical errors.

3. That, once tabled, the report be posted on the Committee's webpage.

2.3. Information from NSW Health following St Leonards visit

The Committee considered an email received from NSW Health ***

3. ***

4. ***

5. General business

***

The Committee thanked committee staff for their work on the inquiry into the implementation of PC2 recommendations relating to the workforce issues, workplace culture and funding considerations.

The Committee noted that a draft report cover would be circulated to members after the meeting. If the suggested cover was not agreed to, a standard report cover would be used.

6. Next meeting

The meeting adjourned at 3:37pm, until 26 August 2024.

Appendix Seven – Glossary

Organisation or term	Abbreviation
Aboriginal Community-Controlled Health Organisation	ACCHO
Aboriginal medical service	AMS
Activity based funding	ABF
Australasian College for Emergency Medicine	ACEM
Australian College of Nurse Practitioners	ACNP
Australian College of Rural and Remote Medicine	ACRRM
Australian Lawyers Association	ALA
Australian Medical Association NSW	AMA NSW
Australian Paramedics Association NSW	APA NSW
Australian Salaried Medical Officers' Federation NSW	ASMOF
Bulgarr Ngaru Medical Aboriginal Corporation	Bulgarr Ngaru
Charles Sturt University	CSU
Clinical nurse educator	CNE
Collaborative Care Program	CCP
Emergency department	ED
Emergency medicine	EM
Ernst & Young	EY
Full time equivalent	FTE
General Practitioner	GP
Health Administration Unit	HAU
Health Education and Training Institute	HETI
Independent Review – Rural Health Inquiry (Ernst & Young)	the EY report
Intensive Care Paramedics	ICP
Isolated Patients Travel and Accommodation Assistance Scheme	IPTAAS
Legislative Council Portfolio Committee No. 2 – Health	PC2
Local Government NSW	LGNSW
Local Health District	LHD
Locum medical officer	locum
Maari Ma Health Aboriginal Corporation	Maari Ma
National Disability Insurance Scheme	NDIS
National Rural Health Alliance	NRHA
New England Virtual Health Network	NEViHN
New South Wales Nurses and Midwives' Association	NMA
People Matter Employee Survey	PMES

Portfolio Committees No. 2 report, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*	the PC2 report
Primary care Rural Integrated Multidisciplinary Health Services	PRIM-HS
Primary Health Network	PHN
Remote, rural and regional	RRR
Royal Australasian College of Medical Administrators	RACMA
Rural Area Community Controlled Health Organisation	RACCHO
Rural Doctors Network	RDN
Rural Generalist	RG
Rural Generalist Training Program	RGTP
Rural Health Workforce Incentive Scheme	the Incentive Scheme
Single Employer Model	SEM
Special Commission of Inquiry	SCOI
Speciality Health Networks	SHN
The Royal Australian College of General Practitioners	RACGP
University of New England	UNE
University of New South Wales	UNSW
Urgent Care Services	USCs
Vendor management system	VMS
Visiting Medical Officer	VMO