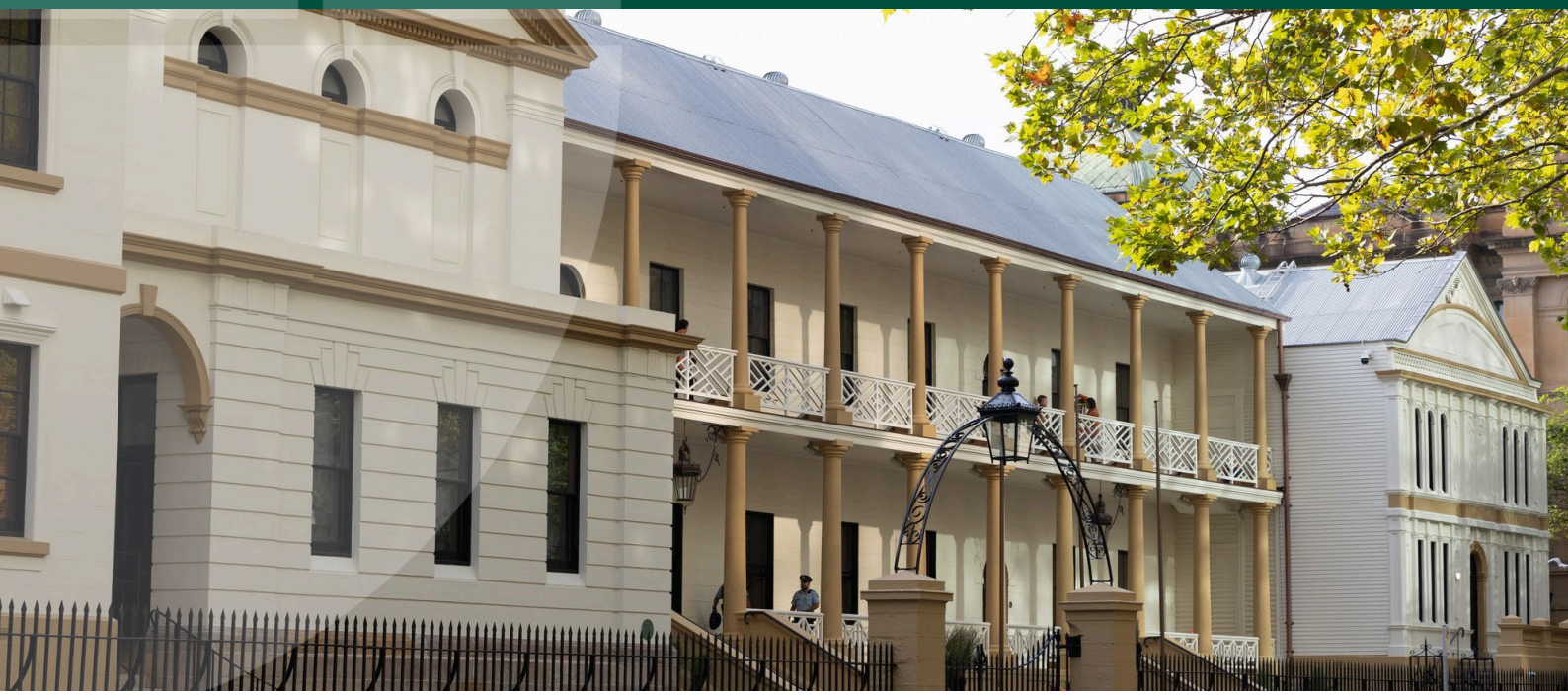
Legislative Assembly Select Committee on Remote, Rural and Regional Health

LEGISLATIVE ASSEMBLY

Report 2 – The implementation of recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW



Report 2/58 – March 2025

New South Wales Parliamentary Library cataloguing-in-publication data:

A catalogue record for this
book is available from the
National Library of Australia

ISBN: 978-1-925214-60-4

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

Membership ___ iii
Chair's foreword ___ iv
Findings and recommendations ___ vi

Chapter One – Maternity and paediatric services ___ 1
Introduction ___ 1
Maternity services ___ 3
Declining hospital birthing services ___ 4
Attraction and retention of obstetric trainees ___ 9
Midwifery workforce challenges ___ 12
Midwifery continuity of care ___ 18
Access to paediatric services ___ 22

Chapter Two – Cancer care ___ 29
Introduction ___ 29
Out-of-pocket costs for cancer care ___ 30
Virtual cancer care and clinical trial participation ___ 34

Chapter Three – Aged care ___ 39
Introduction ___ 39
Growing demand for aged care services ___ 39
Federal aged care reforms ___ 41

Chapter Four – Palliative care ___ 44
Introduction ___ 44
Funding and staffing for palliative care ___ 45
Palliative care taskforce and data collection ___ 48
Culturally safe palliative care services ___ 50

Chapter Five – Mental health and drug and alcohol services ___ 53
Introduction ___ 53
Recent inquiries into mental health services ___ 54
Mental health workforce shortages ___ 56
Alcohol and other drugs service gaps ___ 59

Chapter Six – Aboriginal health services ___ 64
Introduction ___ 64
Cultural safety for First Nations communities ___ 65
Building the Aboriginal health workforce ___ 66

Governance and partnerships in delivering Aboriginal health services ____ 72

Chapter Seven – Patient transport and paramedicine ____ 76

Introduction ____ 76

Financial assistance under the Isolated Patients Travel and Accommodation Scheme (IPTAAS) ____ 77

Community transport ____ 83

Non-emergency patient transport ____ 87

Paramedic services ____ 89

Air transport ____ 93

Appendix One – Terms of reference ____ 96

Appendix Two – Conduct of inquiry ____ 97

Appendix Three – Submissions ____ 99

Appendix Four – Site visit report ____ 102

Appendix Five – Witnesses ____ 104

Appendix Six – Extracts from minutes ____ 108

Membership

Chair	Dr Joe McGirr MP
Deputy Chair	Ms Janelle Saffin MP
Members	Mr Clayton Barr MP Ms Liza Butler MP Mr Justin Clancy MP (from 18 February 2025) Ms Trish Doyle MP Mrs Tanya Thompson MP The Hon. Leslie Williams MP (until 31 January 2025)
Contact details	Legislative Assembly Select Committee on Remote, Rural and Regional Health Parliament House Macquarie Street SYDNEY NSW 2000
Telephone	(02) 9230 2821
E-mail	remoteruralregionalhealth@parliament.nsw.gov.au
Website	Legislative Assembly Select Committee on Remote, Rural and Regional Health

Chair's foreword

Access to timely, affordable and high quality specialist care is critical to improving the health outcomes of remote, rural and regional (**RRR**) communities. This second report of the Select Committee on Remote, Rural and Regional Health (the **Committee**) examines the progress that has been made and the challenges that have persisted in the delivery of various specific health services and specialist care in RRR NSW. As Chair of the Committee, I am pleased to table this important report.

The Committee was established to inquire into and report on the implementation of recommendations made by the Legislative Council Portfolio Committee No. 2 (**PC2**) in its landmark 2022 report, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*. The PC2 report made 44 recommendations, which this Committee has examined over the course of three inquiries.

During the inquiry, the Committee was deeply troubled to hear that access to many specialist services has declined over the past two years, with many rural and regional health services in crisis. We are concerned that the intent of many PC2 recommendations remains unfulfilled, despite NSW Health reporting that these recommendations have been implemented. There continues to be a significant divide between the progress that NSW Health is reporting and the picture being painted by key stakeholders in the regional health system.

We are also disappointed by the NSW Government's response to our first report, which did not appear to put forward new actions to address many of our recommendations. In our first report, we examined the implementation of PC2 recommendations relating to workforce issues, workplace culture and funding. The Committee's impression from the government response is that NSW Health is still not approaching some areas of regional health reform with an appropriate sense of urgency. As discussed in this second report, workforce shortages continue to hinder the delivery of specialist services, and crisis levels have been reached in specialties such as obstetrics and psychiatry.

Each chapter of this report focuses on a different service. The report starts by examining maternity and paediatric services, and highlights the alarming closure of birthing and obstetric services in RRR NSW. We make a number of urgent recommendations, including that NSW Health develop a statewide plan to maintain and re-establish maternity services. We also call for measures to address the crises within the obstetric and midwifery workforces, and the gaps in rural and regional paediatric services.

The following chapters examine whether progress has been made in relation to other specific services in RRR NSW, including cancer care, aged care and palliative care. We were particularly concerned by the lack of progress made in establishing a palliative care taskforce and a statewide platform for data collection, as recommended in the PC2 report. We recommend targeted funding to address inequities in palliative care, the urgent publication of palliative care data sets to inform service planning, and improvements to the delivery of culturally safe end-of life-care.

Although mental health and drug and alcohol services were not explicit areas of focus in the original PC2 report, the Committee was interested to hear what progress has been made in these areas, following numerous other inquiries. Concerningly, we heard that mental health

services are being impacted by significant and escalating workforce shortages. We recommend that NSW Health prioritise the development of a comprehensive, long-term workforce strategy for mental health services across RRR NSW. We also recommend that NSW Health look into early intervention models for alcohol and other drugs treatment to address the service gaps for young people living in these areas. This should include a focus on integration with mental health services.

The Committee was disappointed to hear that genuine collaboration between Local Health Districts (**LHDs**) and Aboriginal Community Controlled Health Organisations (**ACCHOs**) is still not occurring in many areas of NSW. The PC2 report was clear on the importance of reform in this area, and this Committee made recommendations to support the Aboriginal health workforce in its first report, but there are still systemic barriers to the growth of this workforce. We urge regional LHDs to use genuine principles of co-design to map Aboriginal health services and identify unmet needs. We also recommend changes to formally embed Aboriginal community representatives within LHD governance.

Finally, the Committee heard about how a lack of access to patient transport continues to impact communities in RRR NSW. For example, funding for community transport is not sufficient to meet community needs and there is a continued reliance on paramedics for non-emergency patient transport. We were also concerned to hear about restrictions on specialist paramedics that are effectively de-skilling the paramedic workforce in RRR NSW. The final chapter of this report makes a range of recommendations to address the issues in accessing non-emergency patient transport, paramedicine and air transport in RRR NSW.

We also cannot understate the role of primary care in enabling access to specialist services, particularly in rural and regional areas. The Committee remains troubled by general practice (GP) workforce shortages, which we highlighted in our first report. These issues will be examined further in our third and final report, noting that primary care is largely a federal responsibility and requires collaboration between the NSW and Australian governments.

We acknowledge that NSW Health has made progress in implementing some of the PC2 recommendations. For example, there have been improvements in reducing out-of-pocket costs for cancer patients, some funding and staffing increases for palliative care, and significant improvements to the Isolated Patients Travel and Accommodation Assistance Scheme. However, the rate of progress must increase to meaningfully improve access to health care for rural and regional communities.

We believe there is a genuine desire and willingness among health workers to improve the condition of rural and regional health care in NSW. However, the challenges that we have highlighted in this report cannot addressed by LHDs alone, and urgent action is needed at the statewide level to address these challenges. We hope that implementation of the recommendations in this report goes some way towards bringing about improvements across each of the specific health services that we have examined.

On behalf of the Committee, I thank all those who took the time to make a submission, provided evidence at public hearings, and spoke with the Committee during its site visits throughout remote, rural and regional NSW. I also thank my fellow Committee members for their valuable contributions to this report, and Committee staff for their support.

Dr Joe McGirr
Chair

Findings and recommendations

Finding 1 _____ 4

Declining numbers of obstetrics units and closures of hospital birthing services continue to be reported in remote, rural and regional NSW, with no evident plan to re-establish these services.

Recommendation 1 _____ 4

That NSW Health urgently undertake a formal assessment of its maternity services and develop a statewide, publicly accessible plan that sets out how it will maintain and re-establish hospital birthing services in remote, rural and regional areas with appropriate staffing levels. This plan should include:

- changes in service levels over the past 10 years
- key performance indicators that monitor the number of births delivered in rural and regional public hospitals against the birth rate of their catchment population
- consideration of how the tiered perinatal network structure can support smaller units and communities more effectively.

Recommendation 2 _____ 9

That NSW Health work with colleges and other relevant stakeholders to:

- identify and remove barriers to attracting and retaining obstetric trainees in remote, rural and regional NSW, and
- set targets for the number of obstetric specialists and rural generalists that are employed by rural and regional LHDs after completing their training
- ensure that there are fully functioning networked services for clinical support and training.

Finding 2 _____ 12

Despite incentives to attract midwives to remote, rural and regional practice, there are still significant workforce challenges for midwives working in rural and regional maternity services in NSW.

Recommendation 3 _____ 12

That NSW Health work with professional midwifery associations and other relevant stakeholders to address challenges faced by its remote, rural and regional midwifery workforce. As part of this work, NSW Health should work with rural and regional Local Health Districts to:

- collect necessary data to monitor the application of the Rural Health Workforce Incentive Scheme at the local level and ensure it is applied fairly and consistently
- identify where on-call arrangements are not in effect

- increase the number of rural and regional placements available to midwifery trainees and graduates.

Finding 3 _____ 18

Workforce shortages and restrictions on visiting rights create challenges with establishing and sustaining midwifery continuity of care models for remote, rural and regional communities.

Recommendation 4 _____ 18

That NSW Health work with all rural and regional Local Health Districts to prioritise the implementation of midwifery continuity of care models, including co-designed Birthing on Country services for Aboriginal women in remote, rural and regional areas.

Recommendation 5 _____ 18

That NSW Health work with all rural and regional Local Health Districts to actively consider removing restrictions on visiting rights for privately practising midwives, where these restrictions are in place.

Finding 4 _____ 22

A shortage of specialist GPs and allied health clinicians in remote, rural and regional areas has meant that many paediatric specialists working in public hospitals are no longer seeing non-emergency patients, particularly those with developmental conditions.

Finding 5 _____ 22

Paediatric services in NSW regional public hospitals have long wait times that can vary between 18 months to six years, which can exacerbate developmental issues for children in need of paediatric care.

Recommendation 6 _____ 22

That the NSW Government take urgent action to address the shortfall in paediatric services across hospital and community-based settings in remote, rural and regional NSW. Consideration should be given to:

- increasing funding to provide early intervention programs with sustainable financial support
- targeted recruitment efforts to improve the availability of paediatric, GP and allied health services.

Recommendation 7 _____ 27

That NSW Health work with key stakeholders to explore options for addressing paediatric service gaps in rural areas through networked models of care, including through multidisciplinary teams, with a focus on developmental care. This should include the coordination of services between Local Health Districts, Primary Health Networks, relevant government agencies and non-governmental service providers.

Finding 6 _____ 30

There has been a reduction in out-of-pocket costs for cancer care patients in some regional areas, due to the removal of out-of-pocket costs for public cancer patients in some regions and

increased rebates through the Isolated Patients Travel and Accommodation Assistance Scheme.

Finding 7 _____ 30

There are still significant out-of-pocket costs for cancer patients in some regional areas, and not-for-profit organisations are increasingly relied upon to help cover these costs.

Recommendation 8 _____ 30

That NSW Health:

- conduct an audit of regional cancer centres to determine where significant out-of-pocket costs remain for public cancer patients accessing public-private services, and
- work with private providers to address any remaining disparities in these costs across remote, rural and regional NSW.

Recommendation 9 _____ 34

That NSW Health commence an interim evaluation of the Rural, Regional and Remote Clinical Trial Enabling Program (R3-CTEP) within the next six months. The evaluation should identify the extent to which the program has been implemented and to which it has improved access to clinical trials in remote, rural and regional NSW. The findings of the evaluation should be published within the next 12 months to inform the ongoing implementation of the program.

Finding 8 _____ 39

The population of older people living in remote, rural and regional areas is increasing, but aged care services are constrained and not keeping up with this demand.

Recommendation 10 _____ 40

That the NSW Government works with the Australian Government to explore funding options for rural and regional nurses to undertake specialised training in aged care to help meet the growing demand for these services.

Recommendation 11 _____ 40

That NSW Health provide up-to-date information within the next six months on how many peer group C hospitals do not have a geriatric nurse, and outline strategies it intends to take to address any staffing shortfalls in this area.

Recommendation 12 _____ 41

That the NSW Government works with the Australian Government to ensure that local councils in remote, rural and regional NSW are appropriately supported during the implementation of national aged care reforms, including the Support at Home program.

Finding 9 _____ 45

There have been some improvements in regional palliative care since the Portfolio Committee No. 2 report, but significant disparities remain across remote, rural and regional NSW.

Recommendation 13 _____ 45

That the NSW Government provide additional targeted funding for palliative care services to address existing inequities and ensure adequate staffing of palliative care services across remote, rural and regional NSW.

Finding 10 ____ 48

Access to data to inform regional palliative care services remains limited, in the absence of a palliative care taskforce and statewide data collection platform, and there is little visibility of where service gaps exist in remote, rural and regional NSW.

Recommendation 14 ____ 48

That NSW Health urgently publish its new palliative care governance framework and share key palliative care datasets with Local Health Districts and relevant networks within the next six months to inform palliative care service planning.

Finding 11 ____ 50

Access to culturally safe palliative care continues to be impacted by under-resourcing and a lack of collaboration between Local Health Districts and Aboriginal Community Controlled Health Organisations.

Recommendation 15 ____ 50

That NSW Health work with key Aboriginal stakeholders to ensure culturally safe end-of-life care is available to Aboriginal people living in remote, rural and regional communities. This should include consideration of funding for Aboriginal Community Controlled Health Organisations to deliver palliative care services.

Finding 12 ____ 54

The NSW Government is responding to numerous statewide inquiries into mental health services, including the Portfolio Committee No. 2 inquiry into outpatient and community health care in NSW, but most of these inquiries have not been targeted at improvements in remote, rural and regional NSW.

Finding 13 ____ 56

Mental health services across remote, rural and regional NSW are being impacted by significant and escalating workforce shortages.

Recommendation 16 ____ 56

That NSW Health prioritise the development of a comprehensive, long-term workforce strategy for mental health services across remote, rural and regional NSW. This strategy should address:

- any funding considerations necessary to support recruitment
- the development of training pathways that will adequately support mental health services.

Finding 14 ____ 61

Mental health, drug and alcohol treatment services within remote, rural and regional NSW remain poorly integrated.

Finding 15 62

The prevalence of addiction earlier in life is increasing, and there are significant gaps in alcohol and other drugs services for young people in regional NSW, with not enough services specifically tailored for youth.

Recommendation 17 62

That NSW Health, in collaboration with the Department of Communities and Justice, investigate innovative and effective early intervention models for alcohol and other drugs treatment to address the service gaps for young people living in remote, rural and regional NSW. This should include a focus on integration with mental health services.

Finding 16 67

There are systemic barriers to the growth and development of NSW Health's Aboriginal workforce under the existing industrial frameworks, scopes of practice, and career pathways.

Recommendation 18 67

That NSW Health work with relevant stakeholders to review the relevant industrial frameworks for its Aboriginal workforce, including the Aboriginal Health Workers' (State) Award 2023, and progress negotiations to address barriers to recruitment and retention under the Award.

Recommendation 19 68

That NSW Health review its Aboriginal Health Worker Guidelines and work with key stakeholders, including Aboriginal Community Controlled Health Organisations (ACCHOs), to develop statewide scopes of practice for all levels and occupations of the Aboriginal health workforce.

Finding 17 70

Although Aboriginal Community Controlled Health Organisations are essential primary health care providers, they are not included in state-level approaches to recruitment and retention, and are unable to access key state-level incentives for regional health workers.

Recommendation 20 70

That the NSW Government prioritise incentives to support the growth of the Aboriginal community-controlled health sector, either through targeted incentive mechanisms for Aboriginal Community Controlled Health Organisations (ACCHOs), or by amending the *Health Services Act 1997* to include ACCHO staff that are working in partnership with NSW Health or providing services directly to Aboriginal communities.

Finding 18 72

Although NSW Health reports longstanding partnerships between Local Health Districts and Aboriginal Community Controlled Health Organisations, there are barriers to establishing formal partnership agreements in many regional areas.

Finding 19 72

Genuine and effective collaboration between Local Health Districts (LHDs) and Aboriginal Community Controlled Health Organisations remains a challenge, even where partnership agreements have been formalised, as LHDs are often making unilateral decisions about Aboriginal health care.

Recommendation 21 _____ 73

That all regional Local Health Districts work with Aboriginal Community Controlled Health Organisations and Primary Health Networks, using genuine principles of co-design, to:

- conduct an assessment of needs within the district, and
- map the Aboriginal health services offered to identify unmet needs and reduce any duplication of services.

Recommendation 22 _____ 75

That NSW Health amend the *Health Services Act 1997* to formalise the requirement for at least one Aboriginal community representative on each LHD's governing board.

Finding 20 _____ 77

Significant improvements have been made to the Isolated Patients Travel and Accommodation Assistance Scheme to increase subsidies and make financial assistance available for a broader number of services.

Finding 21 _____ 79

Community transport passengers are frequently ineligible to claim subsidies under the Isolated Patients Travel and Accommodation Assistance Scheme. This has created a significant service gap that increases inequities across remote, rural and regional NSW.

Recommendation 23 _____ 79

That NSW Health urgently address the community transport service gap under the Isolated Patients Travel and Accommodation Assistance Scheme to allow patients to claim subsidies for community transport.

Recommendation 24 _____ 81

That NSW Health identify and address additional service gaps within the Isolated Patients Travel and Accommodation Assistance Scheme and consider expanding the eligibility of services, including further allied health services, as part of the ongoing monitoring and evaluation of the Scheme.

Finding 22 _____ 84

Funding for community transport is not sufficient to meet community needs across remote, rural and regional NSW. As a result, not-for-profit providers are having to cover out-of-pocket costs and supplement community transport services.

Recommendation 25 _____ 84

That the NSW Government provide additional funding for community transport providers, through the Community Transport Program and NGO Grants Program, and work with the Australian Government and relevant providers to address any funding gaps for community transport services across remote, rural and regional NSW.

Recommendation 26 _____ 86

That the NSW Government work with community transport providers to improve the affordability of community transport across remote, rural and regional NSW, through the

development of pricing benchmarks for passenger co-payments and publicly accessible guidelines for community transport fees. This should include any updates to the Isolated Patients Travel and Accommodation Assistance Scheme, as per Recommendation 23 of this report.

Recommendation 27 _____ 88

That NSW Health evaluate the first tranche of the Patient Transport Service rollout to rural and regional Local Health Districts and identify priority areas for the continued expansion of the service in order to relieve pressure on paramedics across remote, rural and regional NSW.

Recommendation 28 _____ 90

That NSW Health provide an update within six months that tracks progress against the commitment to deliver an additional 500 paramedics to remote, rural and regional NSW. This update should include information on the numbers and locations of Intensive Care Paramedics and Extended Care Paramedics. It should also identify any barriers to implementation of the commitment and outline the actions that NSW Health will take to address these barriers.

Finding 23 _____ 91

NSW Ambulance is restricting Intensive Care Paramedics to large stations and limiting training for Extended Care Paramedics outside of metropolitan areas, which is disincentivising senior paramedics from working in remote, rural and regional NSW and effectively de-skilling the paramedic workforce.

Recommendation 29 _____ 91

That NSW Ambulance urgently remove restrictions on Intensive Care Paramedics working in Category C and D stations, and develop a plan to address identified barriers to the expansion of these specialist paramedics to ensure their equitable distribution across remote, rural and regional NSW.

Recommendation 30 _____ 91

That NSW Ambulance implement options for paramedics to undertake training and skills consolidation for Extended Care Paramedics and other specialist roles locally across remote, rural and regional NSW.

Recommendation 31 _____ 92

That NSW Health evaluate the Integrated Paramedic Workforce Model, based on the initial pilots, and publish the findings within six months. This evaluation should include discussion of how the model can be widely implemented in remote, rural and regional NSW.

Finding 24 _____ 93

There are significant issues with the supply of pilots under the current NSW Ambulance air transport contract, which is placing critical pressure on other air transport services in remote, rural and regional NSW.

Recommendation 32 _____ 93

That NSW Health urgently publish its review of air transport funding and work with the Australian Government and key service providers to ensure adequate provision of air transport services across remote, rural and regional NSW.

Chapter One – Maternity and paediatric services

Introduction

1.1 The 2022 report from Portfolio Committee No. 2 (PC2) identified that women in remote, rural and regional (RRR) NSW did not have access to the same standard of maternity care that was available to women in metropolitan areas.[1]

1.2 PC2 made numerous recommendations that aimed to improve the state of maternity services in RRR NSW, including that rural and regional Local Health Districts (LHDs) review and develop plans for midwifery, obstetric and newborn services. The report also recommended workforce improvements for nurses and midwives and the implementation of the midwifery continuity of care model across RRR NSW.[2]

1.3 In its 2024 Progress Report on the implementation of the PC2 recommendations, NSW Health stated that it had completed most of the actions it had proposed to address these recommendations.[3] However, during the current inquiry, the Committee was concerned to hear that there have been no significant improvements to RRR maternity services.[4] A range of stakeholders, including NSW Health, told us that they continued to observe challenges with maternity care in RRR NSW.[5]

---

[1] 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 142.

[2] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 99-100, 142.

[3] NSW Health, *Progress Report: Parliamentary inquiry into health outcomes and access to health and hospital services in Rural, Regional and Remote New South Wales*, September 2024, pp 44-49, 59-62.

[4] Ms Alison Weatherstone, Chief Midwife, Australian College of Midwives, Transcript of evidence, 31 May 2024, p 7; Mr Michael Whaites, Assistant General Secretary, NSW Nurses and Midwives' Association, Transcript of evidence, 31 May 2024, p 7.

[5] Submission 9, Moree Plains Shire Council, p 1; Submission 34, Australian College of Rural and Remote Medicine, p 2; Submission 36, Gunnedah Shire Council, p 2; Submission 42, Rural Doctors Network, p 3; Submission 48, NSW Nurses and Midwives' Association, p 12; Submission 43, NSW Health, p 10; Submission 44, Australian Salaried Medical Officers' Federation NSW, p 4; Submission 50, Leeton Shire Council, pp 1-2; Submission 55, Inverell Health Forum, p 3; Submission 56, National Rural Health Alliance, p 5; Submission 58, Australian College of Midwives, p 11; Submission 60, Australian Medical Association NSW, p 6; Submission 63, Rural Doctors Association of NSW, p 4; Submission 65, Royal Australasian College of Medical Administrators, p 7; Submission 67, Older Women's Network NSW, p 1; Cr Neil Westcott, Mayor, Parkes Shire Council, Transcript of evidence, 28 May 2024, pp 40-41, 45; Dr Ross Wilson, Member, Bathurst Community Health Committee, Transcript of evidence, 28 May 2024, pp 12-13; Associate Professor Randall Greenberg, Associate Professor, Deputy Head of Rural Clinical School, School of Rural Health, Orange, the University of Sydney, Transcript of evidence, 28 May 2024, p 32; Dr Anna Noonan, Associate Lecturer, the University of Sydney, School of Rural Health, Orange, Transcript of evidence, 28 May 2024, p 38; Ms Aya Emery, Policy Officer, Australian College of Midwives, Transcript of evidence, 31 May 2024, p 2; Mr Whaites, Evidence, 31 May 2024, p 3; Dr Lilach Leibenson, Senior VMO Obstetrician and Gynaecologist, and Representative for Rural and Remote NSW, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Transcript of evidence, 3 June 2024, p 4; Dr Michelle Moyle, Assistant Secretary/Treasurer, Australian Salaried Medical Officers' Federation NSW, Transcript of evidence, 3 June 2024, p 5; Dr Tony Sara, Secretary, Australian Salaried Medical Officers' Federation NSW, Transcript of evidence, 3 June 2024, p 5; Dr Rachel Christmas, President, Rural Doctors'

1.4 We found that hospital birthing services continue to close and there is little evidence of plans to re-establish rural and regional birthing units. Stakeholders also noted that there are persistent and unresolved workforce challenges, including challenges with attracting and retaining obstetric trainees and midwives. Additionally, we heard that Midwifery Continuity of Care (MCoC) models are yet to be broadly adopted across RRR NSW.[6]

1.5 Improving maternity services for RRR communities will involve addressing a number of complex, inter-related challenges. This first chapter of the Committee's report begins by examining the decline in hospital birthing services and the clinical staffing shortages that are contributing to this. It explores the work needed to continue attracting and retaining obstetric trainees, and the barriers that are also affecting the growth of the RRR midwifery workforce. Consideration is also given to the opportunities presented by MCoC models, particularly Birthing on Country models, which have the potential to improve outcomes for Aboriginal mothers and babies in RRR NSW.

1.6 To help address the issues facing RRR maternity services, we recommend that:

- NSW Health formally assess its maternity services and develop a statewide plan, with clear performance indicators, for maintaining and re-establishing hospital birthing services across RRR NSW
- NSW Health work with stakeholders to attract and retain rural obstetric trainees
- NSW Health collaborate with stakeholders to address midwifery workforce challenges
- NSW Health work with all rural and regional LHDs prioritise the implementation of MCoC models and Birthing on Country services.

1.7 This chapter also discusses paediatric services in RRR NSW. During the inquiry, stakeholders told us that there are issues with accessing paediatric specialists, including long wait times that can range from 18 months to six years in some RRR areas.[7] The Committee is concerned that if there were any change to state responsibilities for paediatric management, under the National Disability Insurance Scheme, this would tip the state's paediatric services into crisis.

1.8 We recommend that NSW Health take urgent action to address the shortfall in paediatric services across hospital and community-based settings in RRR NSW, including through consideration of increased funding and targeted recruitment

---

Association NSW, Transcript of evidence, 3 June 2024, p 14; Dr Alam Yoosuff, Vice President, Rural Doctors' Association NSW, Transcript of evidence, 3 June 2024, p 15; Mr Luke Sloane, Deputy Secretary, Regional Health, NSW Health, Transcript of evidence, 3 June 2024, pp 37-38; Dr Andrew Woods, Senior Clinical Advisor, Obstetrics, NSW Health, Transcript of Evidence, 3 June 2024, p 40.

[6] Submission 9, p 1; Submission 48, p 12; Submission 50, p 2; Submission 60, p 6; Submission 63, p 3; Dr Wilson, Evidence, 28 May 2024, pp 12, 15; Dr Sara, Evidence, 3 June 2024, p 5; Professor Peter O'Mara, Chair, Rural Doctors Network, Transcript of evidence, 3 June 2024, p 6; Dr Leibenson, Evidence, 3 June 2024, p 4; Dr Christmas, Evidence, 3 June 2024, p 14; Submission 58, p-11; Ms Emery, Evidence, 31 May 2024, p 2; Mr Whaites, Evidence, 31 May 2024, p 5.

[7] Submission 45, Royal Far West, pp 3-4.

efforts. We also recommend that NSW Health work with key stakeholders to address service gaps in this area through networked models of care, with a focus on developmental care.

Maternity services

'Maternity services' refers to the care provided to women during pregnancy, birth and the postnatal period. It includes care provided by obstetricians, as well as midwives.[8]

These services may be provided through formalised arrangements between maternity and neonatal services within and across Local Health Districts, known as tiered perinatal networks. Under these arrangements, tertiary hospitals provide support to facilities with lower service capability where higher level care is required.[9]

1.9 The PC2 report recommended that rural and regional LHDs, and metropolitan LHDs that service regional areas, review their maternity services to create plans for midwifery, GP obstetrics, specialist obstetrics and newborn services (Recommendation 27).[10]

1.10 During the current inquiry, NSW Health reported that the implementation of this recommendation has been completed. They noted that a range of measures have been undertaken in response to Recommendation 27, including:

- publication of *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW* in March 2023 and work on a correlated implementation plan
- an ongoing annual investment of $6.19 million in the midwifery and obstetric workforce as part of Pregnancy Connect, a new regionally focused program that connects at-risk women in NSW to early and regular care during pregnancy
- training for paramedics to provide labour, birth and early postnatal care during unplanned emergencies.[11]

1.11 In addition to these new initiatives, NSW Health highlighted the annual requirement for LHDs to provide an update on their maternity and neonatal service capability levels. NSW Health stated that they would request LHDs to conduct an additional Maternity and Neonatal Service Capability Assessment by

[8] NSW Health, Maternity care in NSW, viewed 28 February 2025.

[9] NSW Health, Policy Directive: Tiered Networking Arrangements for Perinatal Care in NSW, 19 October 2023, pp 4 and 6.

[10] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 142.

[11] Submission 43, pp 10-11; Dr Woods, Evidence, 3 June 2024, p 38; *Progress Report*, September 2024, pp 61-62; NSW Health, Greater support and care for pregnant women and babies in NSW, media release, 18 March 2024, viewed 23 January 2025.

the end of 2024, which would assist LHDs in identifying issues that require a risk assessment.[12]

1.12 Despite these reported developments, obstetricians and maternity care specialists in RRR NSW reported that they have not observed any 'real or meaningful improvement' in regional maternity services since the PC2 report.[13]

1.13 This section explores the declining number of birthing services in regional hospitals, including staffing shortages that are affecting these services and the impact of declining services for women in RRR NSW. It then discusses the attraction and retention of obstetric trainees, workforce challenges for midwives, and Midwifery Continuity of Care models.

Declining hospital birthing services

Finding 1

Declining numbers of obstetrics units and closures of hospital birthing services continue to be reported in remote, rural and regional NSW, with no evident plan to re-establish these services.

Recommendation 1

That NSW Health urgently undertake a formal assessment of its maternity services and develop a statewide, publicly accessible plan that sets out how it will maintain and re-establish hospital birthing services in remote, rural and regional areas with appropriate staffing levels. This plan should include:

- **changes in service levels over the past 10 years**
- **key performance indicators that monitor the number of births delivered in rural and regional public hospitals against the birth rate of their catchment population**
- **consideration of how the tiered perinatal network structure can support smaller units and communities more effectively.**

1.14 During the current inquiry, we heard that birthing services in rural NSW continue to close or are on the verge of closure.[14] Specifically, stakeholders told us that obstetric services at Bathurst, Lithgow, Kempsey and Cootamundra are on the brink of closing down.[15]

1.15 The decreasing number of rural maternity services is a historic and nationwide challenge. Stakeholders noted that hospital maternity unit closures across

[12] Submission 43, p 9; *Progress Report*, September 2024, pp 61-62; NSW Health, Greater support and care for pregnant women and babies in NSW, media release, 18 March 2024, viewed 23 January 2025.

[13] Submission 44, p 5.

[14] Dr Wilson, Evidence, 28 May 2024, p 13; Cr Westcott, Evidence, 28 May 2024, p 40; Dr Leibenson, Evidence, 3 June 2024, p 4; Dr Yoosuff, Evidence, 3 June 2024, p 15; Answers to questions on notice and supplementary questions, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 28 June 2024, pp 2-3.

[15] Dr Wilson, Evidence, 28 May 2024, p 13; Dr Yoosuff, Evidence, 3 June 2024, p 15.

Australia began decades ago and have continued since.[16] Rural Doctors Network noted that from 1990 to 2015, almost half of Australia's birthing services closed.[17]

1.16 Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) observed that while larger rural hospitals in Orange and Wagga Wagga are delivering over 1200 babies are year, they are understaffed. For both hospitals, they observed that smaller maternity units in the hospital's surrounding region have closed or are operating with reduced activity.[18]

1.17 The Committee also heard that rural maternity units are not distributed according to population needs, and smaller rural services may be unable to deliver babies at the birth rate of their local town. Dr Alam Yoosuff, Vice President, Rural Doctors' Association NSW, noted that although the Riverina town of Tumut has an expected annual birth rate of 150-200 for its catchment area of 15 000 people, only 30 to 40 babies are delivered locally.[19]

Clinical staffing shortages are affecting maternity services

1.18 The Committee heard that the limited availability of maternity services is a result of significant staffing shortages in obstetrics and gynaecology services. Stakeholders reported staffing shortages and/or workforce challenges for obstetricians, including GP and specialist obstetricians, and midwives in RRR NSW.[20]

1.19 Across Australia, only 15 per cent of obstetricians are based in rural and remote areas.[21] In NSW, RANZCOG noted severe staffing shortfalls for obstetrics in Dubbo and Orange, where there are multiple registrar and consultant positions vacant. Obstetrics shortages were also reported in Bathurst and Wagga Wagga.[22]

1.20 Stakeholders pointed specifically to a declining or limited number of GP obstetricians.[23] Professor Peter O'Mara, Chair, Rural Doctors Network, stated that the increased workload for specialist obstetricians is partly due to a decreased number of GP obstetricians in NSW.[24]

---

[16] Submission 42, p 3; Submission 56, p 5.

[17] Submission 42, p 3.

[18] Answers to questions on notice and supplementary questions, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 28 June 2024, pp 2-3.

[19] Submission 56, p 5; Dr Yoosuff, Evidence, 3 June 2024, p 15

[20] Submission 9, p 1; Submission 44, pp 4-6; Submission 48, p 12; Submission 60, p 6; Submission 63, pp 2-3; Dr Wilson, Evidence, 28 May 2024, pp 12, 15; Dr Sara, Evidence, 3 June 2024, p 5; Professor O'Mara, Evidence, 3 June 2024, p 6; Dr Leibenson, Evidence, 3 June 2024, p 4; Dr Christmas, Evidence, 3 June 2024, p 14; Mr Sloane, Evidence, 3 June 2024, pp 37-38; Dr Woods, Evidence, 3 June 2024, p 40.

[21] Dr Yoosuff, Evidence, 3 June 2024, p 17.

[22] Dr Wilson, Evidence, 28 May 2024, pp 12-13; Answers to questions on notice and supplementary questions, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 28 June 2024, pp 2-3.

[23] Submission 48, p 12; Dr Wilson, Evidence, 28 May 2024, p 13; Professor O'Mara, Evidence, 3 June 2024, p 6; Dr Christmas, Evidence, 3 June 2024, p 14; Answers to questions on notice and supplementary questions, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 28 June 2024, p 3.

[24] Professor O'Mara, Evidence, 3 June 2024, p 6.

GP obstetricians are general practitioners with additional skills in maternity care that are recognised as essential to maternity services. In rural and regional settings, they work as part of a clinical team to deliver babies in hospitals.[25]

1.21 A lack of GP obstetricians can present a barrier to implementing midwifery models of maternity care. If GP obstetricians are not available in a rural or regional hospital, it can also lead to 'patchy' or 'absent' clinical oversight for midwives working in these areas.[26]

1.22 The Select Committee on Birth Trauma highlighted this in its 2024 report and recommended that the NSW Government invest in the GP obstetric workforce to improve continuity of care in rural areas. In its response, the NSW Government recognised 'the need to support a stable clinical workforce, including the need to boost the number of junior doctors choosing general practitioner training'.[27]

1.23 To cover obstetric staffing shortages, we heard that rural and regional facilities continue to employ locums and fly-in fly-out workers. Locums are medical officers that are commonly employed in regional areas to cover temporary staffing gaps.[28]

1.24 The frequency and type of obstetrics locum cover needed may vary across rural towns in NSW. During the public hearings, Dr Lilach Leibenson, Senior VMO Obstetrician and Gynaecologist, and Representative for Rural and Remote NSW, RANZCOG, told us that locums account for half of the on-call consultant and registrar workforce in Tamworth, whereas Armidale is entirely staffed by locum consultants.[29]

1.25 Employing obstetrician locums can come at the expense of continuity of care and have serious effects for women. It can also make it difficult for local practitioners to take scheduled leave if a locum withdraws at the last moment.[30] We noted locum and workforce challenges in RRR NSW in our first report, and made a number of recommendations that the NSW Government has supported in principle.[31]

1.26 In addition to obstetrician shortages, maternity services in RRR NSW are affected by midwifery staffing shortages. Inquiry participants observed severe staffing

[25] Submission 48, p 12; Better Health Channel: Victoria State Government, Who's who during pregnancy, birth and newborn care, viewed 29 January 2024.

[26] Submission 48, p 12; Dr Vanessa Scarf, NSW Branch Chair, Australian College of Midwives, Transcript of evidence, 31 May 2024, p 9.

[27] Select Committee on Birth Trauma, *Birth Trauma*, report no. 1, Parliament of NSW, May 2024, p 82; NSW Government, Response to Inquiry into Birth Trauma, Parliament of NSW, 29 August 2024, viewed 31 January 2025, pp 5-31.

[28] Dr Leibenson, Evidence, 3 June 2024, pp 4-5.

[29] Dr Leibenson, Evidence, 3 June 2024, p 4.

[30] Dr Leibenson, Evidence, 3 June 2024, p5.

[31] Select Committee on Remote, Rural and Regional Health, *Implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, report 1/58, Parliament of New South Wales, August 2024, pp ix-xi; NSW Government, *Response to Inquiry into the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, February 2025, pp 7 - 9.

shortages in Tamworth, where there is a 58 per cent deficit in midwifery staffing. We also heard that registered and assistant nurses are backfilling midwives.[32] Midwifery workforce challenges more broadly are explored later in this chapter.

1.27 Stakeholders further noted the impact of declining critical medical services that support maternity care, such as pathology and anaesthetic services, on hospital birthing services.[33] RANZCOG told us that onsite pathology services at Gunnedah Hospital closed two years ago, with collection only available at limited times. Due to this lack of onsite pathology services and after-hours theatre cover, Gunnedah Hospital is now delivering between 25 to 35 elective caesarean deliveries, which is a significant reduction from its previous number of 200 deliveries.[34] The Committee is also concerned that a potential change to pathology services at Cootamundra Hospital may impact obstetric services for that community.

Declining birthing services have far reaching consequences

1.28 A decline in rural maternity services is detrimental for women, their families and the broader health system in RRR NSW. As a result of unavailable and/or understaffed birthing and obstetric services, the Committee heard that women from RRR areas are being required to travel for up to hundreds of kilometres.[35] We note that this may lead to a decrease in care during pregnancy, particularly for women who may find it challenging to travel to other centres.

1.29 Without access to local birthing facilities, pregnant women are also at a higher risk of intervention and giving birth before reaching a health facility. Relocating from home to give birth in a different city or town can also negatively affect mothers' mental health and generate additional costs for parents.[36]

1.30 More broadly, the closure of rural maternity services may de-skill or shrink the local medical workforce and downgrade other health services. This affects the ability of regional communities to access a wider range of healthcare services locally. For example, the removal of maternity services can result in the loss of local anaesthetic and surgical services and supporting staff.[37]

1.31 Councillor Neil Westcott, Mayor, Parkes Shire Council, told the Committee about the ramifications for health services at Parkes hospital after its birthing unit closed:

---

[32] Submission 48, pp 5, 14; Mr Whaites, Evidence, 31 May 2024, p 7; Dr Leibenson, Evidence, 3 June 2024, p 4; Mr Sloane, Evidence, 3 June 2024, pp 37-38; Dr Woods, Evidence, 3 June 2024, p 40; Answers to questions on notice and supplementary questions, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 28 June 2024, p 2.

[33] Submission 55, p 3; Dr Moyle, Evidence, 3 June 2024, p 5; Answers to questions on notice and supplementary questions, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 28 June 2024, p 4.

[34] Answers to questions on notice and supplementary questions, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 28 June 2024, pp 3-4.

[35] Submission 9, p 1; Submission 34, p 2; Submission 36, p 2; Submission 44, p 4; Submission 55, p 3; Dr Christmas, Evidence, 3 June 2024, p 18.

[36] Submission 34, p 2; Submission 56, p 5; Submission 67, p 1; Weatherstone, Evidence, 31 May 2024, p 8; Dr Yoosuff, Evidence, 3 June 2024, p 17; Answers to questions on notice and supplementary questions, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 28 June 2024, p 3.

[37] Submission 34, p 2; Submission 63, p 6; Cr Neil Westcott, Evidence, 28 May 2024, p 40.

> …the loss of birthing service in our brand-new Parkes Hospital back in 2019. That was the canary in the coalmine. The loss of that single facility has meant the loss of anaesthetists, the loss of midwives, the downgrading of surgery—albeit, we have the most modern of facilities, the most modern of hardware and the lack of people to procedure in those.[38]

1.32 The closure of local maternity services can also add to the workloads of understaffed clinical teams in larger rural hospitals that take in patients from these communities. Dr Alam Yoosuff, Vice President, Rural Doctors' Association NSW, reported that in these instances, rural base hospitals face an increased workload and unmanageable theatre list, which is further complicated when they have a limited number of obstetricians available.[39]

Plans are needed to maintain and re-establish hospital maternity services

1.33 To support the maintenance and improvement of maternity services in RRR settings, stakeholders called for the development of key performance indicators against which services can be measured.[40] Dr Rachel Christmas, President, Rural Doctors' Association NSW, proposed the development of a framework with performance indicators such as 'the re-opening of maternity services' and 'increasing the percentages of women birthing rurally'. She noted that this type of framework would promote government accountability for specific outcomes.[41]

1.34 During the public hearings, Mr Luke Sloane, Deputy Secretary, Regional Health, NSW Health, told the Committee that if a town's birth rate is low, this may impact the ability of clinical staff to maintain their skills. He highlighted the need to consider patient safety when maintaining or re-establishing services.[42]

1.35 However, Dr Yoosuff explained that a town's low birth rate may be a result of limited local maternity services and women being transferred to other facilities to give birth. Dr Yoosuff emphasised the need to develop services with a focus on a town's population, rather than its current birth rate:

> If town X only has 40 births per year, then you could say, "Look, this is not a viable place for a clinician to get hands-on experience. It will be a safety issue for mothers. It is not a well-run place in that number of cases, so we need to be looking at closing it down." That's one way to look at it. The other way to look at it is town X will only have 40 deliveries per year, but town X's catchment is 15,000 or 20,000 population. Where are these people going?[43]

1.36 The Committee supports the idea that, where services are operating with reduced capability, those services should be built up and not further reduced by default. This needs to be done with consideration of a town's population size.

1.37 We were pleased to hear that NSW Health has taken action to re-open the Glen Innes maternity service in the Hunter New England LHD, with a new collaborative

[38] Cr Neil Westcott, Evidence, 28 May 2024, p 40.

[39] Dr Yoosuff, Evidence, 3 June 2024, p 17

[40] Dr Christmas, Evidence, 3 June 2024, p 14; Dr Yoosuff, Evidence, 3 June 2024, pp 15-16.

[41] Dr Christmas, Evidence, 3 June 2024, p 14.

[42] Mr Sloane, Evidence, 3 June 2024, p 38.

[43] Dr Yoosuff, Evidence, 3 June 2024, p 17.

model of care.[44] However, we note that this appears to be an isolated example, and more needs to be done at the statewide level to re-establish deteriorating maternity services. We are deeply concerned that, although PC2 Recommendation 27 was reported as complete, there is limited evidence of plans to re-open services that have closed across RRR NSW.

1.38 Greater clarity and transparency in maternity service planning is clearly warranted. The Committee is of the view that NSW Health needs to take the lead on this work and play a stronger role in planning for maternity services. We recommend that NSW Health urgently assess its maternity services and develop a statewide plan for maintaining and re-establishing hospital birthing services across RRR NSW. These plans should incorporate performance indicators, including the number of births delivered in regional and rural public hospitals against the birth rate of their catchment population. They should also capture changes in service levels over the last decade, and consider how the tiered perinatal network structure can support smaller units and communities more effectively.

1.39 We believe that these actions will address the intent of the original PC2 recommendation. Developing a statewide, publicly accessible plan to maintain and re-establish services will at least improve accountability and provide greater transparency around the measures that NSW Health intends to take to address maternity service deterioration across RRR NSW.

Attraction and retention of obstetric trainees

Recommendation 2

That NSW Health work with colleges and other relevant stakeholders to:

- **identify and remove barriers to attracting and retaining obstetric trainees in remote, rural and regional NSW, and**
- **set targets for the number of obstetric specialists and rural generalists that are employed by rural and regional LHDs after completing their training**
- **ensure that there are fully functioning networked services for clinical support and training.**

1.40 As noted above, obstetrician shortages can significantly impact the availability of maternity services in RRR NSW. Any plans to maintain and re-establish these services need to consider the attraction and retention of both GP Obstetric and specialist obstetric trainees.

1.41 Recommendation 14 of the PC2 report urged NSW Health to work with stakeholders to increase rural GP and specialist training positions. NSW Health has since reported some progress on this recommendation, including funding for

[44] Mr Sloane, Evidence, 3 June 2024, p 39; NSW Health, Glen Innes Hospital launches maternity services for pregnant women, media release, 5 May 2024, viewed 28 February 2025; *Progress Report*, September 2024, p 60.

some new intern and postgraduate junior doctor positions.[45] However, there are barriers affecting rural obstetric training which we believe will impact the growth of the obstetric workforce in RRR NSW.

1.42 The Committee was pleased to hear of some successful recruitments of obstetric graduates in Tamworth and Dubbo.[46] However, Royal Australasian College of Medical Administrators stated that there is limited access to obstetric and gynaecology training in rural and regional areas, including for GPs seeking to upskill in these areas. This is placing pressure on rural and regional maternity service planning.[47]

1.43 We were particularly concerned by the low numbers of GP Obstetric trainees. In 2024, NSW Health reported that there were approximately 147 rural and regional obstetric and gynaecology specialist trainees. However, there were only two GP Obstetric trainees in both 2023 and 2024, and this number has been declining since 2019.[48] This is an alarming shortfall, as rural and regional specialist services like obstetrics are primarily delivered by General Practitioners that are contracted to hospitals as Visiting Medical Officers (GP VMOs).[49]

1.44 We also heard that although specialist obstetric students may opt for a rural pathway during their training, they may not continue on with rural practice after completing study.[50] In 2016, RANZCOG began offering a Rural Integrated Training Pathway (RITP) as part of their training program for specialist obstetric trainees. Since this time, ten trainees have started the RITP and three have completed the fellowship, but none are based in rural specialist practice.[51]

To become a specialist obstetrician in Australia, an individual must complete the six year Fellowship of Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) training program. [52]

1.45 The Committee heard that there is a 'rural reluctance' among medical graduates to train and work in both GP and specialist obstetrics due to demanding workloads.[53] RANZCOG told us that junior doctors do not want to train and work in GP obstetrics, which can leave training positions vacant in areas like Orange and Tamworth. We also heard that a disproportionate number of obstetric

[45] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 77; *Progress Report*, September 2024, pp 35-36.

[46] Associate Professor Greenberg, Evidence, 28 May 2024, p 37; Dr Woods, Evidence, 3 June 2024, p 41.

[47] Submission 65, p 7.

[48] Answers to questions on notice and supplementary questions, NSW Health, 24 June 2024, p 5.

[49] Submission 43, p 5; Submission 63, p 5; Dr Christmas, Evidence, 3 June 2024, p 14.

[50] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Fellowship of RANZCOG specialist training, viewed 4 February 2025; Answers to questions on notice and supplementary questions, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 28 June 2024, p 1.

[51] Answers to questions on notice and supplementary questions, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 28 June 2024, p 1.

[52] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Fellowship of RANZCOG specialist training, viewed 4 February 2025; Answers to questions on notice and supplementary questions, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 28 June 2024, p 1.

[53] Dr Wilson, Evidence, 28 May 2024, p 15.

trainees are staying in metropolitan areas, with high workloads and stress being common deterrents to working in rural obstetrics.[54]

1.46 Dr Lilach Leibenson, Senior VMO Obstetrician and Gynaecologist, and Representative for Rural and Remote NSW, RANZCOG, told the Committee that GP obstetricians do not want to be on-call at hospitals due to the high level of risk they are exposed to and limited professional support. She asserted that obstetrics in rural and regional areas is an 'extremely difficult' and 'dangerous' profession, which is undesirable for a majority of doctors who could risk losing their practising license over any clinical mistake.[55]

1.47 We also heard that practitioners who provide obstetric services in rural areas are often burnt out, have no sick leave, lack professional support and experience challenges maintaining clinical skills.[56] For example, RDA NSW told us that accommodations to support GP obstetric trainees to practice locally with experienced staff are frequently rejected. They stated that this has led to an 'unattractive, unsupported perception of training in rural obstetrics'.[57]

1.48 Ms Fiona Davies, Chief Executive Officer, Australian Medical Association NSW, urged NSW Health to prioritise growing and stabilising the regional obstetrics workforce, and making it one that trainees want to join.[58]

1.49 The Committee is of the view that obstetrics in rural and regional NSW is reaching a crisis point and urgent action is needed to develop a specialised workforce to keep local services viable. Ensuring a sustainable pipeline of new trainees that are able to enter the regional obstetrics workforce is an essential part of this.

1.50 In our first report, we recommended a range of measures to retain medical students in regional areas and system wide improvements to employment conditions and workplace culture in RRR health services.[59] These recommendations were mostly supported in principle by the NSW Government[60] and, if implemented, would be a start in improving the desirability of RRR obstetrics practice.

1.51 However, the Committee considers that improving the appeal of training and working in rural obstetrics is needed. This includes offering more professional support and addressing workplace issues such as burnout and stress. We also believe that setting targets for the employment of trainees in rural and regional

[54] Dr Leibenson, Evidence, 3 June 2024, p 8; Answers to questions on notice and supplementary questions, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 28 June 2024, p 2.

[55] Dr Leibenson, Evidence, 3 June 2024, p 9.

[56] Submission 9, p 1; Submission 44, p 4; Submission 60, p 6; Submission 63, p 3; Dr Sara, Evidence, 3 June 2024, p 5; Professor O'Mara, Evidence, 3 June 2024, p 6; Dr Leibenson, Evidence, 3 June 2024, p 9.

[57] Submission 63, p 3.

[58] Ms Fiona Davies, Chief Executive Officer, Australian Medical Association, Transcript of evidence, 3 June 2024, p 16.

[59] *Implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, August 2024, pp ix-xi.

[60] NSW Government, *Response to Inquiry into the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, February 2025, p 12.

LHDs will help to improve the number and distribution of obstetricians in the rural health system. Additionally, there need to be functioning networks of support for trainees and practitioners, whereby higher level services provide clinical advice and training to other services as required, in a truly collegiate manner. We recommend that NSW Health work with colleges and relevant stakeholders to:

- identify and remove barriers to the attraction and retention of trainees in rural and regional obstetrics
- set targets for the number of obstetric specialists and rural generalists that are employed by rural and regional LHDs after completing their training
- ensure that there are fully functioning networked services for clinical support and training.

Midwifery workforce challenges

Finding 2

Despite incentives to attract midwives to remote, rural and regional practice, there are still significant workforce challenges for midwives working in rural and regional maternity services in NSW.

Recommendation 3

That NSW Health work with professional midwifery associations and other relevant stakeholders to address challenges faced by its remote, rural and regional midwifery workforce. As part of this work, NSW Health should work with rural and regional Local Health Districts to:

- **collect necessary data to monitor the application of the Rural Health Workforce Incentive Scheme at the local level and ensure it is applied fairly and consistently**
- **identify where on-call arrangements are not in effect**
- **increase the number of rural and regional placements available to midwifery trainees and graduates.**

1.52 The PC2 report made a number of recommendations to support the rural and regional midwifery and nursing workforce. Specifically, Recommendation 19 called on rural and regional Local Health Districts (LHDs) to:

- formalise and remunerate on-call arrangements in line with industrial awards
- engage with emergency departments (EDs) to create plans that address security issues

- increase and formalise professional development opportunities, ensuring that these opportunities are considered in rostering.[61]

1.53 Recommendation 20 also urged NSW Health to:

- strengthen partnerships with the university sector to support local people to become midwives through rurally and regionally based education
- develop partnerships across rural, regional and metropolitan LHDs to devise programs for midwives to practice in rural and remote locations
- roll out professional, financial and career enhancement incentives for rurally and remotely based midwives[62]

1.54 The Committee explored the implementation of Recommendations 19 and 20 in its first report.[63] NSW Health has since reported that the implementation of Recommendation 19 is in progress and the implementation of Recommendation 20 has been completed, citing various measures including workforce incentives.[64]

1.55 However, the Committee is concerned that the RRR midwifery workforce continues to face staffing shortages, challenges with on-call arrangements and limited professional development opportunities, as detailed below. The Committee notes that workforce shortages create problems for professional support and workplace well-being. Conversely, these workforce issues can make working as a midwife in RRR NSW less appealing and subsequently make addressing workforce shortages more difficult.

1.56 Midwives are integral to delivering maternity care, and rural and regional maternity services cannot be strengthened without a strong midwifery workforce. The Committee recommends that NSW Health work with relevant stakeholders to address workforce challenges faced by midwives in RRR NSW, with a focus on issues related to the Rural Health Workforce Incentive Scheme, on-call arrangements and local placements.

Incentives for rural midwives

1.57 The Committee is pleased to note that NSW Health has taken some positive steps to attract midwives to rural and remote NSW, including the introduction of a one-off $20 000 bonus for midwives relocating to small rural towns and remote communities. The six-month trial has been implemented under the Rural Health Workforce Incentive Scheme (RHWIS) and will end on 31 March 2025. There is also a New Graduate Nursing and Midwifery Rural Support Incentive that

[61] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 99.

[62], *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 100.

[63] *Implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health,* August 2024, pp 37-38.

[64] *Progress Report*, September 2024, pp 44 – 48.

provides a one-off $1000 payment to assist non-local graduate registered nurses and midwives looking for employment in rural LHDs with relocation costs.[65]

1.58 Although there was some acknowledgement of incentives available to midwives during the inquiry,[66] stakeholders also described the inequitable application of the RHWIS and noted that incentives may be overlooking midwives that are already based in rural areas.[67] This issue appears to have persisted since the Committee's first inquiry.[68]

1.59 NSW Nurses and Midwives' Association (NMA) stated that there are slight variations in how the RHWIS is applied across and within LHDs. For example, eligibility for staff working at the same regional site may depend on which sub-locale they are from. They told us that the scheme is divisive and has prompted resignations.[69]

1.60 NSW Health stated that rural health workforce incentives are geared towards attracting and retaining health professionals in these areas.[70] However, Ms Aya Emery, Policy Officer, Australian College of Midwives (ACM), told us that incentives can exclude midwives and may 'fail to recognise the contribution and retention of midwives who already live in rural and remote locations in New South Wales.'[71]

1.61 In our first report, we recommended that the RHWIS be reviewed and modified to ensure it is implemented fairly and actually incentivises staff retention (in addition to recruiting new staff).[72] The NSW Government has since supported this recommendation in principle, noting that the RHWIS Policy Directive was updated in April 2024 to 'provide more definition and clarity in the scheme's local administration'. The NSW Government response also notes that the RHWIS was 'designed with fairness principles' and that it applies to 'new and existing health workers working in eligible positions.'[73]

1.62 The Committee is pleased to hear that the RHWIS Policy Directive was updated last year to provide greater clarity on its local implementation. However, we are also of the view that updating policy guidelines will not necessarily guarantee fairer application of the RHWIS in practice. We recommend that NSW Health collect necessary data on the application of the RHWIS at the local level so that it

[65] NSW Government, $20,000 sign-on bonus to fill midwifery roles in regional NSW | NSW Government, viewed 7 February 2025; Submission 43, p 12; Health Education and Training, New Graduate Nursing and Midwifery Rural Support Incentive, viewed 10 February 2025.

[66] Submission 48, p 11; Dr Leibenson, Evidence, 3 June 2024, p 12.

[67] Submission 48, pp 5, 10; Ms Emery, Evidence, 31 May 2024, p 2; Mr Whaites, Evidence, 31 May 2024, p 3.

[68] *Implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, August 2024, pp 19-20.

[69] Submission 48, p 10.

[70] Submission 43, p 11; Mr Richard Griffiths, Executive Director, Workforce Planning and Talent Development, Ministry of Health, NSW Health, Transcript of evidence, 3 June 2024, p 33;

[71] Ms Emery, Evidence, 31 May 2024, p 2.

[72] *Implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, August 2024, pp 19-20.

[73] NSW Government, *Response to Inquiry into the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, February 2025, p 6.

can effectively monitor how the Scheme is being applied across rural and remote LHDs.

On-call arrangements

1.63 NSW Health has reported that there are on-call arrangements for nurses and midwives in most regional LHDs.[74] However, the Committee heard that formalised on-call arrangements have not consistently been implemented across public health facilities in NSW and that these arrangements are lacking in many birthing units across remote, rural and regional NSW.[75]

1.64 NSW NMA expressed concern that this has led to informal on-call arrangements that do not offer sufficient compensation to midwives. In these circumstances, midwives are asked to work additional hours or overtime, and can feel obligated to accept requests when they are aware of staffing limitations at their workplace.[76]

1.65 This point was also made in the ACM submission, which reported results from a member survey. RRR midwives who completed the survey described on-call arrangements during their shift work as 'inadequate and underpaid'. The survey revealed examples of midwives being on call for long durations of time without compensation, and instances of managers recording on-call shifts as regular shifts to avoid paying on-call rates.[77]

Professional development opportunities

1.66 In reporting on progress made against Recommendation 20, NSW Health noted various professional development programs that enable midwives to experience rural and remote practice. These programs have been devised through partnerships between rural, regional and metropolitan LHDs. NSW Health state that LHDs are also running various education programs to develop the local midwifery workforce, including professional development and leadership pathways.[78]

1.67 However, the Committee heard that there is limited exposure to rural practice for new career midwives. When considering a 'plight' of graduates in the midwifery field, NSW NMA observed that in 2024, a 12-month metropolitan/rural exchange program was available to nurses, but not midwives. ACM stated that, in some instances, the relationships to facilitate such exchanges between regional and metropolitan LHDs have deteriorated. NSW NMA recommended that the program be reinstated for graduate midwives, noting that a metropolitan-rural exchange program could enhance RRR midwifery and refine skills.[79]

1.68 Stakeholders also stated that there are limited professional development opportunities for midwives and that undertaking training is contingent upon

[74] *Progress Report*, September 2024, p 44.
[75] Submission 48, p 7; Submission 58, p 4; Mr Whaites, Evidence, 31 May 2024, p 5.
[76] Submission 48, p 7; Mr Whaites, Evidence, 31 May 2024, p 5.
[77] Submission 58, pp 4-5; Ms Emery, Evidence, 31 May 2024, p 5.
[78] *Progress Report*, September 2024, pp 47-48.
[79] Submission 48, p 9; Submission 58, p 8.

'staffing shortages and local workplace priorities.'[80] The Committee heard that midwives' study leave requests are rarely approved and when they are, attending training may be costly.[81] ACM further noted that accommodation and travel costs to attend training are not remunerated and are often covered by regional midwives themselves.[82]

Traineeships and placements

1.69 NSW Health report that there are robust partnerships between all regional LHDs and education providers to aid local workforce growth and development. Some of this work includes improving access to training and clinical placements for local students. For example, the Central Coast LHD has placement agreements with various universities for undergraduate and postgraduate nursing and midwifery students. Local students are given priority for these placements. Additionally, the Southern NSW LHD has a university partnership for regional students to complete undergraduate midwifery studies while at home.[83]

1.70 Mr Luke Sloane, Deputy Secretary, Regional Health, NSW Health, also told the Committee that there are 'good pipelines for midwives', including MidStart. MidStart is a recruitment process that offers postgraduate midwifery student positions at public hospitals to registered nurses training as midwives. MidStart is also connected to NSW Health's Mentoring in Midwifery (MiM) program, as it pairs participants with a MiM mentor.[84]

1.71 Additionally, NSW Health offers $5000 rural undergraduate scholarships to nursing and midwifery students, and post-graduate scholarships that range up to $10 000.[85]

1.72 In July 2024, the Midwifery Pathways in Practice (MidPiP) was launched to assist practising and trainee midwives to navigate 'opportunities for professional growth, support and optimal practice.' A Midwifery Leaning Navigator Tool is being created in partnership with the Health Education and Training Institute (HETI) as part of MidPiP.[86]

1.73 NSW Health also report that there is extra support available to midwives, including graduates, as a result of increased Clinical Midwife Educator (CME) positions. CMEs provide clinical education for new and current midwifery staff.[87]

1.74 Inquiry participants noted some improvements for students training as midwives, such as additional government funding for Graduate Diploma in Midwifery

[80] Submission 48, p 7; Submission 58, p 6; Submission 63, p 3; Ms Emery, Evidence, 31 May 2024, p 2.

[81] Submission 48, p 7; Submission 58, p 6.

[82] Submission 58, p 6.

[83] *Progress Report*, September 2024, pp 47-48; Submission 43, pp 14-15.

[84] Mr Sloane, Evidence, 3 June 2024, p 39; NSW Health, 2025 MidStart Handbook, 28 March 2024, viewed 7 February 2025, pp 1, 5.

[85] *Progress Report*, September 2024, pp 44-46; Submission 43, pp 12, 15-16.

[86] *Progress Report*, September 2024, p 46; NSW Health, Midwifery Pathways in Practice (MidPiP) fact sheet, viewed 7 February 2025.

[87] Submission 43, p 14; NSW Health, Clinical Nurse/Midwifery Educator (CN/MA) Leader Success Profile, August 2024, viewed 10 February 2025, p 9.

positions and a successful exchange program for metropolitan midwifery trainees in Broken Hill.[88]

1.75 However, the Committee also heard that there are challenges with midwifery training, including insufficient funding for CME staffing to support training and for backfilling positions of nurses training to become midwives. Various issues were raised in relation to placements, such as:

- a considerable shortage of placements
- issues with the coordination of metropolitan placements for rural trainees, such as short placement notices that can affect trainees' childcare and accommodation arrangements
- access to accommodation for rural placements.[89]

1.76 ACM called for improved support for midwifery students to experience rural and remote practice and to train locally among their communities.[90]

Other workforce challenges

1.77 Stakeholders raised a number of other challenges related to workplace and employment conditions, including ongoing security concerns, despite NSW Health reporting that they have addressed Emergency Department security issues.[91] Stakeholders also expressed concerns about a low pay loading for midwifery group practice, a short supply of accommodation for practising midwives relocating to RRR areas, and lack of midwifery leadership.[92] We are particularly concerned by this latter issue, noting the importance of leadership in improving workplace culture.

1.78 In summary, the Committee notes that there are complex challenges impacting on the retention of the midwifery workforce in RRR NSW, including the fair and consistent implementation of incentives, on-call arrangements, and local placements. We recommend that NSW Health work with professional midwifery associations, rural and regional LHDs and other relevant stakeholders to address these challenges at both the state and local level.

[88] Submission 58, p 8.

[89] Submission 48, p 9; Submission 58, pp 7-8.

[90] Ms Emery, Evidence, 31 May 2024, p 2.

[91] *Progress Report*, September 2024, pp 44-46; Submission 43, pp 15-16.

[92] Submission 48, p , 12; Submission 58, pp 4-5, 9; Ms Emery, Evidence, 31 May 2024, p 2; Mr Whaites, Evidence, 31 May 2024, pp 3, 7; Dr Scarf, Evidence, 31 May 2024, p 4; Dr Leibenson, Evidence, 3 June 2024, p 4; Answers to questions on notice and supplementary questions, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 28 June 2024, p 2.

Midwifery continuity of care

Midwifery Continuity of Care (MCoC) refers to maternity care models where the same midwife, or small team of midwives, provides care to women during and after their pregnancy. MCoC has many benefits for mothers and babies, such as:

- improved physical and psychosocial outcomes, including early risk identification during pregnancy
- lower probability of intervention and birth trauma
- a decreased rate of developmental and behavioural challenges for children.[93]

MCoC models are more cost effective for the health system, when compared to other models of maternity care, and may assist in recruiting and retaining RRR midwives. Australian College of Midwives noted that midwives are more satisfied working in these models and are less likely to burn out or experience psychological distress.[94]

Finding 3

Workforce shortages and restrictions on visiting rights create challenges with establishing and sustaining midwifery continuity of care models for remote, rural and regional communities.

Recommendation 4

That NSW Health work with all rural and regional Local Health Districts to prioritise the implementation of midwifery continuity of care models, including co-designed Birthing on Country services for Aboriginal women in remote, rural and regional areas.

Recommendation 5

That NSW Health work with all rural and regional Local Health Districts to actively consider removing restrictions on visiting rights for privately practising midwives, where these restrictions are in place.

1.79 The PC2 report acknowledged that implementing the midwifery continuity of care model would ensure women received consistent support throughout their pregnancy and birth. Recommendation 26 of the report called for the NSW Government to roll out the midwifery continuity of care model across remote, rural and regional NSW.[95]

1.80 During the current inquiry, NSW Health told us that MCoC models, including Midwifery Group Practice, are available in each Local Health District.[96] They also reported that the implementation of Recommendation 26 had been completed,

[93] Submission 58, p 10; Ms Weatherstone, Evidence, 31 May 2024, p 4; Dr Scarf, Evidence, 31 May 2024, p 8.

[94] Submission 48, p 14; Submission 58, p 10; Ms Weatherstone, Evidence, 31 May 2024, p 8.

[95] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 124,142.

[96] Answers to questions on notice and supplementary questions, NSW Health, 24 June 2024, p 7.

noting publication of the *Connecting Listening and Responding: Blueprint for Action – Maternity Care in NSW* (the Blueprint) and the updated *NSW Health Continuity of Care Models: A Midwifery Toolkit.*[97]

1.81 The Blueprint seeks to address organisational challenges in maternity care including, 'establishing and sustaining continuity of care and models of maternity care'. NSW Health has set up two committees to implement the Blueprint, including the NSW Health Maternity Expert Advisory Group. The group's membership includes Obstetric and Midwifery District Co-leads.[98] NSW Health has also set up a Midwifery Continuity of Care Community of Practice (CoP) which meets monthly. The CoP is a forum for midwifery leaders to discuss the 'development, implementation and sustainability of midwifery continuity of care models in their services.'[99]

1.82 However, during our inquiry, stakeholders did not agree that Recommendation 26 had been implemented in practice. Australian College of Midwives (ACM) asserted that 'widespread implementation' of midwifery continuity of care models has not been achieved in NSW, especially in rural and regional areas. ACM reported that, as of October 2023, only 22 per cent of women in NSW received continuity of care throughout their perinatal period.[100]

1.83 While the Committee heard that there are some successful examples of MCoC models in some regional and remote areas,[101] we were told that progress with establishing midwifery group practice in these areas has been slow. Stakeholders reported challenges with establishing and maintaining regional MCoC models, including midwifery staffing shortages.[102]

1.84 NSW Health acknowledged that recruiting obstetricians and midwives to regional areas is challenging and affects the provision of continuity of care.[103] Mr Luke Sloane, Deputy Secretary, Regional Health, NSW Health, told us that returning birthing services to regional communities is largely dependent on recruitment, particularly of midwives.[104]

1.85 Mr Michael Whaites, Assistant General Secretary, NSW Nurses and Midwives' Association (NMA), also noted that attracting midwives to midwifery group practice is challenging. He stated that although this is the desired model of work, remuneration needs to be improved to recruit and retain midwives into these models of care.[105]

---

[97] *Progress Report*, September 2024, pp 59-60; NSW Health, *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW*, March 2023; NSW Health, *Continuity of Care Models: A Midwifery Toolkit*, June 2023.

[98] *Progress Report*, September 2024, p 59.

[99] *Progress Report*, September 2024, p 59.

[100] Submission 58, p 11; Ms Emery, Evidence, 31 May 2024, p 2.

[101] Submission 48, pp 5, 11-12.

[102] Submission 58, pp 11-12; Dr Scarf, Evidence, 31 May 2024, p 4; Submission 48, pp 11-12.

[103] Submission 43, p 10; Mr Sloane, Evidence, 3 June 2024, p 39.

[104] Mr Sloane, Evidence, 3 June 2024, p 39.

[105] Submission 48, p 12; Mr Whaites, Evidence, 31 May 2024, p 4.

1.86 MCoC can also be provided by privately practising midwives (PPMs) with visiting and admitting rights in hospitals. These rights allow PPMs to provide care to women in public health facilities.[106] However, we heard that a majority of Australian hospitals do not permit visiting rights for PPMs, even though care provided by midwives with these rights can have more positive clinical outcomes than alternative options.[107]

1.87 ACM also noted that limitations on visiting rights are an obstacle to expanding Birthing on Country services.[108]

Birthing on Country models

1.88 Under Birthing on Country (BoC) models, midwives provide culturally safe continuity of care to Aboriginal women and babies. BoC models have been shown to improve maternal outcomes for Aboriginal women and babies, as women are more likely to attend antenatal visits, less likely to have a premature birth, and more likely to exclusively breastfeed when discharged from hospital.[109]

1.89 The importance of culturally safe maternity care was recognised by the Select Committee on Birth Trauma in 2024, which recommended that the NSW Government invest in and expand Birthing on Country models. In its response, the NSW Government supported this recommendation and noted the provision of significant funding to support the establishment of Waminda's Gudjaga Gunyahlamai Birth Centre and Community Hub in Nowra. The centre will be Australia's first Aboriginal owned and midwifery-led freestanding birth centre, and is based in the community rather than in a hospital.[110]

1.90 During our inquiry, many stakeholders praised Waminda as an effective, best practice example of the BoC model.[111] More information about Waminda is included below.

[106] Submission 58, pp 10, 12; NSW Health, Policy Directive: Visiting Endorsed Midwife Practice, 30 October 2023, viewed 11 February 2025, p 1.

[107] Submission 58, p12; Dr Scarf, Evidence, 31 May 2024, p 6.

[108] Submission 58, pp 11-12.

[109] NSW Health, NSW Government supports first Birthing on Country program, media release, 13 June 2024, viewed 21 February 2025; NSW Government, Development of Australia's first Aboriginal owned and midwifery-led free standing birth centre underway in NSW, media release, 1 October 2024, viewed 21 February 2025.

[110] *Birth Trauma*, May 2024, p 112; NSW Government, Response to Inquiry into Birth Trauma, Parliament of NSW, 29 August 2024, viewed 24 February 2025, p 23; NSW Government, Development of Australia's first Aboriginal owned and midwifery-led free standing birth centre underway in NSW, viewed 21 February 2025.

[111] South Coast Women's Health and Wellbeing Aboriginal Corporation, Waminda, viewed 28 February 2025; Submission 48, p 12; Ms Weatherstone, Evidence, 31 May 2024, p 5; Dr Scarf, Evidence, 31 May 2024, p 5; Mr Whaites, Evidence, 31 May 2024, p 6; Mr Edwards, Chief Operating Officer, Rural Doctors Network, Transcript of evidence, 3 June 2024, p 8.

Case study: Waminda

Waminda is an Aboriginal health service located in Nowra that uses BoC principles to provide culturally safe maternity care to women and their families in the South Coast region. Waminda offers continuity of care throughout pregnancy, birth and post birth. It also offers holistic care outside of pregnancy and birth, including pre-conception and childhood support.[112]

In May 2024, Waminda launched the Minga Gudjaga Midwifery Practice with the support of Illawarra Shoalhaven Local Health District (ISLHD). Under this phase of Waminda's Birthing on Country initiative, Waminda's privately practising midwives (PPMs) provide labour and birth care to women at Shoalhaven Memorial District Hospital. This is supported by visiting rights for Waminda's PPMs.

Waminda has a decades-long vision that was co-designed with local healthcare providers and the community. This long-term vision is a departure from many healthcare pilots, which are in place for two to three years.[113]

1.91 The Committee is pleased to see the progress that has been made in the South Coast region and the commitment from ISLHD to support Waminda. However, as we heard during the inquiry, this is just one example, and there are large Aboriginal communities in regional centres such as Wagga Wagga and Dubbo that are in need of similar Birthing on Country services.[114] ACM called for the 'upscale and rollout' of Birthing on Country models to be funded and prioritised.[115]

1.92 The Committee is also concerned that there may be an underrepresentation of Aboriginal employees within the midwifery workforce. NSW NMA highlighted that only 1.3 per cent of the national midwifery workforce has an Aboriginal and Torres Strait Islander background. They explained that this lack of representation poses barriers to service access and impacts the delivery of culturally appropriate care.[116] Issues relating to the broader Aboriginal health workforce in RRR NSW are explored in more detail in Chapter Seven.

1.93 The Committee acknowledges the importance of expanding MCoC, including co-designed Birthing on Country services for Aboriginal women in RRR areas. We recommend that all rural and regional Local Health Districts prioritise the implementation of these models at the local level. This should include consideration of removing restrictions on visiting rights for privately practising midwives, where relevant. We are also of the view that midwifery leaders should be included in the planning and execution of these models, in order to ensure that they are functional and sustainable.

[112] Submission 48, p 12; Ms Weatherstone, Evidence, 31 May 2024, p 5; Dr Scarf, Evidence, 31 May 2024, pp 5-6; Mr Whaites, Evidence, 31 May 2024, p 6; Mr Edwards, Evidence, 3 June 2024, p 8.

[113] Mr Edwards, Evidence, 3 June 2024, p 8.

[114] Dr Scarf, Evidence, 31 May 2024, p 5; Mr Whaites, Evidence, 31 May 2024, p 6.

[115] Submission 58, p 14.

[116] Submission 48, p 13.

Access to paediatric services

Finding 4

A shortage of specialist GPs and allied health clinicians in remote, rural and regional areas has meant that many paediatric specialists working in public hospitals are no longer seeing non-emergency patients, particularly those with developmental conditions.

Finding 5

Paediatric services in NSW regional public hospitals have long wait times that can vary between 18 months to six years, which can exacerbate developmental issues for children in need of paediatric care.

Recommendation 6

That the NSW Government take urgent action to address the shortfall in paediatric services across hospital and community-based settings in remote, rural and regional NSW. Consideration should be given to:

- **increasing funding to provide early intervention programs with sustainable financial support**
- **targeted recruitment efforts to improve the availability of paediatric, GP and allied health services.**

1.94 The Portfolio Committee No. 2 (PC2) report did not make any specific findings or recommendations with respect to paediatric services in RRR NSW. However, the report highlighted the long distances and extensive wait times that NSW's remote, rural and regional residents faced in accessing publicly funded specialist and allied health services. It cited examples of wait times ranging from months to years, including a two year wait-list for a family to see a paediatrician.[117]

1.95 During the current inquiry, NSW Health told the Committee about initiatives to improve paediatric services, including:

- the Newborn and paediatric Emergency Transport Service (NETS), which provides on-call tertiary advice to support acute services
- virtualKIDS, which is an all hours 'nurse-led virtual care service offering remote clinical advice, education and support to NSW families'
- reforms to allow GPs to co-prescribe some medications with paediatricians and psychiatrists.[118]

[117] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 22-24.

[118] Dr Helen Goodwin, Chief Paediatrician, NSW Health, Transcript of evidence, 3 June 2024, p 45; NSW Government, virtualKIDS, viewed 19 February 2025.

1.96 NSW Health also has a Paediatric Healthcare Team, which supports providing 'the right care, in the right place, at the right time'.[119]

1.97 However, the Committee notes that none of these measures focus on improving access to paediatric care specifically in rural and regional areas. We heard that regional paediatric services are experiencing 'crisis'[120] and in need of desperate support,[121] and that paediatric waitlists have worsened.[122] The Committee is also concerned that if there were any change to state responsibilities for paediatric management, under the National Disability Insurance Scheme, this would tip the state's paediatric services into crisis.

1.98 The following sections consider challenges with accessing RRR paediatric services, including the paediatric, specialist GP and allied health workforce shortages that are contributing to long waitlists. To address these challenges, we recommend urgent action to address the shortfall in paediatric services across hospital and community-based settings, including increased funding and targeted recruitment efforts. We also recommend that NSW Health works with key stakeholders to explore options for addressing paediatric service gaps through networked models of paediatric care and improved coordination of services.

Lack of access to non-emergency paediatric care

1.99 The Committee heard that access to paediatric services in regional hospitals has 'significantly declined' in the time since the PC2 report.[123]

1.100 Ms Jacqui Emery, Chief Executive Officer, Royal Far West (RFW), stated that a shortage of specialist GPs and allied health practitioners, combined with an increased demand for services, has led to many paediatricians no longer accepting appointments for non-emergency patients. The Committee was particularly concerned to hear that children with developmental or mental health conditions may not be able to get appointments. This results in long waitlists that can vary between 18 months to six years in some rural facilities.[124]

1.101 Waitlists to see a paediatrician for developmental and behavioural issues were reported in multiple regional public hospitals, including Coffs Harbour, Bega, Tamworth and Wagga Wagga. We also heard that paediatric services in Dubbo and Orange are no longer accepting referrals for developmental or behavioural conditions. In their submission, RFW observed that long waitlists had been an ongoing issue that had worsened in the first half of 2024.[125]

1.102 Under these circumstances, regional families may attempt to access paediatric services in other locations. However, the Committee heard that this presents its own challenges. For example, families looking to access paediatric services in a

[119] NSW Health, Paediatric healthcare, viewed 19 February 2025.
[120] Submission 45, p 3.
[121] Submission 60, pp 6-7.
[122] Submission 45, pp 3-4.
[123] Ms Davies, Transcript of evidence, 3 June 2024, p 13.
[124] Ms Emery, Evidence, 31 May 2024, p 3.
[125] Submission 45, pp 3-4.

different region may be rejected by the service if they are not local.[126] Long waitlists of up to two years may also apply to these paediatric services that are already located some distance away.[127] As observed by Ms Emery:

> In Tamworth, it's now a six-year wait. We have had families report to us that, 'Your next best option is to go to Coffs Harbour'—it is quite a way from Tamworth to Coffs Harbour and there's also a two-year waitlist in Coffs Harbour—or be referred to Royal Far West.[128]

1.103 For regional families seeking to access paediatric services, another option is to see a privately practising paediatrician.[129] However, accessing private services can involve prohibitive costs or travelling long distances.[130] These services may also have limited availability and long waitlists of their own.[131]

1.104 The Committee heard that rural and regional families continue to travel long distances to access paediatric services in NSW.[132] National Rural Health Alliance (NRHA) noted, anecdotally, that some families from Bega have been travelling to Sydney due to long local waitlists.[133]

1.105 Ms Margaret Deerain, Director, Policy and Strategy Development, NRHA, also told us that 'rural children are already behind on a lot of health and education outcomes'.[134] The Committee is concerned that long wait times and a lack of access to relevant healthcare support are exacerbating developmental issues for children. When children fall through service gaps, they may start their schooling with developmental delays. For children facing behavioural challenges, these challenges can worsen without treatment.[135]

1.106 RFW noted that the average age of children presenting to their developmental assessment service has reached 10 years old, mostly due to delayed paediatrician referrals.[136] They stated that, at this age, a child's issues 'are much harder and more expensive to address.'[137]

---

[126] Submission 56, p 8.

[127] Submission 45, p 4; Submission 56, p 8; Ms Emery, Evidence, 31 May 2024, p 6.

[128] Ms Emery, Evidence, 31 May 2024, p 6.

[129] Submission 45, p 3; Submission 56, p 8; Ms Emery, Evidence, 31 May 2024, p 3.

[130] Submission 45, p 3; Ms Emery, Evidence, 31 May 2024, p 3.

[131] Submission 56, p 8.

[132] Submission 36, p 2; Submission 45, p 4; Submission 56, p 8.

[133] Submission 56, p 8.

[134] Ms Margaret Deerain, Director, Policy and Strategy Development, National Rural Health Alliance, Transcript of evidence, 3 June 2024, p 29

[135] Submission 45, p 5.

[136] Submission 45, p 4.

[137] Submission 45, p 4.

Workforce challenges

1.107 Multiple stakeholders reported challenges with the paediatric, specialised GP and allied health workforce.[138]

1.108 The Australian Medical Association NSW reported that numerous regional Local Health Districts are experiencing issues with attracting and retaining paediatricians.[139] Inquiry participants also noted instances of paediatricians leaving the workforce without staffing arrangements to backfill their role.[140]

1.109 Dr Helen Goodwin, Chief Paediatrician, NSW Health, told us that although recruiting paediatricians is likely to be more difficult in regional areas, this is a broader issue affecting other places, including metropolitan areas.[141] She stated that there is 'significant and unmet need in the community for children, particularly with developmental and behavioural problems.'[142] She also noted that difficult-to-fill paediatrician roles remain open, despite progress in filling some positions in regional NSW.[143]

1.110 The Committee is concerned that progress has not been felt consistently across different areas within RRR NSW, as paediatric workforce shortages affecting these communities continue to be reported.[144] Mr Michael Whaites, Assistant General Secretary, NSW Nurses and Midwives' Association, told the Committee that a lack of paediatricians means that interventions and specialised care are inaccessible.[145]

1.111 Dr Marcel Zimmet, Chief Medical Officer, RFW, stated that in addition to staff exiting the workforce, there is an increased workload associated with handling complex cases.[146] Local paediatricians have reported 'explosions' of complex behavioural and mental health challenges presenting in children, at an earlier age than has been observed before.[147] Dr Zimmet stated that there are various factors contributing to the complexity of these developmental conditions, including hangover effects from the COVID-19 pandemic, cost of living pressures and natural disasters. He added that, despite a higher workload, there 'hasn't been a system in place to support the local paediatricians or allied health teams to be upskilled'.[148]

1.112 The Committee is concerned that challenges affecting the GP workforce are exacerbating long wait times for paediatricians and delaying timely access to

[138] Submission 45, pp 3, 5-6; Submission 56, p 8; Submission 60, pp 6-7; Ms Emery, Evidence, 31 May 2024, pp 3, 6; Mr Whaites, Evidence, 31 May 2024, p 3; Dr Marcel Zimmet, Chief Medical Officer, Royal Far West, Transcript of evidence, 31 May 2024, p 6; Mr Sloane, Evidence, 3 June 2024, p 46.

[139] Submission 60, p 6.

[140] Ms Emery, Evidence, 31 May 2024, p 6; Submission 56, p 8.

[141] Dr Goodwin, Evidence, 3 June 2024, p 45.

[142] Dr Goodwin, Evidence, 3 June 2024, p 45.

[143] Dr Goodwin, Evidence, 3 June 2024, pp 45-46.

[144] Submission 45, pp 3, 5.

[145] Mr Whaites, Evidence, 31 May 2024, p 3.

[146] Dr Zimmet, Evidence, 31 May 2024, p 6.

[147] Ms Emery, Evidence, 31 May 2024, p 6.

[148] Dr Zimmet, Evidence, 31 May 2024, p 6.

developmental care for RRR children. For example, Royal Far West (RFW) told us that children may be waiting months to be seen by practitioners as a result of rural GP staffing shortages. RFW also noted that developmental issues that were promptly managed by GPs in the past are now being referred on to paediatricians.[149]

1.113 Mr Luke Sloane, Deputy Secretary, Regional Health, NSW Health, also told the Committee that GPs who specialise in paediatric care are difficult to recruit. He highlighted the low numbers of GPs undertaking an advanced traineeship in paediatrics, noting zero uptake in 2024.[150]

1.114 In addition to a shortage of paediatricians, we heard that there is a 'serious shortage' of allied health services that support children's development, including speech and occupational therapy and clinical psychology services.[151] RFW told us that an insufficient supply and an unequal spread of allied health professionals represent a significant barrier to rural communities accessing these health services.[152] They submitted that this shortage of allied health professionals in rural NSW, along with limited paediatrics and diagnostic services, is contributing to long wait times.[153]

Funding of early intervention services for children

1.115 During the inquiry, Royal Far West (RFW) told the Committee that early intervention health services continue to be 'significantly underfunded'.[154]

1.116 RFW also noted that funding for children's assessment and intervention services lies between health and education portfolios.[155] As a result, not-for-profits like Royal Far West plug services gaps, although they may not have sufficient funding to do so. At the public hearing, Ms Emery told the Committee that RFW's developmental referrals for children are surging, but there has been no extra funding for this increased demand.[156] RFW called for the funding of place-based early intervention and assessment programs for children.[157]

1.117 Local Health Districts' budgetary considerations may also be related to an unsustainable paediatric workforce model in regional hospitals.[158]

1.118 The Committee acknowledges that NSW Health is operating in a budgetary context that may be constrained, and we are not of the view that funding increases alone will solve the challenges facing RRR paediatric care. However, in light of the risk that treatment needs and service costs will increase for children who have not been able to access care earlier in their lives, we believe that an

[149] Submission 45, p 5.
[150] Mr Sloane, Evidence, 3 June 2024, p 46.
[151] Submission 45, p 5.
[152] Submission 45, p 6.
[153] Submission 45, pp 5-6.
[154] Submission 45, p 6.
[155] Submission 45, p 7.
[156] Ms Emery, Evidence, 31 May 2024, p 6.
[157] Submission 45, p 7.
[158] Submission 45, p 6.

injection of funding into early, preventative care may lead to significant benefits for NSW, in terms of health outcomes for both children and young people in RRR communities.

1.119 We recommend that the NSW Government take urgent action to address the shortfall in paediatric services across hospital and community-based settings in RRR NSW. This should include consideration of increasing funding to provide early intervention programs with sustainable financial support. Consideration should also be given to targeted recruitment efforts to improve the availability of paediatric, GP and allied health services. We are of the view that this will help to build the capacity of paediatric services in rural and regional hospitals and reduce long wait times for these services. We believe that this will also contribute to alleviating pressure on not-for-profit organisations such as RFW.

1.120 The Committee also notes the importance of exploring formalised networks of paediatric care to ensure that appropriately tiered services are available to RRR communities as needed. This is discussed in more detail in the following section.

Networked models of care and coordinated service provision

Recommendation 7

That NSW Health work with key stakeholders to explore options for addressing paediatric service gaps in rural areas through networked models of care, including through multidisciplinary teams, with a focus on developmental care. This should include the coordination of services between Local Health Districts, Primary Health Networks, relevant government agencies and non-governmental service providers.

1.121 The Committee heard that managing children with complex developmental conditions can be impacted by coordination issues between government departments, health facilities and not-for-profit organisations.[159] In particular, we heard that there are challenges with coordination between health, education and child protection services for highly vulnerable families facing complex issues.[160]

1.122 There may also be communication challenges between paediatric hospital services and not-for-profit organisations that support children with developmental conditions. Ms Jacqui Emery, Chief Executive Officer, Royal Far West, illustrated this through an example of a recent referral in Dubbo:

> …we had a letter from the outpatient clinic in Dubbo, just this week, back to one of our paediatricians. We had assessed a child that had been referred to us. We have completed that assessment, and that child is on medication and needs to be transitioned back to a local paediatrician. We basically got the standard letter back, that clearly stated "we are not seeing children with developmental challenges and here is where you could go to"—basically referring [them] back to Royal Far West.[161]

1.123 Dr Helen Goodwin, Chief Paediatrician, NSW Health, told the Committee that child developmental and behavioural conditions are a broader issue that NSW

[159] Dr Zimmet, Evidence, 31 May 2024, p 6; Ms Emery, Evidence, 31 May 2024, p 7.

[160] Dr Zimmet, Evidence, 31 May 2024, p 6.

[161] Ms Emery, Evidence, 31 May 2024, p 7.

Health cannot resolve alone, as it requires a 'whole-of-community response'. She called for strengthened working relationships across government departments.[162] Similarly, RFW recommended 'better coordination and planning between health, education, and child protection/family services locally'.[163]

1.124 Mr Luke Sloane, Deputy Secretary, Regional Health, NSW Health, described collaborative paediatric initiatives that are in place across Local Health Districts (LHDs). For example, he referred to the Sydney Children's Hospitals Network's KidsGPS program, which offers coordinated support for very specialised care needed in multiple LHDs. He also noted that a number of paediatricians in Bega's South East Regional Hospital have been working closely with local GPs.[164]

1.125 The Committee acknowledges that developmental care requires more than access to a paediatrician, and that adequate capability and capacity across other health disciplines is also needed in RRR NSW. As Mr Sloane observed:

> …it's one thing to have a paediatrician come in and do that specialty assessment, but then the continuum of care falls back to the GP or the allied health team or the multidisciplinary team that will take care of that child going forward, and their family as well.[165]

1.126 Dr Goodwin suggested transitioning towards networked models of care, with health professionals working at their full scope of practice. This may include multidisciplinary teams, including nurse practitioners and allied health professionals, that collaborate to provide coordinated care that is integrated with education and early childhood settings.[166]

1.127 The Committee recommends that NSW Health work with key stakeholders to find ways to address rural paediatric service gaps through networked models of care. These models of care should involve multidisciplinary teams and have a particular focus on developmental care. This work should also include the coordination of services across Local Health Districts, Primary Health Networks, relevant government agencies, and non-government service providers. This coordinated service provision, both within and outside of the health system, is critical to addressing paediatric service gaps in RRR NSW and meeting the health needs of children facing complex developmental challenges.

[162] Dr Goodwin, Evidence, 3 June 2024, p 46.
[163] Submission 45, p 7.
[164] Mr Sloane, Evidence, 3 June 2024, p 46.
[165] Mr Sloane, Evidence, 3 June 2024, p 46.
[166] Dr Goodwin, Evidence, 3 June 2024, p 46.

Chapter Two – Cancer care

Introduction

2.1 Portfolio Committee No. 2 (PC2) found that cancer patients in regional NSW faced significant out-of-pocket costs, which resulted in patients experiencing severe financial distress and often choosing to skip life-saving cancer treatments.[167]

2.2 To address this, the 2022 PC2 report recommended that NSW Health work with the Commonwealth and all relevant service providers to investigate strategies to reduce out-of-pocket costs for public patients accessing public-private services in regional cancer centres (Recommendation 21). The PC2 report also recommended that NSW Health investigate telehealth cancer care models to improve access to cancer treatment to boost clinical trial participation in regional areas (Recommendation 30).[168]

2.3 During the current inquiry, the Committee was pleased to note the progress that has been made in reducing out-of-pocket costs through the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS).[169] We also acknowledge the work that NSW Health has done to eliminate out-of-pocket costs for patients in public-private cancer centres in the Riverina region.[170]

2.4 However, stakeholders continue to report significant out-of-pocket costs for cancer patients in some parts of remote, rural and regional (RRR) NSW.[171] The Committee heard that cancer patients are also increasingly reliant on not-for profit organisations for financial support and transportation.[172] We recommend that NSW Health conduct an audit to determine where significant out-of-pocket costs remain, and work with private providers to reduce any remaining disparities across RRR NSW.

2.5 The Committee is also concerned about the lack of evident progress in improving access to clinical trials. We recommend that NSW Health conduct an interim evaluation of the Rural, Regional and Remote Clinical Trial Enabling Program (R3-CTEP) within the next six months to assess the extent to which the program has

---

[167] 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 139.

[168] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 139, 145 – 146.

[169] Submission 43, NSW Health, p 36; NSW Health, *Progress Report: Parliamentary inquiry into health outcomes and access to health and hospital services in Rural, Regional and Remote New South Wales*, September 2024, p 50.

[170] NSW Health, Cancer patients receive increased access to affordable care in Wagga Wagga, viewed 13 January 2025; Dr Vanessa Johnston, Director of Cancer Information and Support Services, Cancer Council NSW, Transcript of evidence, 31 May 2024, p 33; Submission 32, Can Assist, p 5; Submission 49, Cancer Council NSW, p 10.

[171] Mrs Meggan Harrison, Transcript of evidence, 31 May 2024, p 34; Ms Helen Goodacre, Transcript of evidence, 28 May 2024, p 18.

[172] Submission 32, pp 5-6; Submission 49, p 10.

improved clinical trial participation and to inform its broader implementation across RRR NSW.

Out-of-pocket costs for cancer care

Finding 6

There has been a reduction in out-of-pocket costs for cancer care patients in some regional areas, due to the removal of out-of-pocket costs for public cancer patients in some regions and increased rebates through the Isolated Patients Travel and Accommodation Assistance Scheme.

Finding 7

There are still significant out-of-pocket costs for cancer patients in some regional areas, and not-for-profit organisations are increasingly relied upon to help cover these costs.

Recommendation 8

That NSW Health:

- **conduct an audit of regional cancer centres to determine where significant out-of-pocket costs remain for public cancer patients accessing public-private services, and**
- **work with private providers to address any remaining disparities in these costs across remote, rural and regional NSW.**

2.6 The PC2 report highlighted the significant out-of-pocket costs associated with oncology treatment and the burden this placed on cancer patients. It noted that up to 43 per cent of cancer patients reported financial distress and a further 21 per cent of patients were choosing to skip treatments due to costs.[173]

2.7 PC2 also acknowledged evidence that out-of-pocket costs were being exacerbated by public-private partnerships in regional communities not served by public cancer clinics.[174]

A public-private partnership is a long-term arrangement between the public and private sector for service delivery, usually via public infrastructure. These partnerships offer opportunities to improve service provision.[175]

However, as Cancer Council NSW notes, private healthcare providers set their own fees. These fees may be larger than the Medicare rebate, resulting in significant out-of-pocket costs for patients who are accessing treatment at public-private cancer centres.[176]

[173] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 103 - 105.

[174] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 105 and 139.

[175] NSW Treasury, Public Private Partnerships, viewed 24 January 2025.

[176] Cancer Council NSW, Overview of the Australian healthcare funding system, viewed 24 January 2025; Cancer Council NSW, The financial cost of healthcare, viewed 24 January 2025, p 3.

2.8 The PC2 report recommended that NSW Health, the Commonwealth, and relevant service providers investigate strategies to ensure that public patients being treated in regional cancer centres can access public-private services while reducing out-of-pocket costs (Recommendation 21).[177]

2.9 During the current inquiry, Dr Vanessa Johnson, Director of Cancer Information and Support Services, Cancer Council NSW, highlighted the continuing impact of out-of-pocket costs on cancer outcomes in RRR NSW:

> *Poor cancer outcomes for those in regional and remote New South Wales can be partly attributed to poorer access to high-quality cancer care, clinical trials, diagnostic services, supportive care and palliative care. Even when these services are available, our researchers told us that people may opt out of treatment or skip treatment due to the cost of the service or the transport.*[178]

2.10 The Committee also heard that not-for-profit providers are increasingly relied upon to help cover these costs. For example, the cancer assistance network Can Assist reported that in the first half of 2023-24, they delivered 42 per cent more assistance compared to the same period in the year prior. This assistance covers out-of-pocket costs for treatment, end-of-life drugs and equipment hire, and transport.[179]

2.11 The following sections provide more detail on the out-of-pocket costs associated with public-private cancer treatment and travel for cancer patients in RRR NSW.

Out-of-pocket costs for public-private treatment

2.12 The Committee heard that significant progress has been made since the PC2 report in reducing out-of-pocket costs for public-private cancer services in some regional areas. For example:

- In June 2023, the new private radiotherapy service in Griffith began operating with zero out-of-pocket costs for all patients.[180]
- In July 2024, out-of-pocket costs were removed for all patients at the Riverina Cancer Care Centre in Wagga Wagga, under a new agreement between Murrumbidgee Local Health District (MLHD) and the private operator.[181]

2.13 Can Assist were supportive of these 'considerable advancements' in the Riverina region. However, they noted that a range of additional out-of-pocket costs remain for services that are only offered by private providers in Wagga Wagga. For example, in addition to radiotherapy and/or chemotherapy, a patient with a 12-month cancer treatment profile will typically require 10-12 doctors'

---

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

[178] Dr Johnston, Evidence, 31 May 2024, p 33.

[179] Submission 32, p 6.

[180] Submission 32, p 5; Cancer patients receive increased access to affordable care in Wagga Wagga; Cancer Care, Cancer Care Griffith officially open, viewed 13 January 2025.

[181] Cancer patients receive increased access to affordable care in Wagga Wagga; Dr Johnston, Evidence, 31 May 2024, p 33; Submission 32, p 5; Submission 49, p 10.

appointments (with out-of-pocket costs of $70-$140 per appointment), pathology services, surgery and at least two PET scans. Can Assist reported that these additional costs can easily exceed $10 000 over the course of a year.[182]

2.14 The Committee acknowledges that the Medicare Safety Net can help to limit out-of-pocket costs for out of hospital services. However, this can still result in out-of-pocket costs of several thousand dollars per year.

Under the Extended Medicare Safety Net, a Medicare card holder will be reimbursed for 80 per cent of out-of-pocket costs once they reach the threshold amount for the year. As of 1 January 2025, this threshold amount was $2 615.50 (or $834.50 for concessional cardholders).[183]

2.15 We also heard that there are still significant out-of-pocket costs for public-private services in other regions of NSW. For example, at the Southern Highlands Cancer Centre, which is operated under a public-private partnership, public patients accessing chemotherapy are charged $340 per consultation.[184]

2.16 Cancer Council NSW told us that despite improvements in some areas, the extent of this issue is unclear and there is more work to do in uncovering where patients continue to experience significant out-of-pocket costs. To address this, Cancer Council NSW recommended an audit or stocktake to better understand where public patients are still paying significant out-of-pocket costs in public-private cancer centres.[185]

2.17 The Committee agrees that an audit of regional cancer centres will help to identify regions in NSW where cancer patients are unable to access free or low-cost cancer services, and to determine the breadth of the issue. This is also a necessary step to address any disparities in out-of-pocket costs for public-private patients across RRR NSW.

Out-of-pockets costs associated with travel

2.18 For many people in RRR NSW, the costs associated with travelling long distances can be a barrier to receiving high quality cancer care and can increase the financial burden of a cancer diagnosis.[186]

2.19 Since the PC2 inquiry, NSW Health has sought to address these issues through improvements to the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS). These improvements included increased rebates for patients using private transport and expanded eligibility under the scheme to patients accessing non-commercial clinical trials.[187]

[182] Submission 32, pp 5-6.

[183] Services Australia, What are the Medicare Safety Nets Thresholds?, viewed 28 February 2025.

[184] Mrs Harrison, Evidence, 31 May 2024, p 34.

[185] Dr Johnston, Evidence, 31 May 2024, pp 33-34; Submission 49, p 3.

[186] Submission 49, p 7; Submission 44, Australian Salaried Medical Officers' Federation NSW (ASMOF), p 8.

[187] Submission 43, p 36; *Progress Report*, September 2024, p 12.

2.20 During the current inquiry, stakeholders spoke positively of the progress that has been made in this area. Cancer Council NSW noted that the increase in IPTAAS funding has been 'incredibly well received' and clients have reported 'fewer financial worries due to the improved subsidy rates'.[188]

2.21 In reporting on progress against Recommendation 21, NSW Health noted that the increased use of hypofractionated radiation therapy is also reducing the amount of travel for patients with breast cancer. This type of treatment divides the total radiation dose into fractions that have higher doses than non-hypofractionated treatment. In 2022, 97 per cent of early-stage breast cancer patients in public facilities and 88 per cent in private facilities received hypofractionated external beam radiation.[189]

2.22 Professor Tracey O'Brien, Chief Executive, Cancer Institute, NSW Health, told the Committee:

> What that means for a patient, say, with early stage breast cancer, is that instead of having 30 fractions, which can take five weeks if you have to travel, they can have that done in 15 fractions, or three weeks of travel. We've undertaken, at a statewide level, to ensure that's in every radiotherapy facility.[190]

2.23 However, despite these improvements, several local councils and community groups continued to report a lack of adequate cancer services in their area. These stakeholders told us that their communities often have to travel long distances to access treatment.[191] For example, Gunnedah Shire Council noted that patients are still travelling 200km to Tamworth, due to a lack of locally-based cancer services.[192]

2.24 Southern Highlands Cancer Centre also told us that cancer patients who access community transport from the Southern Highlands to Campbelltown for treatment must wait until all commuting patients have completed their treatment before returning, which may result in a six hour wait. This means that a patient travelling for a 30-minute immunotherapy infusion may spend almost eight hours away from home, once travel time is also factored in.[193]

2.25 The Committee heard that, where travel is required to access cancer care, the co-payment for accessing community transport can be another substantial barrier to accessing these services. In these instances, not-for-profit organisations are often helping to cover the costs.[194]

---

[188] Dr Johnston, Evidence, 31 May 2024, p 34; Submission 49, p 7.

[189] Cancer Institute NSW, Breast Hypofractionation, viewed 24 January 2025; *Progress Report*, September 2024, pp 50-51.

[190] Professor Tracey O'Brien, Chief Executive, Cancer Institute, NSW Health, Transcript of evidence, 3 June 2024, p 43.

[191] Submission 5, Southern Highlands Cancer Centre, pp 1-2; Submission 36, Gunnedah Shire Council, p 3; Submission 50, Leeton Shire Council, p 5; Submission 67, Older Women's Network NSW, p 3; Mrs Jill McGovern, Older Women's Network, Transcript of evidence, 31 May 2024, p 31; Submission 1, Local Government NSW, p 7.

[192] Submission 36, p 3.

[193] Submission 5, pp 1-2.

[194] Submission 49, p 7; Submission 32, pp 2-3.

2.26 For example, Can Assist told us that their funds are being stretched to meet unmet community transport needs and that they are increasingly needing to pay for community transport tickets. Their Forbes branch noted that their greatest expenditure is on travel and accommodation for clients.[195]

2.27 We also heard that, despite improvements to IPTAAS, there is a significant gap within the Scheme, as patients are ineligible to access subsidies for community transport where the provider receives government funding.[196] This issue is explored in more detail in Chapter Seven.

2.28 Cancer Council's Transport to Treatment is a free service for people who cannot afford the community transport co-payment, or have other barriers in accessing community transport. In 2022-23, Transport to Treatment volunteers dedicated more than 25 000 hours to transport over 1600 clients to cancer treatment and other cancer-related appointments. However, in the following financial year, Cancer Council had to introduce more restrictive eligibility criteria. While this helped ensure the sustainability of the service, it also resulted in unmet need.[197]

2.29 These issues associated with travel in RRR NSW are not limited to cancer care. The challenges of improving patient transport, more broadly, are explored in more detail in Chapter Seven.

Virtual cancer care and clinical trial participation

Recommendation 9

That NSW Health commence an interim evaluation of the Rural, Regional and Remote Clinical Trial Enabling Program (R3-CTEP) within the next six months. The evaluation should identify the extent to which the program has been implemented and to which it has improved access to clinical trials in remote, rural and regional NSW. The findings of the evaluation should be published within the next 12 months to inform the ongoing implementation of the program.

2.30 As part of its recommendations on virtual care, PC2 recommended that NSW Health 'investigate telehealth cancer care models to improve access to cancer treatment including the Australasian Tele-trial model to boost clinical trial participation in regional areas' (Recommendation 30).[198]

2.31 Rural Doctors Network acknowledged NSW Health's ongoing implementation of their *Virtual Care Strategy 2021-26*, including the associated work in improving care for rural oncology patients.[199] However, the Committee notes that

[195] Submission 32, pp 2-3; Submission 32a, p 1.

[196] Submission 32, p 1; Submission 61, Community Transport Organisation Ltd, p 2; Ms Tara Russell, Chief Executive Officer, Community Transport Organisation, Transcript of evidence, 31 May 2024, p 14.

[197] Submission 49, p 8; Ms Brenna Smith, Manager Community, Cancer Information and Support Services, Cancer Council NSW, Transcript of evidence, 31 May 2024, p 37.

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

[199] Submission 42, NSW Rural Doctors Network (RDN), p 7.

telehealth is not enough to support patients on its own, and there is a risk of overreliance on telehealth in RRR NSW.[200]

2.32 The Committee also acknowledges that there has been some investment in improving clinical trial participation, through the Rural, Regional and Remote Clinical Trial Enabling Program (R3-CTEP) program. However, the impact of this funding remains unclear and we are concerned by the lack of evident progress. We recommend that NSW Health commence an interim evaluation of the program within the next six months to identify the extent to which the program has been implemented and to which it has improved clinical trial participation in RRR NSW. The evaluation findings should be published within 12 months to inform the ongoing implementation of the program.

Virtual cancer care

2.33 During the current inquiry, the Australian Salaried Medical Officers' Federation (ASMOF) reported that those living in RRR areas are 1.3 times more likely to die from cancer. People with cancer in RRR areas also have a cancer survival rate that is five years lower, compared to those in metropolitan locations.[201]

2.34 Virtual models of care can 'act as a bridge between specialist hospital services and community care.'[202] Telehealth is one approach that can be used to achieve continuity of care for oncology patients, and can be more convenient and affordable for patients.[203]

2.35 The National Rural Health Alliance explained there is evidence to support the use of technology in cancer care:

> A body of evidence has been building over the past decade to support the use of telehealth broadly and in the context of cancer care in rural areas. Recent Australian research supports the use of telehealth models of care in rural areas across the spectrum of cancer care, from diagnostic radiology to chemotherapy, radiation oncology and to increase access to clinical trials.[204]

2.36 Cancer Council NSW also highlighted some of the positives of virtual care models, as reported by cancer patients that responded to the Bureau of Health Information's Outpatient Cancer Clinics Survey 2023:

- 94 per cent of patients said that virtual care was very good or good and 86 per cent would use virtual care again or in some circumstances.
- Respondents mentioned that virtual care was convenient, saved time, saved money, and they felt that they received the right care at the right time.[205]

2.37 The Royal Australasian College of Medical Administrators told the Committee that virtual care has become an integral part of the delivery of healthcare,

[200] Submission 44, p 9; Ms Smith, Evidence, 31 May 2024, p 35.
[201] Submission 44, p 8.
[202] Submission 49, p 11.
[203] Submission 49, p 11; Submission 42, p 7.
[204] Submission 56, National Rural Health Alliance, p 11.
[205] Submission 49, p 11.

especially following the COVID-19 pandemic.[206] Similarly, the NSW Council of Social Services (NCOSS) highlighted that virtual care is flexible, convenient and affordable, and can reduce the impact of healthcare access barriers like costs associated with travel.[207]

2.38 However, stakeholders cautioned NSW Health against relying on telehealth and virtual health as solutions to healthcare workforce issues.[208] NCOSS also noted that there are circumstances where people can't or don't want to use virtual care and prefer face-to-face options.[209]

2.39 Ms Brenna Smith, Manager Community, Cancer Information and Support Services, Cancer Council NSW, emphasised that telehealth alone is not enough to ensure that patients feel well supported in their local community where they live and work.[210] Similarly, ASMOF told the Committee that 'digital consultations have their place'. However, two thirds of respondents to an ASMOF survey indicated that there was 'a strong overreliance on telehealth in their primary regional location'.[211]

2.40 The Australian College of Rural and Remote Medicine believes the best model of care is one where patients continue to live within their community while receiving co-ordinated collaborative care, led by a local medical practitioner. Under this model, patients can benefit from a 'usual GP' that they have a longstanding relationship with, as well as receiving treatment while being supported by their family and wider network.[212]

2.41 The Committee also heard that some professions may not be set up to deliver care via telehealth. For example, the Pharmaceutical Society of Australia (PSA) told us that pharmacists are not funded to deliver care through telehealth arrangements.[213]

2.42 The PSA proposed that the existing community pharmacy network could be expanded upon, to deliver improved care and medicine safety in cancer care. They argued that funding to train pharmacists in speciality areas like cancer care in RRR NSW would expand access in those areas.[214]

Virtual clinical trial participation

2.43 Participation in clinical trials supports the development of new cancer treatments and allows people with cancer to access advanced therapies and expand their options for treatment.[215]

---

[206] Submission 65, Royal Australasian College of Medical Administrators (RACMA), p 8.

[207] Submission 3, NSW Council of Social Service (NCOSS), p 10.

[208] Submission 3, p 10; Submission 65, p 8.

[209] Submission 3, p 10.

[210] Ms Smith, Evidence, 31 May 2024, p 35.

[211] Submission 44, p 9.

[212] Submission 34, Australian College of Rural and Remote Medicine, p 5.

[213] Submission 52, Pharmaceutical Society of Australia, p 9.

[214] Submission 52, p 9.

[215] Submission 49, p 11.

2.44 However, as Cancer Council NSW noted, participation in clinical trials usually requires frequent visits to specialists in major cities.[216] As a result, there is a 'significant disparity' in access to lifesaving cancer clinical trials between metropolitan and regional populations.[217]

2.45 As part of its recommendations on virtual care, the PC2 report recommended that NSW Health investigate the Australasian Tele-trial model to boost clinical trial participation in regional areas (Recommendation 30).[218] The Australasian Tele-trial model was developed by the Clinical Oncology Society of Australia (COSA) to decentralise clinical trials through the use of telehealth and increase access for patients in rural and remote locations.[219]

2.46 During the current inquiry, Cancer Council NSW cited the Australian Teletrial Program (ATP) as an example of how clinical trials may be brought closer to home for patients in rural and regional areas across Australia. The ATP implements the Australasian Tele-trial model and was supported by $75.2M in funding over five years (2021 – 2026) to create telehealth infrastructure in regional communities. All Australian states and territories, except for NSW and the ACT, are participating in the program.[220]

2.47 Although the ATP does not extend to NSW and the ACT, the NSW Office for Health and Medical Research is currently leading the implementation of a program to 'deliver increased and more equitable access to clinical trials' for regional communities in NSW and the ACT. The Rural, Regional and Remote Clinical Trial Enabling Program (R3-CTEP) is supported by a $30.6M grant from the Australian Government Medical Research Future Fund over five years (2022-2027). The program is being delivered in nine LHDs across Northern, Western and Southern NSW.[221]

2.48 The NSW Health Progress Report noted that R3-CTEP will deliver 13 infrastructure projects and initiatives over the next three years, which 'address the barriers of geographical isolation, workforce capacity, and workforce capability,' to increase rural and regional patients' participation in clinical trials.[222]

2.49 NSW Health report that R3-CTEP will use the existing infrastructure of the Virtual Care Platform to explore opportunities for a new clinical trial delivery model, with the goal to increase access to clinical trials through a 'decentralised model' that reduces the burden of travel for participants.[223]

---

[216] Submission 49, p 11.

[217] Mr Gellert, Evidence, 31 May 2024, p 35

[218] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 146.

[219] Mr Gellert, Evidence, 31 May 2024, p 38; Submission 56, p 13; Clinical Oncology Society of Australia, Australasian Tele-trial Model, p 3.

[220] Submission 49, p 11; Australian Teletrial Program, Australian Teletrial Program, viewed 9 January 2025.

[221] Submission 43, p 37; *Progress Report*, September 2024, p 69 - 70; Mr Gellert, Evidence, 31 May 2024, p 38; Mrs Harrison, Evidence, 31 May 2024, p 38.

[222] *Progress Report*, September 2024, p 70.

[223] *Progress Report*, September 2024, p 69.

2.50 The Progress Report also noted that the Decentralised Clinical Trials (DCT) project will be completed in phases, beginning with an environmental scan and feasibility assessment undertaken in phase 1.[224]

2.51 Mr Brad Gellert, Manager Policy and Advocacy, Cancer Council NSW, told the Committee that the funding for R3-CTEP indicated 'positive movement' to set up a system that would enable greater access to future trials. However, he was not aware of any improvement in the numbers of people in RRR NSW that could access clinical trials as a result of that funding.[225]

2.52 While the Committee welcomes the funding for the R3-CTEP, we note that the impact of this funding on RRR communities is currently unclear. We are particularly concerned by the lack of evident progress in improving clinical trial participation, given the length of time since the funding was allocated. We recommend that NSW Health commence an interim evaluation of R3-CTEP within the next six months. The evaluation should identify the extent to which the program has been implemented and the extent to which it has improved access to clinical trials in RRR NSW. The findings of the evaluation should be published within the next 12 months to inform the ongoing implementation of the program.

[224] *Progress Report*, September 2024, p 70.

[225] Mr Gellert, 31 May 2024, Evidence, p 38.

Chapter Three – Aged care

Introduction

3.1 In remote, rural and regional NSW, aged care services are funded by the Australian Government, but provided in a range of settings. These include private and community-operated residential aged care facilities, and Multipurpose Services operated by NSW Health.

3.2 The Royal Commission into Aged Care Quality explored aged care issues in depth in its 2021 report,[226] and a range of reforms are currently underway at the federal level. Noting this remit, Portfolio Committee No. 2 (PC2) only made one recommendation regarding aged care in its 2022 report. This recommendation related to staffing and training in hospitals.[227]

3.3 Two years on, access to health services continues to be a concern for the growing population of older people living in remote, rural and regional (RRR) NSW. The Committee was interested to know what progress has been made in supporting the health of older persons in RRR communities, and in supporting the workforce and facilities that provide services to them.

3.4 In particular, the Committee is of the view that developing nurses' specialised knowledge in aged care could help to address the growing demand for aged care services. For this reason, we recommend that the NSW Government work with the Australian Government to explore options for specialist aged care training for nurses to strengthen supports for older people in regional communities.

3.5 The Committee also heard that the upcoming transition to the Support at Home program, as part of the national aged care reforms, could make it more difficult for local councils to provide aged care services. We recommend collaboration across all levels of government to ensure that local councils in remote, rural and regional NSW are appropriately supported during the implementation of the Support at Home program and other national reforms.

Growing demand for aged care services

Finding 8

The population of older people living in remote, rural and regional areas is increasing, but aged care services are constrained and not keeping up with this demand.

[226] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect*, March 2021.

[227] 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 98.

Recommendation 10

That the NSW Government works with the Australian Government to explore funding options for rural and regional nurses to undertake specialised training in aged care to help meet the growing demand for these services.

Recommendation 11

That NSW Health provide up-to-date information within the next six months on how many peer group C hospitals do not have a geriatric nurse, and outline strategies it intends to take to address any staffing shortfalls in this area.

3.6 As observed by the PC2 report, there is a larger, growing demographic of older people living in remote, rural and regional communities, with residents aged over 75 expected to become the largest demographic in these areas by 2036.[228]

3.7 The PC2 report also recognised the importance of appropriately trained and available staff in providing care to older people living in RRR NSW. PC2 Recommendation 18 was that NSW Health employ a geriatric nurse in all peer group C hospitals. The recommendation specified that annual geriatric care training should be provided to staff wherever a geriatric nurse is not employed.

3.8 However, despite this increasing demand for regional aged care, the Committee heard that services remain limited or at capacity, with some services closing. For example, Councillor Ken Keith, Parkes Shire Council, reported that in Parkes, one aged care facility is closing and the two facilities in the community are at capacity.[229]

3.9 Additionally, limited access to rural and regional aged care can have broader implications on the health system by placing increased pressure on hospital resources. For example, Mr Joe Sullivan, Mudgee Health Council, told the Committee that a reduction of nursing home beds in Mudgee has put 'strain on hospital beds.'[230]

Aged care training

3.10 During our first inquiry, NSW Health stated that many Local Health Districts (LHDs) employ clinical nurse consultants and specialists who are skilled in aged care. They also noted that staff have access to online training modules to assist them in caring for older people and scholarships for nurses undertaking post graduate study in aged care.[231]

3.11 NSW Health has since reported the development and launch of its Aged Care Nursing Education Navigator Tool in June 2024. The tool is targeted at nurses

---

[228] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 98.

[229] Submission 36, Gunnedah Shire Council, p 3; Submission 37, Culcairn LHAC, p 1; Submission 42, NSW Rural Doctors Network, p 6; Cr Ken Keith, Councillor, Parkes Shire Council, Transcript of evidence, 28 May 2024, p 42; Mr Joe Sullivan, Chairperson, Mudgee Health Council, Transcript of evidence, 28 May 2024, p 12.

[230] Mr Sullivan, Evidence, 28 May 2024, p 12.

[231] 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, Submission 11, NSW Health, pp 14 and 18.

working in aged care and is available to staff through NSW Health's online learning platform, My Health Learning. It contains 79 resources across various topics including mental health, wellbeing and person-centred care.[232]

3.12 While the NSW Nurses and Midwives' Association (NMA) welcomed NSW Health's new online learning resources, they asserted that they do not go far enough in building the level of proficiency that nurses need to care for an ageing population. The NSW NMA noted that services involving specialist aged care nurses deliver safer care, reduce the duration of stay after hospital admissions, and lower healthcare costs. They called for increased funding and supports for nurses to study and train in aged care.[233]

3.13 An appropriately trained workforce is essential in addressing the health needs of a growing older population in RRR NSW. While the Committee recognises that nurses undertake aged care training in their undergraduate studies and have access to online resources, further educational supports are needed.

3.14 We recommend that the NSW Government works with the Australian Government to explore investment in comprehensive training courses for rural and regional nurses to specialise in aged care. Noting that this is likely to require longer term collaboration, we are of the view that NSW Health should take a leading role in supporting the development of the regional aged care workforce, where appropriate.

Appropriate staffing

3.15 NSW Health has reported PC2 Recommendation 18 as complete, noting its progress on broader staff training, as outlined above. However, it is unclear whether any progress has been made regarding the employment of geriatric nurses in all peer group C hospitals, which was a key component of the recommendation.[234]

3.16 The Committee notes that improving geriatric care in hospitals requires appropriately qualified staff, not just training.

3.17 To improve transparency around staffing levels, we recommendation that NSW Heath provides up-to-date information on how many peer group C hospitals do not have a geriatric nurse. NSW Health should also outline strategies it intends to take to address any staffing shortfalls in this area.

Federal aged care reforms

Recommendation 12

That the NSW Government works with the Australian Government to ensure that local councils in remote, rural and regional NSW are appropriately

[232] NSW Health, *Progress Report: Parliamentary inquiry into health outcomes and access to health and hospital services in Rural, Regional and Remote New South Wales*, September 2024, p 43.

[233] Submission 48, NSW Nurses and Midwives' Association, pp 6 & 21.

[234] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 98; *Progress Report*, September 2024, p 43.

supported during the implementation of national aged care reforms, including the Support at Home program.

3.18 Aged care is primarily a Commonwealth responsibility, and the Committee notes that there have been policy developments at a national level that are relevant to this inquiry. The Royal Commission into Aged Care Quality and Safety has prompted significant federal reforms, including the introduction of the new Aged Care Act 2024 (Cth). This legislation was passed on 25 November 2024 and will commence from 1 July 2025.[235]

3.19 A key pillar of the reforms is the upcoming transition to the Support at Home program, which will commence from 1 July 2025 as part of a staged approach. The existing Commonwealth Home Support Program is expected to transition to the new Support at Home program no earlier than 1 July 2027.[236]

Support at Home

The Support at Home program will combine existing in-home aged care programs to enable older people to live independently at home for longer. The Australian Government states that the new program will include an increased focus on early interventions and provide higher levels of care for older people with complex needs.[237]

From 1 July 2025, Support at Home will replace the following programs:

- Home Care Packages Program, which supports older people with complex needs to stay at home.[238]
- Short-Term Restorative Care Programme, which provides services to older people for up to eight weeks to help them delay or avoid long-term care.[239]

The Commonwealth Home Support Program provides entry-level support for older people to live independently in their homes and communities. It is expected to operate as a separate program for existing clients and new clients with low-level needs until 1 July 2027.[240]

3.20 During the Committee's inquiry, Local Government NSW (LGNSW) expressed concerns that funding arrangements under the new Support at Home program will lead to uncertainty for aged care service providers. Currently, the

[235] Australian Government Department of Health and Aged Care, About the new Aged Care Act, viewed 6 February 2025.

[236] Australian Government Department of Health and Aged Care, About the Support at Home program, viewed 4 March 2025.

[237] Australian Government Department of Health and Aged Care, About the Support at Home program, viewed 4 March 2025.

[238] Australian Government Department of Health and Aged Care, About the Home Care Packages Program, viewed 4 March 2025.

[239] Australian Government Department of Health and Aged Care, Short-Term Restorative Care Programme, viewed 4 March 2025.

[240] Australian Government Department of Health and Aged Care, About the Commonwealth Home Support Programme, viewed 4 March 2025.

Commonwealth Home Support Program issues funding to providers, including many local councils, through grant agreements. Providers use these grants to offer subsidised services to older people. However, the new Support at Home program will mostly issue funds using a fee-for-service model that will compensate providers after a service is delivered.[241]

3.21 LGNSW noted that a shift towards fee-for-service models means that contracts are 'less commercially viable for councils to run' because there is less certainty in the amount of funding that a council may be reimbursed for providing services. This presents challenges for councils, because the ability to scale their operations up and down according to service provision is harder with a smaller workforce and a growing ageing population.[242]

3.22 LGNSW also told the Committee that councils are concerned that the new Support at Home program may not offer enough funding. Some believe the upcoming reforms will lead to further competition and force some councils out of the aged care market, while other councils 'have already decided to transition out' of the market. LGNSW acknowledges that the new program will offer additional grants to aged care providers functioning in thin markets. However, 'uncertainty remains' in the aged care sector and undertaking a transition process to the new Support at Home model may not be financially viable for some councils.[243]

3.23 The Committee acknowledges that fee-for-service models may operate effectively in metropolitan areas. However, we are concerned that this is not always the case in rural areas, and that the transition to a fee-for-service model may lead to the closure of council-run aged care services in RRR areas. We recommend that the NSW Government work with the Australian Government to ensure that local councils in RRR NSW are appropriately supported during the implementation of the program and other national aged care reforms.

[241] Submission 1, pp 9-10; Cr Darriea Turley, President, Local Government NSW, Transcript of Evidence, 3 June 2024, p 20; Mr David Reynolds, Chief Executive, Local Government NSW, Transcript of Evidence, 3 June 2024, pp 22-23.

[242] Mr Reynolds, Evidence, 3 June 2024, pp 22-23.

[243] Submission 1, pp 9-10.

Chapter Four – Palliative care

Introduction

4.1 The Portfolio Committee No. 2 (PC2) report found that there was a lack of palliative care services in remote, rural and regional (RRR) NSW. To address this, the report recommended the urgent establishment of a palliative care taskforce to plan and map services, collect palliative care data, and ensure culturally appropriate palliative care services for Aboriginal communities (Recommendation 23).[244]

4.2 The PC2 report also recommended the expansion of innovative models of care, including the Far West NSW Palliative and End-of-Life Model of Care, across other rural and remote settings (Recommendation 24).[245]

4.3 In the current inquiry, stakeholders reported noticeable improvements in regional palliative care and 'movement in the right direction' in the two years since the PC2 report was handed down.[246] However, these improvements started from a low base, and continued investment is needed to address the inequities across regions.[247]

4.4 The Committee was also concerned to hear that stakeholders were unaware of progress made on the recommended taskforce and its key activities, including palliative care data collection.[248] To address this, we recommend that NSW Health publish its palliative care governance framework and prioritise the sharing of key palliative care data sets across Local Health Districts (LHDs) and relevant networks.

4.5 Culturally safe palliative care is a further area of concern, as it is impacted by under-resourcing and a lack of collaboration between LHDs and Aboriginal Community Controlled Health Organisations (ACCHOs).[249] We recommend that NSW Health work with key Aboriginal stakeholders to improve access to culturally safe end-of-life care in remote, rural and regional NSW.

---

[244] 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 140-141.

[245] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 141.

[246] Submission 32, Can Assist, p 3; Mrs Jenny Hazelton, President, Orange Push for Palliative, Transcript of evidence, 28 May 2024, pp 7-8; Ms Kirsty Blades, Chief Executive Officer, Palliative Care New South Wales, Transcript of evidence, 31 May 2024, p 26 and 29; Cr Frances Kinghorne, Councillor, Orange City Council, Transcript of evidence, 28 May 2024, p 46.

[247] Submission 32, p 3; Mrs Hazelton, Evidence, 28 May 2024, pp 7-8; Ms Blades, Evidence, 31 May 2024, p 26 and 29.

[248] Ms Blades, Evidence, 31 May 2024, p 28; Submission 66, Aboriginal Health and Medical Research Council of NSW (AH&MRC), pp 5-6; Submission 34, Australian College of Rural and Remote Medicine, p 5; Mrs Hazelton, Evidence, 28 May 2024, p 8.

[249] Submission 66, p 5; Mrs Hazelton, Evidence, 28 May 2024, pp 9-10.

Funding and staffing for palliative care

Finding 9

There have been some improvements in regional palliative care since the Portfolio Committee No. 2 report, but significant disparities remain across remote, rural and regional NSW.

Recommendation 13

That the NSW Government provide additional targeted funding for palliative care services to address existing inequities and ensure adequate staffing of palliative care services across remote, rural and regional NSW.

4.6 The Committee heard that there have been some improvements in remote, rural and regional palliative care since the PC2 report. These improvements include additional dedicated palliative care beds at rural and regional hospitals, funding and staffing increases, and the promotion of effective models of care.[250]

4.7 However, there are still significant disparities across regions, and the rate of progress needs to be accelerated to meet current and future demand for palliative care services in remote, rural and regional NSW.[251] We recommend continued funding for palliative care services to address inequities across remote, rural and regional NSW.

Funding and staffing

4.8 Stakeholders reported noticeable improvements in funding and staffing for regional palliative care since the PC2 report, particularly within Western NSW Local Health District (WNSWLHD) and Illawarra Shoalhaven Local Health District (ISLHD).[252]

4.9 Mrs Jenny Hazelton, President of the community advocacy group Orange Push for Palliative, described the report as a 'springboard' for palliative care initiatives and improvements in Orange. She told the Committee that the recommendations had already made an impact and she felt that the government was 'listening and receptive to feedback'.[253]

4.10 For example, at Orange Hospital, an additional three dedicated palliative beds have been allocated, in addition to the two dedicated beds already established. Smaller hospitals within the district have also received funding for palliative care units, including Cowra, Blayney, Canowindra and Molong. [254]

---

[250] Mrs Hazelton, Evidence, 28 May 2024, pp 7 and 9; Cr Ken Keith, Councillor, Parkes Shire Council, Transcript of evidence, 28 May 2024, p 46; NSW Health, *Progress Report: Parliamentary inquiry into health outcomes and access to health and hospital services in Rural, Regional and Remote New South Wales*, September 2024, p 56, viewed 4 October 2024; Submission 43, NSW Health, pp 34-35; Ms Blades, Evidence, 31 May 2024, p 28.

[251] Submission 32, p 3; Mrs Hazelton, Evidence, 28 May 2024, pp 7-8; Ms Blades, Evidence, 31 May 2024, p 26 and 29.

[252] Submission 32, pp 3-4; Mrs Hazelton, Evidence, 28 May 2024, pp 7-8; Ms Blades, Evidence, 31 May 2024, p 26 and 29.

[253] Mrs Hazelton, Evidence, 28 May 2024, p 7.

[254] Mrs Hazelton, Evidence, 28 May 2024, pp 7-8.

4.11 In terms of staffing, Can Assist observed that WNSWLHD has more than doubled its palliative care staff from 21 to 50 full-time equivalent (FTE) employees during this time. The district is also trying to recruit a specialist palliative care physician.[255]

4.12 In ISLHD, face-to-face palliative care hours have been extended, with staffing from 6am to 11pm, 7 days a week. Can Assist observed that extending the working day and increasing the nursing resources during these hours has allowed palliative care teams in the district to undertake better anticipatory care, which significantly reduces the need for assistance during the non-face-to-face period.[256]

4.13 However, the Committee heard that these improvements started from a very low base and many regional areas have been 'playing catch-up in a non-level playing field' for a long time. For example, in Orange, stakeholders reported that the two dedicated palliative care beds were 'never going to be enough' and in Parkes, the improvements in palliative care have prevented the situation from 'going backwards'.[257]

4.14 Ms Kirsty Blades, from the peak body Palliative Care NSW, told the Committee that workforce shortages continue to impact access to palliative care across rural, regional and remote NSW. Only 25 per cent of Palliative Care NSW members reported an improvement in addressing palliative care workforce shortages, and they observed that the rate of progress needs to be accelerated to meet current and future demand.[258]

4.15 We also heard that there are wide disparities in resources across the state, and even across regions within the same LHD.[259] For example, while ISLHD has extended its face-to-face hours for palliative care, some towns in the Murrumbidgee Local Health District (Deniliquin, Tumut and Leeton) have had to cut back their face-to-face palliative care hours to weekday business hours only.[260]

4.16 Can Assist further noted that palliative social workers are covering large areas, which can restrict visits to 1 or 2 patients a day, yet funded positions are typically fractional, which leaves large areas essentially unserved.[261]

4.17 Despite the improvements reported in some areas, the Committee notes that sustained increases in funding and staffing are needed to ensure that palliative care services meet the needs of remote, rural and regional communities. We recommend continued funding for palliative care services to address inequities

[255] Submission 32, p 3; Mrs Hazelton, Evidence, 28 May 2024, p 10.

[256] Submission 32, p 4.

[257] Submission 32, p 3; Mrs Hazelton, Evidence, 28 May 2024, p 8; Cr Keith, Evidence, 28 May 2024, p 46; Ms Blades, Evidence, 31 May 2024, p 26.

[258] Ms Blades, Evidence, 31 May 2024, p 26.

[259] Submission 32, p 4; Ms Blades, Evidence, 31 May 2024, p 26.

[260] Submission 32, p4.

[261] Submission 32, p4.

and ensure adequate staffing of palliative care services across remote, rural and regional NSW.

Effective models of care

4.18 The PC2 report welcomed 'innovative service delivery methods' such as the Far West NSW Palliative and End-of-Life Model of Care (the Far West model), and recommended that NSW Health and rural and regional LHDs expand this model across other rural and remote settings (Recommendation 24).[262]

4.19 The Far West model is an 'individualised, yet standardised, needs-based approach' for the care of patients with life-limiting disease in the last year of life. The embedding of the model into practice enables the specialist palliative care service to support complex cases while supporting generalist providers to adopt a palliative approach to care.[263]

4.20 The Far West model has also been translated into an electronic resource, known as the electronic Palliative Approach Framework (ePAF). ePAF aims to assist carers and healthcare professionals to assess, plan and care for patients with advancing life-limiting illness.[264]

4.21 NSW Health has reported that implementation of Recommendation 24 is complete, noting that effective models of care like the Far West model have been shared with LHDs and Specialty Health Networks. The Agency of Clinical Innovation also regularly promotes these models, as well as information on the local application of their clinical principles.[265]

4.22 The Committee heard mixed views on how accessible these models of care are. Palliative Care NSW told the Committee that the tools and resources for implementing the model were 'easily accessible', noting that ePAF is publicly available on the Western NSW Primary Health Network website.[266] However, Orange Push for Palliative reported that palliative models of care are not easily accessed and noted that LHDs are not particularly forthcoming when it comes to sharing information about their models of care.[267]

4.23 The Committee also heard that the decision to adopt certain models of care ultimately lies with LHDs, and some have indicated that the Far West model is not necessary suitable for their particular district.[268]

4.24 NSW Health acknowledged this, and reported that various LHDs are implementing alternative models of care to meet the needs of their local communities, including:

---

[262] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 141.

[263] Agency for Clinical Innovation, Palliative and end of life model of care, viewed 4 November 2024.

[264] Agency for Clinical Innovation, Palliative and end of life model of care, viewed 4 November 2024.

[265] *Progress Report*, September 2024, p 56.

[266] Ms Blades, Evidence, 31 May 2024, p 28.

[267] Mrs Hazelton, Evidence, 28 May 2024, p 8.

[268] Ms Blades, Evidence, 31 May 2024, p 28.

(a) after hours telephone support services (Northern NSW LHD)

(b) virtual palliative care physician models (Dubbo, Lightning Ridge and Cobar)

(c) community and palliative nurse models of care (Southern NSW LHD).[269]

4.25 While the Committee acknowledges the development and promotion of innovative end-of-life models of care, it notes that there is still little visibility of what is happening across districts, as detailed below.

Palliative care taskforce and data collection

Finding 10

Access to data to inform regional palliative care services remains limited, in the absence of a palliative care taskforce and statewide data collection platform, and there is little visibility of where service gaps exist in remote, rural and regional NSW.

Recommendation 14

That NSW Health urgently publish its new palliative care governance framework and share key palliative care datasets with Local Health Districts and relevant networks within the next six months to inform palliative care service planning.

4.26 The PC2 report recommended the establishment of a palliative care taskforce to oversee a range of activities, including state-wide palliative care data collection.[270] Although NSW Health has taken steps to review its palliative care governance, the taskforce has not been established and access to palliative care data remains a challenge. NSW Health should prioritise the publication of its new palliative care governance framework and relevant datasets to improve transparency and inform palliative care service planning.

Palliative care taskforce

4.27 The PC2 report recommended that NSW Health work with key stakeholders to urgently set up a palliative care taskforce (Recommendation 23). The purpose of the taskforce was to plan and map services, establish a state-wide platform for the collection of palliative care data, and ensure culturally appropriate palliative care services for First Nations peoples.[271]

4.28 NSW Health has reported that implementation of this recommendation is in progress, noting that they established an internal, state-level governance group (the End of Life and Palliative Care Committee) in 2019 to oversee the implementation of the End of Life and Palliative Care Framework 2019-2024.

---

[269] Mrs Hazleton, Evidence, 28 May 2024, p 7; Ms Blades, Evidence, 31 May 2024, p 28; *Progress Report*, September 2024, p 56.

[270] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 141.

[271] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 141.

4.29 During the inquiry, NSW Health stated that it reviewed the terms of reference for the End of Life and Palliative Care Committee in 2023 to 'satisfy the intent' of the taskforce recommendation.[272] NSW Health also conducted a broader review of the gaps in palliative care governance in December 2023 and noted that actions from the review would be incorporated into a broader palliative care governance framework.[273]

4.30 Although NSW Health has taken steps to review the gaps in palliative care governance, the outcome of these reviews remains unclear.

4.31 The Committee also notes that the purpose of establishing a taskforce was to review gaps in palliative care services, not just governance. Throughout the inquiry, key stakeholders including Palliative Care NSW, the Aboriginal Health and Medical Research Council, and the Australian College of Rural and Remote Medicine stated that they were unaware of any progress made on the taskforce and/or its activities.[274]

4.32 Noting that a palliative care taskforce has not been established, we recommend that NSW Health prioritise the publication of its new palliative care governance framework to improve transparency around the progress that has been made in this area.

Palliative care data

4.33 A key component of PC2 Recommendation 23 was the creation of a state-wide palliative care data platform, with the aim of enabling clinical benchmarking of regional palliative care services.[275]

4.34 Access to current and consistent data is necessary to inform palliative care service planning, especially when services are limited. However, the Committee heard that data collection on palliative and end-of-life care has not been actioned and is still a significant area of concern for stakeholders.[276]

4.35 During the public hearings for this inquiry, Palliative Care NSW observed that the recommended data platform had not been established, and Orange Push for Palliative reported that accessing comparative data across health districts has been 'extraordinarily difficult' and 'very frustrating'.[277]

4.36 The Committee also heard that decisions about palliative care have historically been informed by anecdotal figures, or without any data at all, because there is no central data collection regarding the usage of palliative care beds.[278]

---

[272] *Progress Report*, September 2024, p 54; Submission 43, pp 33-34; Mr Luke Sloane, Deputy Secretary, Regional Health, NSW Health, Transcript of Evidence, 3 June 2024, p 44.

[273] Submission 43, pp 33-34; *Progress Report*, September 2024, p 54.

[274] Ms Blades, Evidence, 31 May 2024, p 28; Submission 66, pp 5-6; Submission 34, p 5.

[275] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 141

[276] Mrs Hazelton, Evidence, 28 May 2024, p 8; Ms Blades, Evidence, 31 May 2024, p 28.

[277] Ms Blades, Evidence, 31 May 2024, p 28; Mrs Hazelton, Evidence, 28 May 2024, p 8.

[278] Mrs Hazelton, Evidence, 28 May 2024, p 8.

4.37 Orange Push for Palliative provided an example that highlighted the importance of transparent palliative care data. In 2023, WNSWLHD undertook robust data collection to inform its palliative care service statement, which validated the need for additional designated palliative care beds at Orange Hospital.

> [The data] said that we needed five to six designated beds right now and that we had been playing catch up to get three additional beds…We have welcomed a much more systematic and structured way to look at where the beds are being used and what the needs are so that has improved, but there's a long way to go.[279]

4.38 In reporting on progress against this aspect of Recommendation 23, NSW Health stated that work on the 'preliminary palliative care indicator set' was in progress and would soon be shared with LHDs and networks. The indicator set will collate existing data items to inform monitoring and evaluation of palliative care services, and will be regularly reviewed to inform further development and refinement.

4.39 The Committee notes that final endorsement of the indicator set was expected before the end of 2024.[280] We recommend that NSW Health prioritise sharing this dataset with all LHDs and relevant networks to improve transparency and inform clinical benchmarking and service planning.

4.40 The lack of progress in this area also comes at a time when voluntary assisted dying is being made available across NSW. While access to palliative care services may be sufficient in metropolitan areas, it appears that this is still not the case for people living RRR areas. There is a significant risk that RRR people will not have the same choices for end-of-life care as those living in metropolitan areas. This is not acceptable.

Culturally safe palliative care services

Finding 11

Access to culturally safe palliative care continues to be impacted by under-resourcing and a lack of collaboration between Local Health Districts and Aboriginal Community Controlled Health Organisations.

Recommendation 15

That NSW Health work with key Aboriginal stakeholders to ensure culturally safe end-of-life care is available to Aboriginal people living in remote, rural and regional communities. This should include consideration of funding for Aboriginal Community Controlled Health Organisations to deliver palliative care services.

4.41 The PC2 report recommended that NSW Health work with a range of peak bodies, including the Aboriginal Health and Medical Research Council (AH&MRC),

[279] Mrs Hazelton, Evidence, 28 May 2024, pp 8-9.

[280] *Progress Report*, September 2024, p 55.

to ensure that culturally appropriate palliative care services are available to Aboriginal people (Recommendation 23).[281]

4.42 In reporting on progress against this recommendation, NSW Health noted that an Aboriginal Palliative Care Network has been established. The Network is a forum for the NSW Aboriginal palliative care workforce, LHDs and Speciality Health Networks. It facilitates information exchange on culturally appropriate palliative care, including training, successful models of care and improvements.[282]

4.43 NSW Health also reported improvements in increasing the Aboriginal palliative care workforce. For example:

- NSW Health has funded 18 full-time equivalent (FTE) Aboriginal Health Workers (AHWs) in palliative care across NSW. As of September 2023, 15 AHWs had been hired, with active recruitments running for the three remaining positions.[283]
- WNSWLHD has employed a full-time Aboriginal Palliative Care Project Officer, hired two Aboriginal Specialist Palliative Care Nurses and engaged an Aboriginal Griefologist to conduct 2-day training workshops for 20 Specialist Palliative Care Staff and 20 Aboriginal Health Workers/Practitioners.[284]
- Illawarra Shoalhaven LHD has a Palliative Care Senior Aboriginal Health Worker to support culturally appropriate care at end of life.[285]

4.44 Palliative Care NSW told the Committee that the focus on hiring palliative care AHWs is having a positive impact and there has been a shift towards assisting First Nations people return to Country as they near end of life.[286]

4.45 However, despite progress, recruitment remains challenging in this space. NSW Health noted that it has been challenging for some LHDs to fill these positions, and they are investigating ways to address this, such as reviewing the Aboriginal Health Worker Award. [287]

4.46 Stakeholders also identified culturally appropriate end-of-life care as a continuing area of concern, noting that culturally safe end-of-life care remains chronically under-resourced, poorly integrated and tough to access.[288]

4.47 The Committee heard that, in WNSWLHD, 13 per cent of the population is Aboriginal. However, despite a higher Aboriginal population than the state average (3 per cent), many Aboriginal communities are reluctant to access

---

[281] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 141.

[282] Mr Sloane, Evidence, 3 June 2024, p 44; *Progress Report*, September 2024, p 54.

[283] *Progress Report*, September 2024, p 55.

[284] Submission 43, p 29.

[285] Submission 43, p 29.

[286] Ms Blades, Evidence, 31 May 2024, pp 28-29.

[287] *Progress Report*, September 2024, p 55; Submission 43, p 28.

[288] Submission 42, NSW Rural Doctors Network, p 6; Submission 48, NSW Nurses and Midwives' Association, p 16; Submission 66, p 5.

mainstream palliative care services. Orange Push for Palliative noted a historical distrust of hospitals and told the Committee that 'creating more beds in a busy, bustling hospital is not the answer for First Nations people.' To address this, they have advocated for a hospice that would allow Aboriginal people to return to country, without creating ongoing trauma.[289]

4.48 Orange Push for Palliative also explained how end-of-life doula training could improve the cultural safety of regional palliative care:

> First Nations people need to be supported by someone who can walk them through the process, someone who can stand beside them – which is what doulas do – explain the process and go with them to hospital if they need or stay with them at home and tell them what to expect.[290]

4.49 The Committee recognises the positive collaboration that has occurred in this space, noting that a joint funding submission for end-of-life doula training has been developed by Orange Push for Palliative, Orange Aboriginal Medical Service and LiveBetter, the primary non-government organisation that administers end-of-life care packages within the district.[291]

4.50 However, the Committee remains concerned about the lack of collaboration between NSW Health and Aboriginal Community Controlled Health Organisations (ACCHOs), and the impacts this may have on ensuring palliative care services are culturally appropriate.

4.51 Stakeholders emphasised the importance of culturally safe initiatives that are co-designed and led by Aboriginal people and organisations.[292] Yet the AH&MRC asserted that palliative care services for Aboriginal people are poorly integrated with ACCHOs and primary care providers.[293]

4.52 AH&MRC submitted that, although NSW Health has established palliative care committees and working groups, they have not involved key Aboriginal stakeholders in the proposed taskforce or the activities that were recommended as part of PC2 Recommendation 23. The AH&MRC also noted that ACCHOs are not issued funding to assist palliative care activities, such as offering transport for patients.[294]

4.53 Culturally safe palliative care requires strong partnerships and engagement with Aboriginal service providers and stakeholders. We urge NSW Health to collaborate with key Aboriginal stakeholders to build culturally safe end-of-life options for Aboriginal people living in remote, rural and regional areas. This should include funding for ACCHOs to support the delivery of palliative care services, if appropriate.

---

[289] Mrs Hazelton, Evidence, 28 May 2024, p 10.

[290] Mrs Hazelton, Evidence, 28 May 2024, p 10.

[291] Mrs Hazleton, Evidence, 28 May 2024, pp 9 and 10

[292] Submission 42, p 6; Submission 48, pp 5 and 16.

[293] Submission 66, p 5.

[294] Submission 66, pp 5-6.

Chapter Five – Mental health and drug and alcohol services

Introduction

5.1 The 2022 Portfolio Committee No. 2 (PC2) report highlighted the 'lack of adequate mental health services' in remote, rural and regional (RRR) NSW. PC2 recommended a further inquiry into mental health services, including services in RRR NSW (Recommendation 25), and also recommended that NSW Health address mental health workforce shortages as part of a broader, ten-year recruitment and retention strategy for the rural and remote health workforce (Recommendation 11).[295]

5.2 PC2 has since completed an inquiry into outpatient and community mental health care in NSW, which NSW Health participated in.[296] The Committee also notes that there have been a number of other inquiries into mental health services, as discussed further below. However, we note that these inquiries have taken statewide approaches, rather than focusing on improving access to mental health services in RRR NSW specifically.

5.3 During the current inquiry, the Committee heard that there has been no noticeable improvement in regional mental health services since the PC2 report.[297] Specifically, we heard that mental health workforce shortages remain a significant issue, with the psychiatry workforce currently in 'crisis'.[298] Noting the ongoing challenges with recruitment and retention, we recommend that NSW Health prioritise the development of a long-term workforce strategy for mental health services in RRR NSW. This strategy should address remuneration, funding, and the development of training pathways that will adequately support mental health services.

5.4 We also heard that there is a lack of integration between alcohol and other drugs (AOD) treatment and mental health services.[299] Stakeholders reported that the prevalence of addiction is increasing earlier in life and there are not enough AOD services in RRR NSW that are specifically tailored for young people.[300] We recommend that NSW Health work with the Department of Communities and Justice to investigate innovative and effective early intervention AOD models that

[295] 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 75 and 141 – 142.

[296] Portfolio Committee No. 2, *Equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW*, report 64, Parliament of NSW, June 2024; Inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW, Submission 148, NSW Health.

[297] Ms Anne Worrad, Mental Health Occupational Therapist, Ramsay Clinic Orange, Transcript of evidence, 28 May 2024, p 23.

[298] Dr Tony Sara, Secretary, Australian Salaried Medical Officers' Federation NSW, Transcript of evidence, 3 June 2024, p 9.

[299] Ms Jess Silva, Program Manager Western NSW, Mission Australia, Transcript of evidence, 28 May 2024, p 29.

[300] Ms Silva, Evidence, 28 May 2024, p 29; Ms Elyse Cain, Policy Lead, NSW Council of Social Service, Transcript of evidence, 31 May 2024, p 23.

could be implemented to address the service gaps that impact young people in RRR communities. This should include further integration between mental health and AOD treatment services in RRR NSW.

Recent inquiries into mental health services

Finding 12

The NSW Government is responding to numerous statewide inquiries into mental health services, including the Portfolio Committee No. 2 inquiry into outpatient and community health care in NSW, but most of these inquiries have not been targeted at improvements in remote, rural and regional NSW.

5.5 In 2022, the PC2 report highlighted the way in which unmet demand for mental health services contributed to greater rates of psychological distress, self-harm and suicide. As mental health services in RRR NSW were not within the inquiry's original terms of reference, PC2 recommended a separate inquiry into mental health services, including services in RRR NSW (Recommendation 25). [301]

5.6 PC2 has since delivered its report on *Equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales,* tabled in June 2024.[302] The NSW Government response to that report noted the 'significant work underway across NSW' to enhance mental health care. This included statewide initiatives such as a $111.8 million investment in community mental health and a $40 million investment in Closing the Gap programs (including those that target Aboriginal mental health workforce development).[303]

5.7 In addition to the PC2 inquiry into community health care, there have also been numerous other inquiries and reviews of mental health services in NSW. In correspondence with the Committee,[304] NSW Health provided an update on actions taken in response to these inquiries, including three additional NSW Parliamentary inquiries,[305] four Commonwealth government inquiries, [306] three inquiries conducted by NSW Health,[307] and two inquiries conducted by the

[301] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 142.

[302] *Equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW,* June 2024.

[303] NSW Government, *Response to Inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW*, September 2024, p 3.

[304] NSW Health, Request for additional information, TAB B and C, pp 8-22.

[305] Committee on Children and Young People, *Prevention of youth suicide in New South Wales*, October 2018; Public Accounts Committee, *Inquiry into the Management of Health Care Delivery in NSW*, September 2018; *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody*, April 2021.

[306] *Accessibility and quality of mental health services in rural and remote Australia – Parliament of Australia*; *Inquiry into and report on the services, support and life outcomes for autistic people in Australia and the associated need for a National Autism Strategy – Parliament of Australia*; *Inquiry into Mental Health and Suicide Prevention – Parliament of Australia*; *Mental health - Public inquiry - Productivity Commission.*

[307] *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*; *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*; *2024 Review of the Mental Health Commission of NSW.*

Mental Health Commission of NSW.[308] In its Progress Report, NSW Health reported that that the intent of Recommendation 25 had been fulfilled.[309]

5.8 The Committee acknowledges that there have been modest developments in RRR mental health services in recent years. For example, in its submission to the current inquiry, NSW Health noted the expansion of its Safe Havens program. Safe Havens are staffed by suicide prevention peer workers and provide an alternative to attending an emergency department for those people experiencing suicidal distress. NSW Health reported that 11 of the 20 Safe Havens in NSW are located in regional areas, including a Bega Safe Haven that opened in March 2024.[310]

5.9 However, despite the work underway in responding to numerous mental health inquiries, we note that most of these inquiries have not been targeted at improving mental health services in RRR NSW specifically. For example, of the 39 recommendations made by the PC2 inquiry into outpatient and community mental health care, only one recommendation explicitly focused on RRR areas. This recommendation related to the opening of additional Safe Havens in 'high-need' RRR areas. In its response, the NSW Government noted, but did not explicitly support, this recommendation.[311]

5.10 During our inquiry, we heard that there have not been significant improvements in mental health services in RRR NSW, or 'any real initiatives' to address the gaps in service provision across mental health or drug and alcohol treatment.[312] Stakeholders told us that it is harder for people to access a mental health service within the public system, and there are issues with the capacity and sustainability of workforces attempting to support RRR communities. [313] These issues are explored in more detail below.

[308] Review of transparency and accountability of mental health funding to health services | Mental Health Commission of New South Wales; Living Well mid-term review | Mental Health Commission of New South Wales

[309] NSW Health, *Progress Report: Parliamentary inquiry into health outcomes and access to health and hospital services in Rural, Regional and Remote New South Wales*, September 2024, p 58.

[310] Submission 43, NSW Health, pp 29-30.

[311] *Equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW*, June 2024, p 105; NSW Government, Response to Inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW, p 24.

[312] Ms Worrad, Evidence, 28 May 2024, p 23.

[313] Ms Worrad, Evidence, 28 May 2024, p 23; Submission 15, Manna Institute, p 2; Professor Myfanwy Maple, Director, Manna Institute, May 31 2024, Transcript of evidence, pp 21-22.

Mental health workforce shortages

Finding 13

Mental health services across remote, rural and regional NSW are being impacted by significant and escalating workforce shortages.

Recommendation 16

That NSW Health prioritise the development of a comprehensive, long-term workforce strategy for mental health services across remote, rural and regional NSW. This strategy should address:

- **remuneration issues (including a plan to achieve pay parity with other states and territories)**
- **any funding considerations necessary to support recruitment**
- **the development of training pathways that will adequately support mental health services.**

5.11 Recommendation 11 of the PC2 report called for the development and implementation of a 10-year Rural and Remote Medical and Health Workforce Recruitment and Retention Strategy. Although the recommended strategy was not specific to mental health, it was intended to address hospital and general practice workforce shortages, including General Practitioners, nurse practitioners, mental health nurses, psychologists, psychiatrists, counsellors, social workers.[314]

5.12 In reporting on progress against this recommendation, NSW Health submitted that a range of actions are currently underway to 'fulfil the intent of the recommendation'. This included an agreement to develop a national mental health workforce strategy, noting that the National Mental Health and Suicide Prevention Agreement was signed by all Australian jurisdictions in 2022.[315]

5.13 However, feedback from the Australian Salaried Medical Officers Federation (ASMOF) suggests that more could be done to alleviate the pressures on chronically short-staffed mental health services in RRR NSW.[316] ASMOF told the Committee that 'simply citing pre-existing initiatives and agreements without taking any substantive action to address the root cause of the issue is not enough'.[317]

5.14 During the current inquiry, we heard that understaffing across the system continues to impact access to mental health services in RRR NSW, with inadequate staffing and vacant positions across psychology,[318] psychiatry,[319] and

[314] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 75.

[315] *Progress Report*, pp 30-31.

[316] Submission 44, Australian Salaried Medical Officers' Federation NSW, p 7

[317] Submission 44, p 7.

[318] Submission 1, Local Government, p 8; Cr Darriea Turley, President, Local Government, Transcript of Evidence, 3 June 2024, p 20; Submission 15, p 2.

[319] Dr Sara, Evidence, 3 June 2024, p 9; Submission 15, pp 2-3; Mr Michael Bowden, Transcript of Evidence, 3 June 2024, p 47.

community mental health.[320] Psychiatry workforce shortages are particularly concerning, as are the impacts on General Practitioners, as discussed further below.

5.15 To address these issues, we recommend that NSW Health prioritise the development of a comprehensive, long-term workforce strategy for mental health services across RRR NSW. This strategy should address remuneration issues, funding considerations, and the development of training pathways that will adequately support mental health services.

Significant psychiatry workforce shortages

5.16 During the public hearings for this inquiry, the Committee heard that the psychiatry workforce in NSW is 'in crisis' due to a large and escalating number of vacancies within the public health system. Dr Tony Sara, Secretary, Australian Salaried Medical Officers' Federation NSW, reported that:

> …at least one-sixth or one-fifth of the workforce positions in staff specialist psychiatry are empty. There are large numbers of positions filled by VMOs and locums at extremely high cost. My sense is that unless something happens in the next few months, this meltdown will continue.[321]

5.17 Dr Sara attributed the vacancies to a range of factors, including a lack of support for both trainees and staff specialists in a high-risk environment, where remuneration is weaker when compared to other states and to the private sector.[322]

5.18 In responding to these concerns, NSW Health acknowledged the challenges in improving remuneration and working conditions for psychiatrists working in public hospitals. Mr Richard Griffiths, Executive Director, Workforce Planning and Talent Development, Ministry of Health, told the Committee that NSW Health was 'working through a range of strategies to improve the attractiveness of psychiatry' for both trainees and staff specialists.[323]

5.19 However, these challenges have only escalated in the past 6 months, with the resignation of more than 200 senior psychiatrists in NSW in January 2025. Although these staff specialists were not limited to RRR areas, we note the significant and widespread impact of these vacancies across NSW. The Royal Australian and New Zealand College of Psychiatrists recently stated:

> The loss of over 200 senior psychiatrists from within the health system will significantly impact people with acute and critical mental health care needs. These are some of the most vulnerable people in our community and disruption to their care will have wide ranging impacts for them, their families, and carers.

---

[320] Submission 44, p 7; Submission 50, Leeton Shire Council, p 4; Submission 1, p 8; Ms Silva, Evidence, 28 May 2024, p 29; Ms Worrad, Evidence, 28 May 2024, p 23; Submission 48, NSW Nurses and Midwives' Association, p 6.

[321] Dr Sara, Evidence, 3 June 2024, p 9.

[322] Dr Sara, Evidence, 3 June 2024, p 9.

[323] Mr Richard Griffiths, Executive Director, Workforce Planning and Talent Development, Ministry of Health, Transcript of evidence, 3 June 2024, p 41.

> Trainee psychiatrists may experience pressure to provide care and treatment to people with severe mental illness for which they are not yet fully qualified. These doctors need the support of skilled supervisors to provide appropriate supervision and care as they train. Without in-house leadership and oversight, we are extremely concerned for trainee wellbeing and patient care.
>
> The workforce shortages of psychiatrists will force patients to seek urgent care from other health providers and emergency departments, which are already stressed and at capacity.[324]

5.20 As of February 2025, one-third of the resigned staff specialist psychiatrists have since rejoined NSW Health in higher paid contractor (Visiting Medical Officer) positions.[325] However, we are concerned that this is not a sustainable solution to persistent and widespread workforce shortages, particularly given the existing challenges with recruiting and retaining for positions in RRR facilities.

5.21 We acknowledge that some efforts are being made at the local level to try to address capacity and meet community need, while taking the burden off public psychiatry services. For example, Tresillian reported that they are working with several Local Health Districts (LHDs) on training programs for trainee psychiatrists, including a pilot in the Mid North Coast LHD for a shared psychiatry trainee to provide services to families that do not meet the clinical threshold of the local Mental Health Acute Care team.[326]

5.22 However, the Committee is of the view that significant and coordinated efforts are needed at the state level to attract psychiatrists to the public health system, particularly in RRR NSW, as previous models of recruitment, retention and remuneration are no longer working. We note that there may be some aspects of supporting the mental health workforce that are reliant on work with the Australian Government, which we will explore further in our final inquiry. However, we do not believe this is an area where NSW can afford to wait for action at the federal level.

5.23 We recommend that NSW Health address the root causes of these workforce shortages by developing a comprehensive, long-term workforce strategy for mental health services across NSW, taking into account the unique needs and challenges facing RRR communities. This strategy should address:

- remuneration issues (including a plan to achieve pay parity with other states and territories)
- any funding considerations necessary to support recruitment
- the development of training pathways to ensure that both trainees and staff specialists are adequately supported.

---

[324] The Royal Australian and New Zealand College of Psychiatrists, Update on New South Wales workforce issues, viewed 26 February 2025.

[325] T. Ibrahim, One-third of New South Wales' resigning psychiatrists rehired as visiting medical officers, ABC News, 8 February 2025, viewed 25 February 2025.

[326] Submission 40, Tresillian, p 15.

Increasing pressure on GPs

5.24 During the inquiry, stakeholders told the Committee that there is 'continual pressure on staff retention' in state-funded community mental health settings.[327] As a result, we heard that GPs are increasingly carrying 'the burden of moderate to severe mental illness' and providing services to those who are no longer deemed severe enough to receive a service from a community mental health team.[328]

5.25 Despite this, Australian College of Rural and Remote Medicine (ACRRM) identified that current funding models do not recognise the level of mental health services provided by rural and remote GPs and Rural Generalists, or the circumstances under which they are delivered:

> These doctors may experience layers of financial disadvantage: they have limited access to subsidised courses… they earn less per hour, and the patients they manage generally experience high levels of disadvantage so GPs tend to bulk-bill these patients in order that they can access care. Despite this, GPs continue to provide mental health care in some of the most disadvantaged areas of Australia.[329]

5.26 ACRRM called for further investment in mental health services provided by GPs in RRR communities. They noted that while these issues are within the remit of the Australian Government, state advocacy would be helpful.[330]

5.27 The Committee acknowledges that adequate support for the primary health sector is crucial, given the significant role of GPs in providing mental health care. This is another area that is reliant on collaboration between the NSW Government and the Australian Government, which we will explore further as part of our final inquiry on cross-jurisdictional collaboration.

Alcohol and other drugs service gaps

5.28 Although alcohol and other drugs (AOD) treatment services were not included in the 2022 Portfolio Committee No. 2 (PC2) report, the Committee was interested in hearing about access to these services as part of the current inquiry. Limitations in the delivery of AOD services are likely to create poorer health outcomes for people in RRR communities, and this will create additional pressures on health services more broadly.

5.29 In its submission, NSW Health reported that new programs and services were established following the Special Commission of Inquiry into the drug 'ice' (the Ice Inquiry). In response to the Ice Inquiry, the NSW Government committed almost $500 million over four years for health and justice initiatives to improve health and social outcomes, with access to services in regional NSW being a key focus of the investment.[331]

---

[327] Ms Silva, Evidence, 28 May 2024, p 24.

[328] Ms Worrad, Evidence, 28 May 2024, p 23.

[329] Submission 34, Australian College of Rural and Remote Medicine, p 4.

[330] Submission 34, p 4.

[331] Submission 43, NSW Health, p 31.

5.30 NSW Health reported that new and enhanced AOD services were being established in all Local Health Districts and Speciality Health Networks, including increased access to complex case management programs such as the Substance Use in Pregnancy and Parenting Service (SUPPS), new services for young people, and new Post-Custodial Support services for people who are approaching their release from custody and are at risk of harm from AOD.[332]

5.31 We also heard that NSW Health is implementing a range of new AOD treatment and support services that are targeted at key priority populations. NSW reported that the following initiatives are currently in progress:

- Ten new regional AOD Hubs are being delivered by NGOs and/or Aboriginal Community Controlled Health Organisations (ACCHOs).
- Two new residential rehabilitation and withdrawal management services are being established. One is for young people in Hunter New England (to be delivered by an NGO) and one is for Aboriginal women with children in Illawarra Shoalhaven (to be operated by an ACCHO).
- Eight new community-based AOD treatment services are being established for young people aged 12-17 years and young adults, 18-24 years, all located in regional areas.
- Three new day rehabilitation and case management programs are being established for parents with dependent children, all located in regional areas.
- Three new community-based withdrawal management, case management and counselling services are being established for priority populations, all located in regional areas.[333]

5.32 The Committee further notes that the NSW Drug Summit was held in November and December 2024, including two days of regional forums in Lismore and Griffith. The aim of the summit was to build consensus on the way NSW deals with drug-related harms, with participation from health experts, police, people with lived experiences, drug user organisations, families and other stakeholders.[334]

5.33 The outcomes of the summit are unclear at this stage and the NSW Government has not yet made any commitments on the basis of the summit, but a final report is expected in early 2025.[335] The Committee looks forward to seeing what actions the government will take to address drug-related harm and improve addiction and recovery services in RRR NSW, following the NSW Drug Summit.

5.34 Despite the initiatives reported, however, the Committee heard that there are still significant service gaps for those accessing AOD treatment services in RRR NSW, as discussed below. It was concerning to hear that many of these service

[332] Submission 43, pp 31-32

[333] Submission 43, NSW Health, pp 31-32.

[334] NSW Health, NSW Drug Summit 2024, viewed 9 January 2025.

[335] J. Hathaway-Wilson, The key takeaways from NSW drug summit's Sydney hearings, ABC News, 7 December 2024, viewed 25 February 2025.

gaps affect young people in RRR communities. We recommend that NSW Health work with the Department of Communities and Justice to investigate innovative and effective early intervention models that could be implemented to address service gaps for young people living in RRR NSW. Any new models or programs should have a focus on integration between AOD treatment and mental health services.

Lack of integration between mental health, drug and alcohol services

Finding 14

Mental health, drug and alcohol treatment services within remote, rural and regional NSW remain poorly integrated.

5.35 The Committee heard that there is a disconnect and lack of integration between mental health and AOD services, which can create barriers for those that need to access both forms of support.

5.36 Ms Jess Silva, Program Manager Western NSW, Mission Australia, spoke on behalf of the Community Living Supports program (a state-wide program that supports people with severe mental illness) and the AOD Continuing Coordinated Care Program, both funded by NSW Health. She suggested that mental health and AOD community-based teams could work together more closely, and 'less as a resisting force against one another':

> We see in our line of work that you either have mental health or you have drug and alcohol—never the two shall cross… We're seeing these barriers sort of feed against themselves, where if there was more push and a focus to unite, we'd maybe remove some of that. [336]

5.37 For example, Ms Silva explained that if a person with schizophrenia is using methamphetamine, they are 'tasked out' to drug and alcohol workers. She noted that this can limit their access to a public psychiatrist, because these specialists are essentially 'gatekept' by the mental health setting.[337]

5.38 Ms Silva further explained that the 'burden' of information sharing between local drug and alcohol services sits with local managers and staff, as there is no formal governance structure to manage information sharing:

> That's dependent on the local relationships, that we do the work to maintain with agencies like Lives Lived Well and LHDs, and how we bring those together. That burden sits with managers and the people on the ground, versus a governance structure that says, "This is how it has to work." [338]

5.39 The Committee notes the importance of ensuring coordinated and integrated mental health and AOD services, particularly for those with co-occurring substance use and mental health issues. We suggest that any further work to

[336] Ms Silva, Evidence, 28 May 2024, p 29.
[337] Ms Silva, Evidence, 28 May 2024, p 29.
[338] Ms Silva, Evidence, 28 May 2024, p 28.

address service gaps, as recommended below, includes a focus on integration between AOD and mental health services.

Service gaps for young people

Finding 15

The prevalence of addiction earlier in life is increasing, and there are significant gaps in alcohol and other drugs services for young people in regional NSW, with not enough services specifically tailored for youth.

Recommendation 17

That NSW Health, in collaboration with the Department of Communities and Justice, investigate innovative and effective early intervention models for alcohol and other drugs treatment to address the service gaps for young people living in remote, rural and regional NSW. This should include a focus on integration with mental health services.

5.40 The Committee was concerned to hear that the prevalence of addiction among children and young people is increasing.[339] This is a significant problem, in light of the fact that there are not enough AOD services in RRR NSW that are specifically tailored for youth.[340]

5.41 When asked what action is needed in the AOD sector, Ms Jess Silva, Program Manager Western NSW, Mission Australia, told the Committee that early intervention models are needed to address the growing numbers of younger people with substance abuse issues:

> We are seeing the rate of occurrence of addiction happening for younger people a lot sooner and these programs are still capped at 18-plus. We moved the mental health space back to 16; we need to recognise that for drug and alcohol for young people as well, to start treating them as adults at 16 because they're recognised in any other setting that way. That's certainly a barrier for a lot of drug and alcohol services around the region—unless you're 18, [there's] not much to happen. [341]

5.42 Similarly, Ms Elyse Cain, Policy Lead, NSW Council of Social Service, told the Committee that there are gaps in AOD services, particularly for young people in RRR communities:

> What we heard on the ground from our members when we held forums in Taree late last year and also in Dubbo is that certainly gaps in AOD services, particularly for young people, are still a huge issue in regional and remote areas—not enough detox beds, not enough services specifically tailored for youth as well. [342]

5.43 Stakeholders also pointed to the increase in demand for young people experiencing acute mental health difficulties in RRR NSW.[343] This need for better

[339] Ms Silva, Evidence, 28 May 2024, p 29.

[340] Ms Cain, Evidence, 31 May 2024, p 23.

[341] Ms Silva, Evidence, 28 May 2024, p 29.

[342] Ms Cain, Evidence, 31 May 2024, p 23.

[343] Submission 54, Isolated Children's Parent's Association of New South Wales, p 4; Submission 3, NSW Council of Social Service, p 9.

health services for young people in RRR communities is not confined to AOD treatment. For example, Local Government NSW reported that young people experience higher levels of suicide in rural and regional communities, which is worsened by a lack of adequate youth counselling services and programs.[344]

5.44 The Committee is deeply concerned that young people affected by substance abuse and/or mental health issues do not have adequate services available in their home communities. We recommend that NSW Health, in collaboration with the youth support units within the Department of Communities and Justice, investigate innovative and effective early intervention models for AOD treatment that could be implemented to address the service gaps for young people living in RRR NSW. This should also include a focus on integration with mental health services to reduce the fragmentation of services for young people with co-occurring issues.

[344] Submission 1, p 9.

Chapter Six – Aboriginal health services

Introduction

6.1 As noted in the 2022 Portfolio Committee No. 2 (PC2) report, First Nations people living in remote, rural and regional (RRR) NSW have poorer health outcomes than their metropolitan counterparts, including significantly lower life expectancies.[345] PC2 also found that First Nations people still experienced unacceptable discrimination in remote, rural and regional hospitals, and that there were significant barriers to accessing culturally appropriate health services.[346]

6.2 The PC2 report made several recommendations to improve the cultural safety of health services for First Nations communities. This included building the Aboriginal workforce across all disciplines (Recommendation 33) and formalising partnerships between NSW Health and Aboriginal Community Controlled Health Organisations (ACCHOs) (Recommendation 34).[347]

6.3 During the current inquiry, the Committee heard that there are still significant barriers to the growth and development of NSW Health's Aboriginal workforce in RRR NSW. To address this, we recommend that NSW Health work with relevant stakeholders to review the relevant industrial frameworks and develop statewide scopes of practice. We also recommend that the NSW Government prioritises incentives to support the growth of the Aboriginal community-controlled health sector, either through targeted incentive mechanisms or by amending the *Health Services Act 1997* to include ACCHOs that are working in partnership with NSW Health.

6.4 Stakeholders also told us that genuine and effective collaboration between Local Health Districts (LHDs) and ACCHOs remains a challenge, despite formal partnerships in many regional areas. The Committee recommends that regional LHDs work with ACCHOs and Primary Health Networks, using genuine principles of co-design, to map the Aboriginal health services offered, identify unmet needs and reduce duplication of services.

6.5 This chapter will look broadly at the cultural safety of health services for First Nations communities in RRR NSW, including workforce barriers, LHD governance, and partnerships with ACCHOs. Culturally appropriate care for specific services, including maternity services, palliative care, mental health and drug and alcohol services, is covered in the relevant chapters on those services.

---

[345] 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 13.

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

[347] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 161 – 162.

Cultural safety for First Nations communities

6.6 The PC2 report acknowledged that the issues faced by First Nations people in accessing health services are influenced by a range of historical, cultural and social factors:

> The interplay of discrimination, racism, poor experiences with healthcare professionals, lack of transport, and the lack of affordable and culturally appropriate healthcare services all contribute to a sense of reluctance by some First Nations people to seek medical assistance.[348]

6.7 The report recommended that NSW Health and the Local Health Districts (LHDs) improve the cultural safety of health services 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.[349] (Recommendation 32)

6.8 In this Committee's first report, we recommended that NSW Health develop and provide more training to staff to improve cultural safety in the public health system.[350]

6.9 NSW Health has since reported that its implementation of Recommendation 32 has been completed. NSW Health report that Respecting the Difference cultural awareness training had been 'refreshed' and 'extension learning' programs were being developed.[351]

6.10 Stolen Generations Organisations (SGO) workshops were also delivered in May 2023, to inform culturally safe support mechanisms for survivors to access healthcare in regional NSW. This included funding grants to four SGOs in regional locations.[352]

6.11 In its submission to this inquiry, the NSW Nurses and Midwives' Association (NMA) spoke positively about NSW Health's cultural awareness training as a foundational tool for promoting cultural competence. However, the NSW NMA

---

[348] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 159.

[349] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 161.

[350] Select Committee on Remote, Rural and Regional Health, *Implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, report 1/58, Parliament of New South Wales, August 2024, p 55.

[351] NSW Health, *Progress Report: Parliamentary inquiry into health outcomes and access to health and hospital services in Rural, Regional and Remote New South Wales*, September 2024, pp 73 – 74; Submission 43, NSW Health, p 25.

[352] Submission 43, p 25.

emphasised that mandatory education is only one component in the journey towards achieving cultural safety for First Nations people.[353]

6.12 It is also unclear to what extent NSW Health's cultural awareness training has been informed by local communities and their experiences of the healthcare system. The Committee notes that incorporating local content was a key aspect of Recommendation 32.

6.13 The NSW NMA suggested that NSW Health expand its training to encompass a comprehensive pathway, from cultural awareness to cultural sensitivity and cultural safety. They cited the 'Cultural Safety Training for Nurses and Midwives', developed by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, as an exemplary model:

> During the Cultural Awareness phase, participants delve into foundational concepts, understanding the essence of Aboriginal culture, its significance, and historical context. Moving into the Cultural Sensitivity phase, emphasis is placed on developing nuanced understandings of cultural nuances, communication styles, and respectful engagement practices. Finally, the Cultural Safety phase equips participants with actionable strategies and tools to actively foster culturally safe environments within clinical settings. This ensures that care delivery is respectful, inclusive, and responsive to the needs of Aboriginal communities and the workforce.[354]

6.14 The Committee is of the view that NSW Health should continue to expand and refine its cultural safety programs and explore best practice models proposed by the sector.

6.15 Stakeholders also told us that the growth and development of NSW Health's Aboriginal workforce, as well as the Aboriginal community-controlled health sector, is crucial to building trust in First Nations communities and creating culturally safe health services.[355] The challenges in building the Aboriginal health workforce and partnerships with ACCHOs are covered in more detail in the following sections.

Building the Aboriginal health workforce

6.16 PC2 recognised the importance of First Nations staff in providing culturally safe health services to First Nations communities. The PC2 report recommended that NSW Health and regional LHDs prioritise building their Aboriginal workforce across all disciplines, job types and locations (Recommendation 33).[356]

6.17 In its submission to this inquiry, NSW Health reported that a number of targets have been established to increase the Aboriginal health workforce, in line with Recommendation 33:

[353] Submission 48, NSW Nurses and Midwives' Association, p 16.

[354] Submission 48, p 17.

[355] Submission 1, Local Government NSW, p 7; Mr Richard Colbran, Chief Executive Officer, Rural Doctors Network (RDN), Transcript of evidence, 3 June 2024, p 7; Submission 18, NAATSIHWP, p 2.

[356] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 161.

- The statewide Aboriginal Workforce Composition Policy, published in December 2023, sets a 3.43 per cent target for the NSW Health Aboriginal workforce by 2031, with incremental targets of 3.10 per cent by 2025 and 3.30 per cent by 2028. [357]
- The Priority Framework for the Regional Health Strategic Plan 2022-2032 further establishes a minimum target of four per cent of Aboriginal staff for regionally based LHDs.[358]
- Aboriginal Health Practitioner targets have been established for each LHD and Speciality Health Network, with a minimum of 53 FTE across rural and regional LHDs.[359]
- Some regional LHDs have established their own local targets. For example, Western NSW LHD aims to have an Aboriginal workforce of 9.3 per cent, and has an active workforce program to attract and retain Aboriginal staff. [360]

6.18 The Committee also heard that positive steps have been taken to establish Aboriginal cadetships. For example, NSW Health offers up to 20 Aboriginal Allied Health Cadetships each year.[361] Further funding was approved in April 2023 to support 20 additional Aboriginal nursing and midwifery cadetship positions for four years, as part of the Building and Sustaining the Rural Health Workforce Policy Proposal.[362]

6.19 However, stakeholders told us that more needs to be done to grow and develop the Aboriginal health workforce in RRR NSW. This includes addressing systemic barriers to recruiting and retaining NSW Health's Aboriginal workforce, and prioritising incentives to attract ACCHO staff. These are discussed in the following sections.

Workforce challenges

Finding 16

There are systemic barriers to the growth and development of NSW Health's Aboriginal workforce under the existing industrial frameworks, scopes of practice, and career pathways.

Recommendation 18

That NSW Health work with relevant stakeholders to review the relevant industrial frameworks for its Aboriginal workforce, including the Aboriginal Health Workers' (State) Award 2023, and progress negotiations to address barriers to recruitment and retention under the Award.

[357] Submission 43, p 24; *Progress Report*, September 2024, p 75.
[358] Submission 43, p 24; *Progress Report*, September 2024, p 75.
[359] *Progress Report*, September 2024, pp 75 – 76.
[360] Submission 43, p 24.
[361] Submission 43, p 24.
[362] *Progress Report*, September 2024, p 75.

Recommendation 19

That NSW Health review its Aboriginal Health Worker Guidelines and work with key stakeholders, including Aboriginal Community Controlled Health Organisations (ACCHOs), to develop statewide scopes of practice for all levels and occupations of the Aboriginal health workforce.

6.20 During the inquiry, we heard that there are ongoing challenges to recruiting and retaining Aboriginal health workers, due to current industrial frameworks, guidelines and scopes of practice.[363]

6.21 The *Aboriginal Health Workers' (State) Award 2023* applies to two broad categories of the health workforce, which can be described as two distinct yet related professions:

- Aboriginal Health Workers (AHWs) provide non-clinical services such as advocacy, support, liaison, and health promotion. AHWs are generally required to undertake a minimum Certificate III in Aboriginal Primary Health Care.
- Aboriginal Health Practitioners (AHPs) provide direct clinical services to Aboriginal communities. AHPs are required to hold a Certificate IV in Aboriginal Primary Health Care Practice, and are registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. AHPs also have a different pay scale to AHWs.[364]

6.22 During the hearings for this inquiry, Mr Richard Griffiths, Executive Director, Workforce Planning and Talent Development, Ministry of Health, explained that there has been 'a slight reduction' in AHW numbers, but a requisite increase in AHPs. This shift was attributed to a focus on embedding practitioners within the NSW Health system.[365]

6.23 However, despite the increase in practitioner numbers, the Committee notes that the target for Aboriginal Health Practitioners across rural and regional LHDs had not been reached as of June 2023, with only 29.02 of the 53 FTE recruited.[366]

6.24 In terms of addressing the challenges for Aboriginal Health Workers, NSW Health told us that they are involved in negotiations to update the Award or potentially design a new industrial instrument. We also heard that they have looked to remove restrictions around movements in and out of the Aboriginal Health Worker classifications in the interim.[367]

6.25 The National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP) spoke positively about the steps already taken by

[363] Submission 43, p 28; Submission 18, p 8.

[364] Submission 18, p 4; Aboriginal Health Worker workforce, viewed 30 January 2025; IB2018_018 Definition of an Aboriginal Health Worker, viewed 30 January 2025; Aboriginal Health Workers' (State) Award 2023, viewed 20 January 2025.

[365] Mr Griffiths, Evidence, 3 June 2024, p 36.

[366] *Progress Report*, September 2024, p 76.

[367] Submission 43, p 28; Mr Griffiths, Evidence, 3 June 2024, p 36.

NSW Health, but raised concerns that these workforce initiatives do not address the systemic barriers impacting on the recruitment, retention and recognition of these professions. Specifically, their submission highlighted underutilisation, lack of career pathways to support continuous learning, and systemic racism.[368]

6.26 NAATSIHWP told us that the current guidelines and frameworks do not encourage AHWs or AHPs to apply the core capabilities that they gained in their qualifications. This means they are working 'below the core capabilities they are qualified to perform', which has resulted in underutilisation of the Aboriginal health workforce:

> This disparity between practice and qualification causes confusion and impacts on the retention, recruitment, and recognition of the workforce. In NSW Health the gap particularly impacts on Aboriginal and/or Torres Strait Islander Health Practitioners, with current guidelines preventing members of this regulated profession from participating fully in health checks and administering medicine in any capacity despite being trained to do so.[369]

6.27 While NSW Health has made a commitment to review the scopes of practice outlined in its Aboriginal Health Worker Guidelines, NAATSIHWP submitted that there has been no progress on this review. They also told us that there are no state-wide scopes of practice for the workforce employed in Aboriginal community controlled or private settings, despite a large proportion of the Aboriginal health workforce working in non-government settings in NSW.[370]

6.28 Although NSW Health have a career structure for its Aboriginal health workforce, NAATSIHWP told us that this structure 'does not provide a well-defined or supported pathway from entrance levels through to leadership positions'. They suggested that best practice career structures and salary scales should:

- draw on the National Aboriginal and/or Torres Strait Islander Health Worker and Health Practitioner qualification framework and benchmark roles against each level of qualification
- clearly set out the activities that AHWs and AHPs at each level should be enabled to perform
- provide incentives to encourage further study as part of career pathways/progression. [371]

6.29 As the peak body for Aboriginal health workers, NAATSIHWP further highlighted the 'presence of systemic racism in healthcare settings', which can lead to funding inequity and limited opportunities for professional development.[372]

---

[368] Submission 18, p 7.
[369] Submission 18, p 7.
[370] Submission 18, p 7.
[371] Submission 18, p 8.
[372] Submission 18, p 8.

6.30 The Committee notes the importance of promoting greater understanding of the skills, training and roles of AHWs and AHPs, to ensure that they are valued within the health workforce and have well-defined, supported career pathways.

6.31 We recommend that NSW Health continue to work with relevant stakeholders in reviewing the Award to address systemic barriers to the recruitment and retention of the Aboriginal health workforce in RRR NSW. We also recommend that NSW Health complete its review of the Aboriginal Health Worker Guidelines with greater urgency. This work should include the development of statewide scopes of practice for all levels and occupations of the Aboriginal health workforce, including those in organisations that work in partnership with NSW Health.

Incentives for Aboriginal Community Controlled Health Organisation staff

Finding 17

Although Aboriginal Community Controlled Health Organisations are essential primary health care providers, they are not included in state-level approaches to recruitment and retention, and are unable to access key state-level incentives for regional health workers.

Recommendation 20

That the NSW Government prioritise incentives to support the growth of the Aboriginal community-controlled health sector, either through targeted incentive mechanisms for Aboriginal Community Controlled Health Organisations (ACCHOs), or by amending the *Health Services Act 1997* to include ACCHO staff that are working in partnership with NSW Health or providing services directly to Aboriginal communities.

6.32 NSW Health reported that the Rural Health Workforce Incentive Scheme has helped to recruit over 3044 health workers and retain over 11 300 health workers in rural and regional NSW since it was introduced in July 2022. This has included 14 Aboriginal Health Practitioners and 54 Aboriginal Health Workers. In August 2023, the value of the incentives also doubled, and NSW Health reported a 20 per cent increase in recruitment and retention.[373]

6.33 However, as Maari Ma Health Aboriginal Corporation identified during our first inquiry, the Incentive Scheme can disadvantage staff working in non-government organisations. Many of these staff work in Local Health District facilities and often perform the same work as NSW Health staff, but for less pay.[374]

[373] NSW Government, *Response to Inquiry into the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, February 2025, pp 2 and 5.

[374] 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, Submission 39, Maari Ma Health Aboriginal Corporation, p 3.

6.34 During the current inquiry, the Aboriginal Health and Medical Research Council (AH&MRC) raised similar concerns about eligibility being limited to NSW Health employees, given the critical role of ACCHOs within the health system.[375]

6.35 We heard that GPs working in ACCHOs are eligible to access the Commonwealth Workforce Incentives Payment. However, this is only sufficient to supplement staff salaries to meet market rates. The Commonwealth scheme does not provide additional support for housing, utilities, travel, professional development, or other entitlements that the NSW scheme provides.[376]

6.36 In advocating for the expansion of the Incentive Scheme to ACCHO staff, the AH&MRC submitted:

> ACCHOs are essential primary health providers of the public health system. Without strong, secure primary health services, patients will present directly to hospitals. ACCHOs should be able to access state-level workforce incentive packages given their role in preventing hospitalisations and reducing presentations to NSW Health facilities. Not only is preventative health care essential, but it also ensures that hospitals are not overburdened to maintain reliable and responsive health systems.[377]

6.37 In this Committee's previous report on workforce issues, we recommended that eligibility for the Incentive Scheme be broadened so that non-government organisations that service RRR communities directly, or in partnership with NSW Health, are able to access the same incentives. We also recommended that the NSW Government provide additional funding to expand the Incentive Scheme to grow the Aboriginal health workforce.[378]

6.38 This first recommendation was not supported by the NSW Government in its response to the report. The NSW Government response explained that 'modifying the Incentive Scheme to enable access by non-government organisations is outside the scope of the *Health Services Act 1997* (NSW)'. It also noted that the 'intent and purpose' of the Incentive Scheme is to incentivise staff to work for NSW Health.[379]

6.39 While we acknowledge the importance of recruiting and retaining NSW Health staff, the Committee considers that restricting incentives in this way may negatively impact recruitment to ACCHOs and other non-governmental organisations (NGOs). We remain of the view that ACCHOs and NGOs delivering services in partnership with NSW Health should be included in state-level approaches to recruitment and retention to ensure that Aboriginal health services remain accessible and culturally safe.

---

[375] Submission 66, AH&MRC, p 6.

[376] Submission 66, p 6.

[377] Submission 66, p 6.

[378] *Implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, August 2024, p 4.

[379] NSW Government, *Response to Inquiry into the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, February 2025, p 4.

6.40 We recommend that the NSW Government prioritises incentives to support the growth of the Aboriginal community-controlled health sector in RRR NSW. This could be achieved by implementing targeted incentives for ACCHO staff delivering health services directly to Aboriginal communities in RRR NSW. Alternatively, the *Health Services Act 1997* could be amended to include ACCHOs that are working in partnership with NSW Health and to bring these staff within the scope of the existing Incentive Scheme. While targeted incentives would help build capacity within the community-controlled sector, we note that bringing ACCHOs within the scope of the Act may facilitate a more coordinated approach to recruitment and retention of the Aboriginal health workforce. This change would also recognise the significant contribution of ACCHOs to the public health system, particularly in RRR NSW.

Governance and partnerships in delivering Aboriginal health services

6.41 The PC2 report recognised the need for formal partnerships and governance structures that embed Aboriginal representation at the highest levels of LHDs. The report recommended:

- That NSW Health and the LHDs prioritise formalising partnerships with all ACCHOs to support the delivery of health services to First Nations people in NSW (Recommendation 34).
- That the NSW Government mandate the requirement for each LHD to have at least one Aboriginal community representative on its governing board (Recommendation 35).[380]

6.42 We heard that despite formal partnerships in many areas, genuine and effective collaboration between the Aboriginal community-controlled sector and regional LHDs remains a challenge. We recommend that all regional LHDs work with ACCHOs and PHNs, using genuine principles of co-design, to map the Aboriginal health services offered to identify unmet needs and reduce any duplication of services. We also recommend that the *Health Services Act 1997* is amended to formalise the requirement for Aboriginal community representation within regional LHDs.

Genuine partnership and co-design between regional Local Health Districts and the Aboriginal community-controlled sector

Finding 18

Although NSW Health reports longstanding partnerships between Local Health Districts and Aboriginal Community Controlled Health Organisations, there are barriers to establishing formal partnership agreements in many regional areas.

Finding 19

Genuine and effective collaboration between Local Health Districts (LHDs) and Aboriginal Community Controlled Health Organisations remains a challenge,

[380] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 162.

even where partnership agreements have been formalised, as LHDs are often making unilateral decisions about Aboriginal health care.

Recommendation 21

That all regional Local Health Districts work with Aboriginal Community Controlled Health Organisations and Primary Health Networks, using genuine principles of co-design, to:

- **conduct an assessment of needs within the district, and**
- **map the Aboriginal health services offered to identify unmet needs and reduce any duplication of services.**

6.43 During the current inquiry, stakeholders reiterated the importance of engaging the Aboriginal community-controlled sector in the design and delivery of Aboriginal health services.[381]

6.44 Rural Doctors Network submitted that:

> Placing these organisations, and the Indigenous communities they represent, at the centre of changes and initiatives, and empowering them to co-design and implement solutions, will best utilise their knowledge, networks, and infrastructure; maximise achievement of culturally safe and accessible health care; and achieve improvements in relation to self-determination for their communities.[382]

6.45 During the hearings, Mr Richard Colbran, Chief Executive Officer, Rural Doctors Network, further explained:

> Not all services are delivered through the ACCHO sector but, at the same time, the notion of providing safe and culturally responsive care in local communities and that are tailored to that community is absolutely critical. It's often overlooked in terms of the way services are designed and the way that workforces are developed.[383]

6.46 In reporting on progress against Recommendation 34, NSW Health noted that the majority of LHDs have reviewed their partnerships with ACCHOs 'or have a variation in place that provides a strong foundation for collaboration with ACCHOs from in their region'.[384]

6.47 Ms Geraldine Wilson, Executive Director, Centre for Aboriginal Health, NSW Health, told us that NSW Health have a funding relationship with 41 Aboriginal Medical Services (AMSs) across NSW, and noted that LHDs are also working with ACCHOs more broadly to address the social determinants of health. When the Committee asked which regions have strong partnerships, Ms Wilson identified Northern NSW (particularly Bulgarr Ngaru AMS) and Western NSW as particularly positive examples.[385]

---

[381] Submission 18, p 10; Mr Colbran, Evidence, 3 June 2024, p 7; Submission 42, Rural Doctors Network, p 4.

[382] Submission 42, p 4.

[383] Mr Colbran, Evidence, 3 June 2024, p 7.

[384] *Progress Report*, September 2024, p 77.

[385] Ms Wilson, Evidence, 3 June 2024, p 37.

6.48 However, stakeholders reported different experiences of the working relationships between LHDs and ACCHOs. For example, during our first inquiry, Bulgarr Ngaru Medical Aboriginal Corporation submitted:

> 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 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.[386]

6.49 The Committee heard similarly mixed experiences during the site visits for this inquiry. When we met with Local Health District executives, they described positive relationships and meetings with local ACCHOs. However, First Nations representatives and ACCHO staff told us that these meetings were high level and, in reality, action and communication at the service level was limited.

6.50 Local Health Districts may also need to be more proactive in seeking information about local First Nations health issues. During the current inquiry, Tamworth Medical Staff Council reported that the vast majority of issues in its large Aboriginal population are managed outside the hospital and 'the health service has no way of knowing what the needs are in that context'.[387]

6.51 The Committee is of the view that, despite formal partnership agreements being in place, genuine and effective collaboration between LHDs and ACCHOs remains a challenge due to the culture within LHDs and poor working relationships.

6.52 Without effective partnerships between LHDs and ACCHOs, continuity of care can be impacted for Aboriginal communities. The AH&MRC described the way in which this can lead to 'fragmented care planning' that disproportionally impacts Aboriginal patients. We heard that service providers are often funded for the same services, while other health needs remain unmet.[388]

6.53 We recommend that all regional LHDs work with the relevant ACCHOs and PHNs, using genuine principles of co-design, to:

- conduct an assessment of needs within the district, and
- map the Aboriginal health services offered to identify unmet needs and reduce any duplication of services.

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

[387] Submission 57, Tamworth Medical Staff Council, p 1.

[388] Submission 66, p 4.

Services that are genuinely co-designed by LHDs, ACCHOs and PHNs will facilitate greater continuity of care and better meet the health needs of Aboriginal communities in RRR NSW.

Embedding Aboriginal community representation within Local Health Districts

Recommendation 22

That NSW Health amend the *Health Services Act 1997* to formalise the requirement for at least one Aboriginal community representative on each LHD's governing board.

6.54 The AH&MRC told us that 'LHDs do not systematically work with ACCHOs as key partners in primary health care delivery', and partnerships continue to be inconsistent across NSW. They identified that commitment to work with the community-controlled sector 'continues to be driven by individual relationships and is yet to be embedded within LHD governance'.[389]

6.55 To address these issues, the AH&MRC suggested that the NSW Government explore 'multi-level improvements to support partnerships and connected care', including amending the Board membership criteria for LHDs to ensure the Aboriginal community is appropriately represented in decision-making roles.[390]

6.56 The Committee notes that mandating Aboriginal community representation was the focus of PC2 Recommendation 35. In reporting on progress against this recommendation, NSW Health told us that 'each regional LHD has at least one designated Aboriginal community representative role' on its board, but there is no express requirement:

> The *Health Services Act 1997* currently requires at least one board member to have "expertise, knowledge or experience in relation to Aboriginal health," but does not expressly require appointment of a member of the Aboriginal community.[391]

6.57 The Committee notes that collaboration is often driven by individual relationships and that these can vary across RRR NSW. In order to ensure Aboriginal communities are represented consistently on LHD boards across regional NSW, we recommend amending the *Health Services Act 1997* to mandate Aboriginal community representation on LHD boards. Formalising this in legislation would be a key step in ensuring that Aboriginal community voices are embedded consistently within and across regional LHD decision-making.

[389] Submission 66, p 4.

[390] Submission 66, p 5.

[391] *Progress Report*, September 2024, p 78.

Chapter Seven – Patient transport and paramedicine

Introduction

7.1 Timely and affordable transport is a crucial enabler of access to healthcare, particularly when health services are highly specialised, or when offering them across all locations is not viable. This becomes even more important in remote, rural and regional (RRR) NSW, where public transport is not delivered reliably and any transportation is challenged by the sheer distances involved.[392]

7.2 In its 2022 report, Portfolio Committee No. 2 (PC2) highlighted the inadequacy of travel subsidies provided under the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS). It also made a number of recommendations to improve and expand access to a range of patient transport services in RRR NSW, including non-emergency patient transport services and paramedic services.[393]

7.3 During the current inquiry, we heard that significant improvements have been made to IPTAAS since the 2022 report.[394] However, there are still notable service gaps in non-emergency patient transport services, as community transport passengers are ineligible to claim subsidies under IPTAAS and current funding for community transport is not sufficient to meet community needs.[395] We recommend that the NSW Government improve the accessibility and affordability of community transport for non-emergency patient travel, including through updates to IPTAAS and additional funding.

7.4 The Committee also heard that senior paramedics are being disincentivised from working in RRR NSW, resulting in a 'de-skilling' of the paramedic workforce.[396] We recommend that NSW Health urgently address issues that may impact the expansion of Extended Care and Intensive Care Paramedics in regional areas. We also recommend that NSW Health evaluate the first tranche of the NSW Patient Transport Service rollout in regional NSW and the Integrated Paramedic Workforce Model Project, in order to inform the future implementation of these initiatives across RRR NSW.

---

[392] Submission 42, NSW Rural Doctors Network, p 4; Submission 61, Community Transport Organisation, p 2.

[393] 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 36, 143, 144.

[394] Submission 43, NSW Health, p 36; NSW Health, *Progress Report: Parliamentary inquiry into health outcomes and access to health and hospital services in Rural, Regional and Remote New South Wales*, September 2024, p 12; NSW Health, *IPTAAS Baseline Monitoring and Evaluation Summary Report*, July 2024, p 3; NSW Government, *Response to Inquiry into the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, February 2025, p 20.

[395] Submission 32, Can Assist (Cancer Assistance Network), p 1.

[396] Submission 33, Australian Paramedics Association (NSW), p 5; Answers to supplementary questions, Australian Paramedics Association (NSW), p 1.

Financial assistance under the Isolated Patients Travel and Accommodation Scheme (IPTAAS)

The Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) offers financial support to NSW patients that are travelling more than 100 kilometres one way or 200 kilometres in a week to the same doctor or health service for specialised medical treatment that is unavailable locally. The Scheme allows patients to claim reimbursements for private vehicle travel, public transport, taxis, air travel (in specific circumstances), and accommodation.[397]

7.5 In its 2022 report, Portfolio Committee No. 2 (PC2) highlighted the inadequacy of IPTAAS reimbursement rates per km travel and the way in which the administrative requirements of the Scheme compounded the 'stress and vulnerability of having to seek ongoing medical treatment far from home'. The PC2 report recommended that the NSW Government review the Scheme as a matter of priority, with the aim of increasing reimbursement rates, expanding the eligibility criteria, simplifying the application process and increasing public awareness of the Scheme (Recommendation 2).[398]

7.6 The Committee considers that, while substantial improvements have been made to IPTAAS since the PC2 report, several service gaps remain. In particular, there are prohibitive restrictions on subsidies for community transport passengers. We recommend that NSW Health urgently address the community transport service gap under the Scheme to allow patients to claim subsidies for community transport. We also urge NSW Health to review IPTAAS for additional service gaps and to consider further expanding the Scheme's eligibility criteria.

Improvements to IPTAAS

Finding 20

Significant improvements have been made to the Isolated Patients Travel and Accommodation Assistance Scheme to increase subsidies and make financial assistance available for a broader number of services.

7.7 NSW Health has reported that its implementation of Recommendation 2 has been completed, noting the following updates to IPTAAS since the PC2 report:

- Transport and accommodation subsidies were reviewed and increased, with the average IPTAAS reimbursement now at its highest at $482 per patient.
- Additional health services were included under the Scheme's eligibility criteria, such as additional highly specialised allied health services, cancer clinical trials and voluntary assisted dying services.

[397] NSW Health, Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS), viewed 20 February 2025.

[398] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 35.

- The application form was improved based on consumer feedback.
- Public awareness campaigns resulted in increased IPTAAS applications, with nine per cent and 36.1 per cent increases following campaigns in 2022 and 2023.
- A monitoring and evaluation framework was developed and implemented.[399]

7.8 The 2023-24 financial year also saw an increase in financial assistance provided under the Scheme, with 99 600 applications approved (surpassing the previous year's number of approved applications by 21 200) and approximately $49 million in subsidies issued to 41 417 patients.[400]

7.9 Additionally, in July 2024, NSW Health published the Baseline Monitoring and Evaluation Summary Report for IPTAAS. This early evaluation found that the statewide average time for processing IPTAAS applications was within the 21-day target and the majority of IPTAAS applicants were happy with the Scheme.[401]

7.10 During the current inquiry, several participants spoke positively about the IPTAAS improvements, particularly increases to the Scheme's funding and reimbursement rates.[402] For example, Cancer Council NSW noted that its clients reported fewer financial concerns as a result of the new subsidy rates.[403]

7.11 We also heard that NSW Health has introduced measures to increase stakeholder involvement in IPTAAS. For example, a consultative stakeholder forum was created in 2023 to focus on identifying barriers, risks and issues with the Scheme. The forum meets quarterly to ensure ongoing input from participants and organisations that use the Scheme.[404]

7.12 Inquiry participants spoke positively about NSW Health's engagement with stakeholders in relation to IPTAAS.[405] For example, Ms Tara Russell, Chief Executive Officer, Community Transport Organisation (CTO), commended NSW Health for their 'proactive, collaborative and positive approach'.[406] Similarly, the cancer assistance network Can Assist observed that the forums have generated meaningful dialogue with NSW Health:

---

[399] Submission 43, pp 36, 43; *Progress Report*, September 2024, pp 12-13; NSW Government, Making it easier for regional patients who need to travel for healthcare, viewed 13 January 2025; Professor Tracey O'Brien, Chief Executive, Cancer Institute, NSW Health, Transcript of evidence, 3 June 2024, p 43; NSW Government, What has changed?, viewed 13 January 2025.

[400] Making it easier for regional patients who need to travel for healthcare, viewed 13 January 2025.

[401] *IPTAAS Baseline Monitoring and Evaluation Summary Report*, July 2024.

[402] Submission 3, NSW Council of Social Service, p 7; Submission 32, p 1; Submission 32a, Can Assist, p 1; Submission 42, p 4; Submission 49, Cancer Council, p 7; Submission 61, p 1; Submission 66, Aboriginal Health and Medical Research Council (AH&MRC) p 4; Dr Vanessa Johnston, Director of Cancer Information and Support Services, Cancer Council NSW, Transcript of evidence, 31 May 2024, pp 33-34.

[403] Submission 49, p 7.

[404] *Progress Report*, September 2024pp 12-13.

[405] Submission 32, pp 1, 6; Submission 49, p 7; Submission 61, p 1; Ms Tara Russell, Chief Executive Officer, Community Transport Organisation, Transcript of evidence, 31 May 2024, p 10.

[406] Ms Russell, Evidence, 31 May 2024, p 10.

> This forum provides open channel feedback and input from a wide variety of grass roots community groups. Voices are heard and remedies addressed.[407]

7.13 NSW Health stated that it is committed to continuously improving IPTAAS and noted that further is work underway. This includes consistently reviewing the IPTAAS policy and assessment guidelines, developing further public awareness campaigns, redeveloping the Scheme's online portal, and implementing a new authentication platform for online users.[408]

7.14 We are also pleased to note that NSW Health will pilot the provision of IPTAAS funds directly to Aboriginal Community Controlled Health Organisations (ACCHOs).[409] During the inquiry, we heard ACCHOs are often left covering the cost of patient transport to specialist care, 'despite not being funded to do so'.[410]

7.15 The Committee commends the NSW Government for its IPTAAS reforms, which have improved this crucial financial support for remote, rural and regional residents who are required to travel to access specialist healthcare services. However, as we discuss below, the Scheme's restrictive eligibility criteria continue to create service gaps and limit access to specialist care in RRR NSW.

Restrictions on community transport subsidies under IPTAAS

Community transport services are delivered by various bodies, including not-for-profit organisations, local councils and private providers. They also frequently rely on volunteers within the community to help meet local patient transport needs, where public transport services are unavailable.[411]

This section looks specifically at subsidies for community transport passengers under IPTAAS. Issues relating to community transport services more broadly are covered later in this chapter.

Finding 21

Community transport passengers are frequently ineligible to claim subsidies under the Isolated Patients Travel and Accommodation Assistance Scheme. This has created a significant service gap that increases inequities across remote, rural and regional NSW.

Recommendation 23

That NSW Health urgently address the community transport service gap under the Isolated Patients Travel and Accommodation Assistance Scheme to allow patients to claim subsidies for community transport.

---

[407] Submission 32, p 6.

[408] *Progress Report*, September 2024, p 13.

[409] *Progress Report*, September 2024, p 13.

[410] Submission 66, p 3.

[411] Submission 3, p 8; Submission 32, p 3; Submission 61, p 2; Ms Russell, Evidence, 31 May 2024, p 10.

7.16 The community transport sector plays a large role in enabling health-related non-emergency travel for patients in RRR NSW. Annually, more than three quarters of community transport trips are for medical reasons.[412] However, restrictive IPTAAS guidelines prevent many community transport passengers from claiming reimbursements under the Scheme.

7.17 During our inquiry, we heard that most patients travelling by community transport do not qualify for IPTAAS reimbursements, as the community transport industry is not an eligible service provider under the relevant guidelines.[413]

7.18 The IPTAAS Assessment Guidelines specify that a patient may only receive a subsidy for community transport if the community transport operator does not receive government funding.[414] This renders a majority of community transport trips ineligible for IPTAAS subsidies, as most operators receive some form of government funding.[415] Funding for the community transport sector is explored later in this chapter.

7.19 The Committee heard that the IPTAAS restriction on community transport subsidies is intended to avoid 'double dipping' by patients receiving rebates for the same trip through various schemes.[416] However, in practice, the restriction has created a financial barrier for community transport passengers travelling long distances to access specialist care.[417]

7.20 The restriction on community transport subsidies is particularly challenging for isolated and remote patients who are the most geographically removed from specialist medical services. The cancer assistance network Can Assist highlighted that government funding for community transport is at a fixed rate of approximately $37 per trip and does not factor in the length of travel. In contrast, reimbursement for private vehicle travel via IPTAAS varies depending on the distance driven and is subsidised at a rate of 40 cents per kilometre.[418]

7.21 As a result, community transport passengers are reimbursed less per kilometre the longer that they need to travel for non-emergency medical care. This creates disparities that increase with remoteness:

> Over the course of a typical 12-month treatment profile, a rural cancer patient living just 100km away from the Tamworth Cancer Centre…would typically clock up a private travel IPTAAS rebate some 2.5 times the size of the equivalent implicit community transport subsidy ($3862 versus $1517). The disparity between the two subsidies grows exponentially with the geographic isolation of the patient since, unlike IPTAAS, the community transport subsidy remains constant. The implicit

[412] Submission 61, p 2.

[413] Submission 3, p 8; Submission 32, p 1; Submission 61, p 2; Ms Russell, Evidence, 31 May 2024, pp 10 and 14; Ms Maureen Field, Treasurer, Can Assist Forbes, Transcript of evidence, 28 May 2024, p 20.

[414] NSW Government, Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) Assessment Guidelines, November 2024, viewed 13 January 2025, p 17.

[415] Submission 3, p 8; Submission 32, p 2; Submission 61, p 2.

[416] Submission 3, p 8; Submission 32, p 2; Ms Russell, Evidence, 31 May 2024, p 14.

[417] Submission 3, p 8.

[418] Submission 32, p 2; NSW Government, Subsidy rates, viewed 14 January 2025.

> government subsidy for community transport is always lower than the equivalent IPTAAS subsidy for isolated patients.[419]

7.22 Ms Tara Russell, Chief Executive Officer, CTO explained the implications of this disparity, noting that some patients that are assessed as needing transport support through Commonwealth funding will 'go away and use their own private car to drive their IPTAAS-eligible journey'. She noted that this option is potentially unsafe and/or uncomfortable for patients.[420]

7.23 For other rural and isolated patients, who may not have access to their own private vehicle, community transport is the only way to travel to health facilities.[421]

7.24 CTO submitted that, where there is unmet need for affordable patient transport, it is 'counterproductive' to exclude an existing transport solution under IPTAAS.[422] Ms Russell told the Committee that:

> …because the eligibility for IPTAAS sits with the patient, it doesn't extend the state budget at all to include community transport in the scheme, because all it is doing is providing another choice for patients to travel. It expands availability of options within the community.[423]

7.25 NSW Council of Social Service similarly called for patients to have greater autonomy in travel decisions:

> Patients should be able to choose and access the best transport option available to them, and make their own decision about which eligible rebate or subsidy scheme to apply for, based on their personal situation.[424]

7.26 The Committee is of the view that the IPTAAS community transport restriction unnecessarily narrows the already limited travel options that are available to patients in RRR NSW. We recommend that NSW Health urgently address this service gap to allow community transport passengers to access subsidies under IPTAAS. We also acknowledge that there are broader challenges to the community transport sector, which we discuss later in this chapter.

Additional service gaps within IPTAAS

Recommendation 24

That NSW Health identify and address additional service gaps within the Isolated Patients Travel and Accommodation Assistance Scheme and consider expanding the eligibility of services, including further allied health services, as part of the ongoing monitoring and evaluation of the Scheme.

---

[419] Submission 32, p 2.

[420] Ms Russell, Evidence, 31 May 2024, p 14.

[421] Submission 3, p 8; Answers to questions on notice, Local Government NSW, 25 June 2024, p 7; Submission 66, p 4.

[422] Submission 61, p 2.

[423] Ms Russell, Evidence, 31 May 2024, p 14.

[424] Submission 3, p 8.

7.27 During the inquiry, we heard that there are further service gaps within the IPTAAS eligibility criteria. These include ineligible subsidies for travel to access some allied health services and long trips made by patients to specialist healthcare services that are below the Scheme's minimum distance requirements. We recommend that NSW Health identify and address these additional service gaps as part of the ongoing monitoring and evaluation of the Scheme.

Allied health services

7.28 Stakeholders told us that there is a lack of allied health services in rural and remote areas of NSW. For example, there are limited speech and occupational therapy services and clinical psychology services with availability for RRR patients. Allied health services in these areas are often located far away, have long wait times, experience high staff turnover or are unable to commit to seeing a patient regularly.[425]

7.29 We heard that access to allied health services can also be challenging for children in RRR NSW where therapy needs to be delivered in blocks of regular appointments.[426] Allied health care cannot always be delivered online, which means that some remote and rural families travel hundreds of kilometres on a regular basis to access this type of care.[427]

7.30 The IPTAAS Assessment Guidelines state that allied health services are eligible for subsidies under IPTAAS if an allied health clinic is considered 'highly specialised'.[428] As noted earlier, NSW Health reported that more allied health services were added into this 'highly specialised' category in 2023.[429]

7.31 However, the Isolated Children's Parents' Association (ICPA) told us that only 'a couple' of allied health services in Sydney can be claimed for, and these services remain 'inaccessible for the majority of rural and remote families.'[430]

7.32 Ms Tanya Mitchell, NSW President, ICPA, also noted that in some instances, families may be unable to access a locally available allied health service because it is full. In these cases, if a family travels to access allied health care, they will be unable to claim an IPTAAS reimbursement as that service is already deemed available within the community.[431]

7.33 The Committee considers the current eligibility criteria for 'highly specialised allied health services' under IPTAAS to be restrictive. We recommend including a broader range of allied health services under IPTAAS to reduce the existing

[425] Submission 45, Royal Far West, p 5; Submission 54, The Isolated Children's Parents' Association of New South Wales Inc, pp 3-5.

[426] Submission 54, pp 3-5.

[427] Submission 54, pp 3-5; Ms Mitchell, Evidence, 31 May 2024, p 13.

[428] Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS): Assessment Guidelines, November 2024, viewed 15 January 2025, p 11.

[429] *Progress Report*, September 2024, p 12.

[430] Submission 54, p 3.

[431] Ms Mitchell, Evidence, 31 May 2024, p 13.

barriers in accessing appropriate specialist allied health care for those in RRR NSW.

Minimum distance requirements

7.34 Additionally, patients that travel for specialised health care are not eligible for IPTAAS if they do not meet the minimum distance requirements of 100 kilometres one way, or a 200 kilometre round trip within a week to the same doctor or health service. We heard that, for residents in Orange and its surrounds, many patients are ineligible for IPTAAS subsidies due to this requirement.[432]

7.35 Can Assist Forbes raised similar concerns about the minimum distance requirement and called for the eligible distance to be reduced for small towns that are situated 70-80 kilometres away from a health facility.[433]

7.36 The Committee recommends that NSW Health identify and address service gaps within IPTAAS and consider expanding its eligibility criteria as part of the ongoing monitoring and evaluation of the Scheme. Expanding the Scheme's eligibility criteria may involve providing travel subsidies for additional allied health services and decreasing the current minimum distance requirements.

Community transport

As noted earlier in this chapter, community transport services are highly diversified across RRR NSW and are delivered by various bodies, including not-for-profit organisations, local councils and private providers. They also frequently rely on volunteers within the community.[434]

7.37 The PC2 report recognised that community transport providers often assist in meeting local patient transport needs in RRR NSW where there is a lack of publicly available transport options. The report recommended that NSW Health, rural and regional LHDs and Transport for NSW (TfNSW) work together to ensure more frequent and affordable transport services for remote, rural and regional patients travelling to appointments (Recommendation 3).[435]

7.38 NSW Health has since reported that the implementation of this recommendation has been completed. The NSW Health Progress Report cited a number of developments, including bus service improvements across various regional cities, as part of the TfNSW 16 Cities Regional Service Improvement Program. NSW Health also noted that it is conducting a review of the Transport for Health policy,

[432] Mr Scott Maunder, Director Community and Cultural Services, Orange City Council, Transcript of evidence, 28 May 2024, p 45.

[433] Submission 32a, p 1.

[434] Submission 3, p 8. Submission 32, p 3; Submission 61, p 2; Ms Russell, Evidence, 31 May 2024, p 10.

[435] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 26 and 36.

and that it continues to work collaboratively with LHDs and TfNSW to administer the NGO Grants Program for community transport grants.[436]

7.39 However, the Committee is concerned that these actions have not led to any significant improvements for communities in RRR NSW and that the intent of Recommendation 3 remains unfulfilled. During our inquiry, we heard that there are various issues with the funding, affordability and accessibility of community transport services. In order to improve equitable access to community transport in RRR NSW, the Committee recommends that the NSW Government implement funding reform, passenger co-payment pricing benchmarks, and guidelines for fees.

Community transport funding is not sufficient to meet community needs

Finding 22

Funding for community transport is not sufficient to meet community needs across remote, rural and regional NSW. As a result, not-for-profit providers are having to cover out-of-pocket costs and supplement community transport services.

Recommendation 25

That the NSW Government provide additional funding for community transport providers, through the Community Transport Program and NGO Grants Program, and work with the Australian Government and relevant providers to address any funding gaps for community transport services across remote, rural and regional NSW.

7.40 During the inquiry, we heard that the community transport sector is unable to meet local demand across RRR NSW due to inadequate funding and resourcing.

7.41 Transport for NSW (TfNSW) provides funding for community transport under a number of government programs, including the Commonwealth Home Support Programme (CHSP), the state-level Community Transport Program (CTP) and NSW Health's Non-Government Organisations (NGO) Grants Program.[437] However, stakeholders reported that these funding streams are siloed, underfunded or at capacity, and there is 'continued unmet need' due to inadequate funding.[438]

7.42 In 2020-21, NSW Health allocated approximately $167 million to over 310 non-government organisations through its NGO Grants Program. NSW Health stated that it works with TfNSW and Local Health Districts to administer and track the governance and performance management of community transport grants offered through the program. They noted that ongoing grant funding is provided

[436] Submission 43, pp 16-18; *Progress Report*, September 2024, pp 15-17.

[437] Submission 3, p 8; Submission 32, p 2; Submission 61, p 2; NSW Government, Community transport operators, viewed 14 January 2025.

[438] Submission 3, p 8; Submission 32, p 2; Dr Johnston, Evidence, 31 May 2024, p 37.

to community transport providers as part of this work, and that assessments of NGO performance were conducted in the 2023-24 financial year.[439]

7.43 However, stakeholders told us that these grants are not consistently available to people using community transport, with government funding of the sector 'delivered via a fundamentally flawed and inequitable allocation process.'[440]

7.44 Cancer Council NSW called for the NGO Grants Program to be reviewed to ensure that sufficient funding is available to facilitate equitable access to non-emergency patient transport across NSW.[441] Similarly, Local Government NSW told us that improved coordination of funding arrangements is needed.[442]

Not-for-profits offer assistance where community transport services are limited

7.45 As discussed in Chapter Two, not-for-profit cancer care organisations are increasingly relied upon to cover the out-of-pocket costs of travel.[443] Can Assist told us that their funds are being stretched to meet unmet community transport needs and that they are increasingly needing to pay for community transport tickets. Their Forbes branch noted that their greatest expenditure is on travel and accommodation for clients.[444]

7.46 Volunteers enlisted by not-for-profit organisations also offer transport services for cancer patients in remote, rural and regional NSW when patients are unable to access or afford community transport trips.[445] For example, Cancer Council NSW provides a free Transport to Treatment service that uses volunteer drivers to supplement existing community transport offerings. However, during 2023-24, Cancer Council had to introduce more restrictive eligibility criteria to ensure the sustainability of the service.[446] This change has impacted accessibility and increased the pressure on other providers to meet community transport needs in some regional areas.[447]

7.47 Where community transport is underfunded and unaffordable, we heard that community transport operators are ultimately relying on volunteer drivers who are 'stretched beyond capacity' and cannot sustainably meet local demand for transport services.[448]

7.48 The Committee acknowledges the critical role that not-for-profit organisations play in subsiding and supplementing limited community transport services for patients in RRR NSW. In addition to providing additional funding for community

[439] Submission 43, p 17; Community transport operators, viewed 17 January 2025; NSW Government, Working with non-Government organisations, viewed 17 January 2025; *Progress Report*, September 2024, p 15.

[440] Submission 32, pp 1-2.

[441] Submission 49, p 8; Dr Johnston, Evidence, 31 May 2024, p 33-34.

[442] Submission 1, Local Government NSW, p 7.

[443] Submission 49, p 8.

[444] Submission 32, pp 2-3; Submission 32a, p 1.

[445] Submission 32, pp 2-3; Submission 49, p 8.

[446] Submission 49, p 8; Ms Brenna Smith, Manager Community, Cancer Information and Support Services, Cancer Council NSW, Transcript of Evidence, 31 May 2024, p 37.

[447] Submission 32, p 3.

[448] Submission 32, pp 2-3; Submission 32a, p 1; Submission 39, Mudgee Health Council, p 3; Submission 67, Older Women's Network NSW, p 3; Answers to questions on notice, Local Government NSW, 25 June 2024, pp 6-7.

transport, we recommend that the NSW Government work with the Australian Government and community transport providers to address any funding gaps and ensure that funding is adequately supporting community transport services in RRR NSW.

Affordability and disparities in costs for community transport

Recommendation 26

That the NSW Government work with community transport providers to improve the affordability of community transport across remote, rural and regional NSW, through the development of pricing benchmarks for passenger co-payments and publicly accessible guidelines for community transport fees. This should include any updates to the Isolated Patients Travel and Accommodation Assistance Scheme, as per Recommendation 23 of this report.

7.49 The Committee heard that funding challenges faced by community transport providers can lead to prohibitive ticket costs for passengers in some regional areas. NSW Council of Social Service stated that as a result of limited funding, transport operators are required to either run at a loss, or pass larger co-payment costs onto patients.[449]

7.50 Stakeholders also told us that community transport operators price tickets differently and there are disparities in the cost of tickets and co-payments across regional NSW. For example, while most operators may double prices for a patient travelling with an escort, others offer heavily discounted rates. Some operators may also charge extra for driver meal allowances and brokerage fees. As a result, tickets can be as low as 17 cents per kilometre for a trip from Forbes to Orange or reach up to two dollars per km for a trip from Tamworth to Newcastle.[450]

7.51 Additionally, the Committee is concerned that when community transport trips are expensive, passengers may be ineligible for IPTAAS subsidies and alternative subsidies may not offer equivalent financial compensation. This issue was discussed earlier in the IPTAAS section of this chapter.

7.52 Noting the issues in affordability and the disparities across regional areas, Cancer Council NSW advocated for statewide pricing benchmarks and publicly accessible guidelines for community transport fees.[451]

7.53 The Committee agrees that these initiatives proposed by Cancer Council NSW will help to improve transparency around costs and reduce the disparities faced by remote, rural and regional patients using community transport services. We recommend that the NSW Government work with community transport providers to develop pricing benchmarks for passenger co-payments and publicly accessible guidelines for community transport fees. This work should also reflect any updates to IPTAAS, as per Recommendation 23 of this report.

[449] Submission 3, p 8.

[450] Submission 32, p 1.

[451] Submission 49, pp 7-8; Dr Johnston, Evidence, 31 May 2024, p 33; Ms Smith, Evidence, 31 May 2024, p 37.

Non-emergency patient transport

In addition to community transport providers, some Local Health Districts (LHDs) also provide non-emergency patient transport services. These services can vary across RRR NSW, with some LHDs managing their own fleets and contracting out services. NSW Health notes that where LHDs do not provide non-emergency patient transport, NSW Ambulance transports patients to and from designated facilities for medical appointments.[452]

7.54 The PC2 report found that NSW Ambulance was supplementing a lack of regional, non-emergency patient transport services. This can result in 'paramedics frequently attending patients who do not require emergency care' and reducing NSW Ambulance's 'capacity to respond to emergencies'.[453]

7.55 To address this, the PC2 report recommended that NSW Health, in conjunction with NSW Ambulance:

> …review the use of ambulance vehicles for patient transfers, and in partnership with the rural and regional Local Health Districts explore extending the hours of operations of patient transfer vehicles to provide 24-hour coverage and minimise the number of low-acuity jobs that paramedics attend to, to relieve pressure on ambulance crews.[454] (Recommendation 28)

7.56 During the current inquiry, we heard that paramedics in remote, rural and regional areas continue to be frequently relied upon for non-emergency patient transport, including to services which could be offered through telehealth.[455] Mr Gary Wilson, Delegate and Former Secretary, Australian Paramedics Association (APA) NSW, informed the Committee that highly trained paramedics are still transporting patients to routine medical appointments and consequently may be unavailable to their local community for hours.[456]

7.57 APA NSW told us that a reliance on paramedics may partially be a result of LHD agreements that restrict where their services can transport between. For example, some LHD transport services may not be able to facilitate travel to and from patients' homes or hospital-based aged care facilities.[457]

7.58 APA NSW also noted that hospitals' patient transport services may only cover one leg of a trip. For example, a patient living over 300km away may have limited options to return home after being transported to a hospital to receive treatment.[458]

---

[452] Submission 43, p 16.

[453] Health outcomes and access to health and hospital services in rural, regional and remote New South Wales, May 2022, p 143.

[454] Health outcomes and access to health and hospital services in rural, regional and remote New South Wales, May 2022, p 143.

[455] Answers to supplementary questions, Australian Paramedics Association, 28 June 2024, p 4.

[456] Mr Gary Wilson, Delegate and Former Secretary, Australian Paramedics Association (NSW), Transcript of evidence, 31 May 2024, p 11.

[457] Mr Wilson, Evidence, 31 May 2024, pp 11-12.

[458] Submission 33, Australian Paramedics Association (NSW), pp 2-3.

7.59 Mr Wilson told the Committee that:

> …whenever there's a lack of resourcing or where there's an administrative barrier, NSW Ambulance and paramedics are left to prop up the system, thereby increasing risk to our communities for those time-critical jobs that we need to do.[459]

7.60 In response to the PC2 recommendations aimed at improving non-emergency patient transport options, NSW Health reported that it is looking to expand the NSW Patient Transport Service (PTS) across RRR NSW. This initiative is discussed below.

Expansion of the non-emergency Patient Transport Service across regional NSW

The NSW Patient Transport Service (PTS), operated by HealthShare NSW, provides non-emergency patient transport for patients who need to be transported to or from health facilities such as hospitals, rehabilitation units or aged care facilities.

PTS is currently operating in greater metropolitan Sydney, as well as the Hunter New England, Central Coast and Illawarra Shoalhaven Local Health Districts. It receives all booking requests for non-emergency patient transport and engages other health agencies for patient transfers as needed, including NSW Ambulance.[460]

Recommendation 27

That NSW Health evaluate the first tranche of the Patient Transport Service rollout to rural and regional Local Health Districts and identify priority areas for the continued expansion of the service in order to relieve pressure on paramedics across remote, rural and regional NSW.

7.61 In reporting on progress against Recommendation 28, NSW Health stated that HealthShare NSW has developed a proposal to expand its non-emergency Patient Transport Service (PTS) into rural and regional Local Health Districts (LHDs).[461]

7.62 Following a successful trial of the Health Patient Transport Reservations Model in the Hunter New England LHD, a proposal has been developed to expand the PTS into other rural and regional LHDs. NSW Health notes that the first rollout of the expanded PTS is planned for 2025 and will include the Mid North Coast and Northern NSW LHDs. Expansion in Mid North Coast LHD has already commenced in a limited capacity.[462]

7.63 A rollout to additional rural and regional LHDs is also planned. However, NSW Health noted that expansion of the service is dependent on LHD engagement and support. NSW Health also stated that Far West LHD is unlikely to implement PTS

[459] Mr Wilson, Evidence, 31 May 2024, pp 12.

[460] Submission 43, p 17; NSW Health, Eligibility for PTS, viewed 21 January 2025; NSW Health, Information for patients, viewed 21 January 2025.

[461] *Progress Report*, September2024, pp 15-16, 63.

[462] Submission 43, p 17; *Progress Report*, September 2024, p 63.

due to specific geographical challenges. This region will instead be offered assistance on locally adapted transport initiatives.[463]

7.64 NSW Health projected that if regional PTS trips are delivered at the same rate as they are in Sydney, the number of NSW Ambulance's patient transfers would reduce by 6000 to 23 000 each year.[464]

7.65 The Committee notes that PTS does not support 24/7 services for non-emergency patient transport as it is 'not reflective of the current demand profile'.[465] However, this may be an area for further monitoring and review. We recommend that NSW Health evaluate the first tranche of the PTS rollout into regional LHDs and identify further sites for continued expansion of the program, with the aim of alleviating pressure on paramedic services in RRR NSW.

Paramedic services

7.66 In addition to the reliance on paramedic services for non-emergency patient transport, Portfolio Committee No. 2 (PC2) found that there were major barriers to the training and deployment of specialist paramedics, including Extended Care Paramedics and Intensive Care Paramedics in RRR NSW.[466]

Extended Care Paramedics (ECPs) are paramedic specialists that have undertaken further education and training to provide care for patients with 'urgent, chronic and complex healthcare needs.' Their role is aimed at addressing chronic and complex low acuity presentations, with a view to reducing emergency department presentations.[467]

In contrast, Intensive Care Paramedics (ICPs) are clinical specialists with an extended scope of practice to deliver additional acute specialist care. They assess and manage a variety of acute illnesses and potentially severe trauma conditions. ICPs also play an important role in providing day-to-day clinical leadership.[468]

7.67 Recommendation 29 of the PC2 report called for specific measures relating to these specialist roles, including policies that would distribute ICPs and ECPs more equitably and expand these specialist programs across more of RRR NSW. It also recommended that NSW Health explore innovative models of care to utilise the skill sets of paramedics within communities that lack primary health care services.[469]

7.68 Since the PC2 report, NSW Health report that they have commenced work to convert over 200 paramedics to ICPs in regional areas. By September 2023, 117

[463] Submission 43, p 17; *Progress Report*, September 2024, p 63.

[464] *Progress Report*, September 2024, p 64.

[465] Submission 33, p 2; Submission 43, p 17.

[466] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, p 144.

[467] Submission 43, pp 20-21.

[468] Submission 43, pp 20-21.

[469] Health outcomes and access to health and hospital services in rural, regional and remote New South Wales, May 2022, p 144.

paramedics had converted to intensive care specialists in regional NSW.[470] We also heard that some progress has been made on the NSW Government's commitment to deliver an additional 500 paramedics to RRR areas. However, the extent of this progress is unclear and we heard that there have been some delays.[471]

7.69 The Committee was also concerned to hear that NSW Ambulance is restricting deployment of ICPs to larger stations and is limiting training for ECPs outside of metropolitan areas.[472] The impact of these decisions is explored further below.

Delivering more paramedics to remote, rural and regional NSW

Recommendation 28

That NSW Health provide an update within six months that tracks progress against the commitment to deliver an additional 500 paramedics to remote, rural and regional NSW. This update should include information on the numbers and locations of Intensive Care Paramedics and Extended Care Paramedics. It should also identify any barriers to implementation of the commitment and outline the actions that NSW Health will take to address these barriers.

7.70 In September 2023, the NSW Government committed to deliver an additional 500 paramedics to RRR NSW. The government has since announced that 125 additional paramedics would be arriving in RRR communities by the middle of 2024, with the full commitment to be rolled out over a four-year period.[473]

7.71 Australian Paramedics Association (APA) NSW told the Committee that additional paramedics had been allocated to Lismore, Parkes, Bathurst, Mudgee, and Lithgow as at June 2024. These staffing enhancements ranged from 2-18 additional staff per station.[474]

7.72 However, the Committee notes that the extent of the progress made against this recommendation is unclear. We were also concerned to hear that additional staffing enhancements had been delayed in many RRR areas. APA NSW reported:

> The enhancements in South West Rocks, Broken Hill, Blayney, Tamworth and Kangaroo Valley have been delayed due to issues raised by staff. Many of them relate to our submissions to the Committee. For example, the staff at South West Rocks are worried about an increase in low acuity night shift transfers due to lack of adequate patient transport options. [For] others, such as in Blayney or Kangaroo

[470] Submission 43, p 21; *Progress Report*, September 2024, p 66.

[471] NSW Government, *500 more paramedics for regional, rural and remote NSW*, media release, 15 September 2023, viewed 4 March 2025; Submission 43, p 19; Answers to supplementary questions, Australian Paramedics Association (NSW), pp 2-3.

[472] Submission 33, p 5; Answers to supplementary questions, pp 1-2.

[473] NSW Government, *500 more paramedics for regional, rural and remote NSW*, media release, 15 September 2023, viewed 4 March 2025; Submission 43, p 19; Answers to supplementary questions, Australian Paramedics Association (NSW), pp 2-3.

[474] Answers to supplementary questions, Australian Paramedics Association (NSW), pp 2-3.

Valley, lack of accommodation for the new staff has prevented the enhancement from proceeding.[475]

7.73 Noting these delays and the issues reported by APA, we recommend that NSW Ambulance provide an update against the commitment to deliver an additional 500 paramedics to RRR NSW. This should include information on the numbers and locations of any ICPs and ECPs, an update on any barriers to implementation, and the actions that are being taken to address these barriers.

Restrictions on the specialist paramedic workforce

Finding 23

NSW Ambulance is restricting Intensive Care Paramedics to large stations and limiting training for Extended Care Paramedics outside of metropolitan areas, which is disincentivising senior paramedics from working in remote, rural and regional NSW and effectively de-skilling the paramedic workforce.

Recommendation 29

That NSW Ambulance urgently remove restrictions on Intensive Care Paramedics working in Category C and D stations, and develop a plan to address identified barriers to the expansion of these specialist paramedics to ensure their equitable distribution across remote, rural and regional NSW.

Recommendation 30

That NSW Ambulance implement options for paramedics to undertake training and skills consolidation for Extended Care Paramedics and other specialist roles locally across remote, rural and regional NSW.

7.74 Australian Paramedics Association (APA) NSW identified a number of barriers that are preventing the expansion of the specialist paramedic workforce. They submitted that although NSW Ambulance has begun to roll out Intensive Care Paramedics (ICPs) to larger Category A and B stations in regional areas, they are preventing ICPs from relocating to Category C and D stations. These smaller stations make up most of the ambulance stations in remote, rural and regional NSW.[476]

7.75 The Committee heard that ICPs had historically been able to maintain their clinical level when they moved to regional areas. However, these specialist paramedics are no longer being allowed move to smaller Category C and D stations unless they agree to give up their advanced clinical skills, title and salary. APA NSW asserted that this policy of restricting ICPs to large centres, as well as the removal of ICP equipment, is 'actively de-skilling' ICPs in regional and rural locations.[477]

7.76 In its submission, NSW Health reported that there were 404 ICPs operating in regional locations and 420 ICPs in metropolitan locations as of 1 February

[475] Answers to supplementary questions, Australian Paramedics Association (NSW), pp 2-3.

[476] Submission 33, p 5; Answers to supplementary questions, Australian Paramedics Association NSW, pp 1-2.

[477] Mr Wilson, Evidence, 31 May 2024, p 16; Answers to supplementary questions, p 1.

2024.[478] However, APA NSW argued that this statistic is misleading, as these specialist paramedics are largely concentrated in peri-urban areas such as greater Newcastle and the Nowra/Shoalhaven area.[479]

7.77 Despite PC2 Recommendation 29, NSW Ambulance has also strongly disincentivised ECP expansion into rural and regional areas through a lack of training in these areas. For example, we heard that ECPs still don't have any training courses offered outside metropolitan areas.[480]

7.78 APA NSW also told us about financial and career development disincentives that exist for regional ECPs. For example, managers who want to become an ECP are often forced to give up their managerial position and salary while undertaking specialist training, with no guarantee that they can return to that position.[481]

7.79 The Committee is concerned to hear that these restrictions on specialist paramedics are contributing to the de-skilling of this critical workforce in RRR NSW. We recommend that NSW Ambulance urgently remove the restrictions on ICPs working in Category C and D stations, and develop a plan to address barriers that are preventing the expansion of ICPs across RRR NSW, such as restrictions preventing them from maintaining their clinical level.

7.80 We also recommend that NSW Ambulance address the barriers to regional expansion of the ECP program. As a starting point, this should include providing local options for paramedics that allow them to undertake training and skills consolidation (for ECP work and other specialist roles), without having to travel to metropolitan areas.

Innovative models of care that use paramedics

Recommendation 31

That NSW Health evaluate the Integrated Paramedic Workforce Model, based on the initial pilots, and publish the findings within six months. This evaluation should include discussion of how the model can be widely implemented in remote, rural and regional NSW.

7.81 A key component of Recommendation 29 from the PC2 report was that NSW Health, in conjunction with NSW Ambulance:

> …explore innovative models of care utilising the skill sets of paramedics to better support communities that lack primary health care services, including consideration of embedding paramedics at facilities that do not have access to a doctor.[482]

7.82 In reporting on progress against this recommendation, NSW Health noted that paramedics had been identified as the first workforce to test 'integrated

[478] Submission 43, p 21.

[479] Answers to supplementary questions, p 2.

[480] Mr Coda Danu-Asmara, Industrial Officer, Australian Paramedics Association (NSW), Transcript of evidence, 31 May 2024, p 12.

[481] Answers to supplementary questions, p 5; Mr Danu-Asmara, Evidence, 31 May 2024, pp 12-13.

[482] *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, May 2022, pp 143-144.

workforce models', as part of a project that is being jointly delivered by the Agency for Clinical Innovation, the Ministry of Health, Local Health Districts, and NSW Ambulance. NSW Health noted that the Integrated Paramedic Workforce Model Project would 'explore the feasibility of a workforce model that integrates paramedics within established multidisciplinary teams' of nurses, doctors, and allied health professionals to better support primary care services.[483]

7.83 The Integrated Paramedic Workforce Model pilots commenced in Mudgee Hospital and Wagga Wagga Base Hospital respectively in September and October 2024. The ten-week trial in Mudgee involved three NSW Ambulance paramedics rostered on in the Emergency Department (ED), in addition to the regular, full suite of ED staff.[484] Similarly, the eight-week trial in Wagga Wagga involved up to two NSW Ambulance paramedics rostered on in the Rapid Access Clinic and Hospital in the Home service, working alongside regular clinic staff.[485]

7.84 We recommend that NSW Health evaluate the Integrated Paramedic Workforce Model pilots and publish the findings within six months. This evaluation should aim to inform future implementation of the model across remote, rural and regional NSW. In exploring the feasibility of the model, NSW Health should focus specifically on its potential implementation in rural and regional settings, where specialist paramedics such as ECPs may be limited.

Air transport

NSW Ambulance offers emergency air transport services to critically ill or injured patients through fixed wing aircraft and helicopters. In some NSW locations, they work with CareFlight and the Royal Flying Doctor Service to run services.[486]

NSW Health also report collaborating with NSW Ambulance and operators, in the event of air services not meeting 'contracted requirements to mitigate any risks that inhibit provision' of 24-hour, responsive and safe aeromedical transport services.[487]

Finding 24

There are significant issues with the supply of pilots under the current NSW Ambulance air transport contract, which is placing critical pressure on other air transport services in remote, rural and regional NSW.

Recommendation 32

That NSW Health urgently publish its review of air transport funding and work with the Australian Government and key service providers to ensure adequate provision of air transport services across remote, rural and regional NSW.

[483] Submission 43, p 22; *Progress Report*, September 2024, p 66.

[484] NSW Government, *Paramedics to work alongside emergency department teams in innovative new trial*, media release, 30 September 2024, viewed 4 March 2025.

[485] NSW Government, *Wagga Wagga added as second site for innovative paramedic pilot*, media release, 17 October 2024, viewed 4 March 2025.

[486] NSW Ambulance, Operations, viewed 20 January 2025.

[487] Answers to supplementary questions, NSW Health, 24 June 2024, p 7.

7.85 The availability of air transport services for remote, rural and regional communities is lifesaving for patients who require timely and critical specialist care.[488] Portfolio Committee No. 2 (PC2) acknowledged the 'essential service air transport provides to regional and remote communities' and recommended that NSW Health review the available funding for air transport (Recommendation 4).[489]

7.86 During the current inquiry, NSW Health reported that the review of air transport funding had been completed. They told the Committee that the review involved consultation with various NSW Health services and agencies, including Local Health Districts, NSW Ambulance and HealthShare NSW (who work with private companies to deliver non-emergency fixed wing transport).[490]

7.87 NSW Health also told us that a steering committee and working group for the review have endorsed the final report. They noted that the report details current conditions and funding of air transport programs and makes recommendations for future operating models and principles. Mr Luke Sloane, Deputy Secretary, Regional Health, NSW Health, told the Committee that NSW Health will be looking to action the review, but noted that this could take time due to its complexity.[491]

7.88 In this Committee's previous report, we expressed concern that little progress had been made against Recommendation 4. We recommended that NSW Health publish future reviews of patient transport schemes, including its review of air transport funding.[492] While the NSW Government response to that report noted that a summary of the air transport funding review will be published 'when it has been finalised', it is still unclear whether this has actually taken place.[493]

7.89 The Committee is also concerned that parts of regional NSW are being left without pilots for emergency air transport. During our site visits, stakeholders advised the Committee that new contracting arrangements and pilot shortages for air transport have created service reliability problems in RRR NSW.

7.90 Associate Professor Randall Greenberg, Deputy Head of Rural Clinical School, University of Sydney, also expressed concerns about how funding uncertainty and pilot staffing shortages can place pressure on air ambulance in NSW. He stated that Air Ambulance's contracted provider is unable to staff the number of pilots it

---

[488] Ms Justine Brindle, School Manager, Charles Sturt University, School of Rural Medicine, Orange, Transcript of evidence, 28 May 2024, pp 33-34.

[489] Health outcomes and access to health and hospital services in rural, regional and remote New South Wales, May 2022, p 36.

[490] *Progress Report*, September 2024, p 18; Answers to supplementary questions, NSW Health, 24 June 2024, p 7.

[491] *Progress Report*, September 2024, p 18; Mr Luke Sloane, Deputy Secretary, Regional Health, NSW Health, Transcript of evidence, 3 June 2024, p 47.

[492] 'Select Committee on Remote, Rural and Regional Health, *Implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, report 1/58, Parliament of New South Wales, August 2024, p 71.

[493] NSW Government, *Response to Inquiry into the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health*, February 2025, p 20.

needs to cover all shift work. He estimated that only three to five out of 10 pilot shifts will be running on a daily basis.[494]

7.91 Associate Professor Greenberg noted that when no pilots are available, NSW Ambulance rely on the Royal Flying Doctor Service in Dubbo to fly to Port Macquarie, leaving Western NSW 'unmanned.' While he acknowledged that there is a worldwide shortage of pilots and that NSW Ambulance is aware of the problem, he described the current circumstances as 'quite dire'.[495]

7.92 The Committee remains concerned about the lack of evident progress in this area and recommends that NSW Health urgently publish its review of air transport funding. This will assist in ensuring that air transport services are appropriately resourced to respond to emergencies and provide critical transport for patients in RRR NSW. We also recommend that NSW Health work with the Australian Government and service providers to ensure that air transport services for regional communities are sufficient. This should include an assessment of how well the current contracting arrangements are working.

[494] Associate Professor Randall Greenberg, Associate Professor, Deputy Head of Rural Clinical School, School of Rural Health, Orange, the University of Sydney, Transcript of evidence, 28 May 2024, p 33.

[495] Associate Professor Greenberg, Evidence, 28 May 2024, p 33.

Appendix One – Terms of reference

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 health outcomes and access to health and hospital services, including:

1) The delivery of specific health services and specialist care in remote, rural and regional New South Wales, including:

    a) Maternity services, obstetrics and paediatrics (including Recommendations 19, 20, 26 and 27)

    b) Patient transport and paramedicine (including Recommendations 3, 28 and 29)

    c) Indigenous health services (including Recommendations 23, 31, 32, 33, 34, 35 and 43)

    d) Mental health services, and drug and alcohol services (including Recommendation 11)

    e) Aged care and palliative care (including Recommendations 18, 23 and 24)

    f) Cancer care and oncology (including Recommendation 21 and 30)

    g) Other specialist care and allied health services, as they pertain to the Portfolio Committee No. 2 recommendations (including Recommendations 5, 10, 30, 42, 43, 44)

2) Any updates or further observations relating to the progress of implementing Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding issues, as per the Select Committee on Remote, Rural and Regional Health's previous inquiry.

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 9 February 2024, the Committee resolved to conduct an inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW.

Call for submissions

The Committee issued a media release on 1 March 2024 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 10 April 2024, the Committee informed stakeholders that it had extended the submissions deadline on 26 April 2024

A total of 68 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

The Committee conducted site visits in Broken Hill and Wilcannia, Orange, and Manning Great Lakes/Port Macquarie during 2024, as part of its inquiry.

On 15 April 2024, the Committee toured the Royal Flying Doctor Service Facility in Broken Hill and visited Broken Hill Base Hospital, where they met with senior hospital staff. The Committee also held a roundtable with a range of local health stakeholders. On 16 April 2024, the Committee met with staff and representatives at Wilcannia Multipurpose Service and visited the Wilcannia Health and Wellbeing Centre.

On 27 May 2024, the Committee toured the Orange Health Service campus and had discussions with representatives from the various health services on the campus. A public hearing was held at the Orange Ex-Services Club on 28 May 2024.

As part of its visit to Manning Great Lakes/Port Macquarie, the Committee visited Manning Base Hospital on 26 August 2024 and Port Macquarie Base Hospital on 27 August 2024. Private roundtables were also held with local health stakeholders.

Further information on the site visits is provided in Appendix Four (Site visit report).

Public hearings

The Committee held three public hearings, including one hearing in Orange on 28 May 2024 and two hearings at Parliament House on 31 May 2024 and 3 June 2024. Representatives from not for profit and Aboriginal health care 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	Local Government NSW
2	Australian College of Mental Health Nurses
3	NSW Council of Social Service (NCOSS)
4	Pharmacy Guild of Australia (NSW Branch)
5	Southern Highlands Cancer Centre
6	Mr Peter Mastello
7	Confidential
8	Clare James
9	Moree Plains Shire Council
10	Confidential
11	A Allan
12	Australasian College of Paramedicine
13	Varian
14	Confidential
15	Manna Institute
16	Mrs Julie Kay
17	Mrs Sandra Chown
18	National Association of Aboriginal and Torres Strait Islander Health Workers And Practitioners (NAATSIHWP))
19	Dr Madhu TamilarasN
20	Arthritis NSW
21	Mrs Margaret Adams
22	Confidential
23	Confidential
24	Australian College of Nurse Practitioners ACNP
25	Ms Sharon Cass
26	Confidential
27	Ms Allison Reynolds
28	Confidential
29	Confidential
30	Confidential
31	Mrs Moira Ryan
32	Can Assist (Cancer Assistance Network)

No.	Author
32a	Can Assist (Cancer Assistance Network)
33	Australian Paramedics Association (NSW)
34	Australian College of Rural and Remote Medicine (ACRRM)
35	The Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
36	Gunnedah Shire Council
37	Culcairn Local Health Advisory Committee (LHAC)
38	Berrigan Shire Council
39	Mudgee Health Council
40	Tresillian
41	NSW Ombudsman
42	NSW Rural Doctors Network (RDN)
43	NSW Health
44	Australian Salaried Medical Officers' Federation NSW
45	Royal Far West
46	Confidential
47	Mrs Fiona Funnell
48	NSW Nurses and Midwives' Association
48a	Confidential
49	Cancer Council NSW
50	Leeton Shire Council
51	Charles Sturt University
52	Pharmaceutical Society of Australia
53	Confidential
54	The Isolated Children's Parents' Association of New South Wales Inc.
55	Inverell Health Forum
56	National Rural Health Alliance
57	Tamworth Medical Staff Council
58	Australian College of Midwives ACM
59	Aspen Medical NSW
60	AMA NSW
61	Community Transport Organisation Ltd
62	ACON
63	Rural Doctors Association of NSW
64	Coolamon Shire Council
65	Royal Australasian College of Medical Administrators (RACMA)

No.	Author
66	Aboriginal Health and Medical Research Council (AH&MRC)
67	Older Women's Network NSW
68	Confidential

Appendix Four – Site visit report

In April, May and August 2024, members of the Select Committee on Remote, Rural and Regional Health undertook site visits and roundtable discussions to support the inquiry. We visited:

- Royal Flying Doctor Service, Broken Hill
- Broken Hill Base Hospital
- Wilcannia Multipurpose Service (NSW Health)
- Wilcannia Health and Wellbeing Centre (Maari Ma Aboriginal Health Corporation)
- Orange Health Service campus, including Orange Hospital and Bloomfield Hospital
- Charles Sturt University, Orange Rural Clinical School
- Manning Base Hospital, Taree
- Port Macquarie Base Hospital

The Committee would like to thank the staff and management of Royal Flying Doctor Service (RFDS) for hosting the Committee in the RFDS Broken Hill facility. In particular, we would like to thank Greg Sam, CEO, and Annabey Whitehead, Executive General Manager, for facilitating the Committee's visit. The visit gave the Committee a clear picture of the scale of air transport services needed across NSW, and how difficult it can be for communities in remote NSW to access quality health services when they live far from a regional centre.

The Committee is very grateful to NSW Health for their assistance in organising the visits to the health facilities in Broken Hill, Wilcannia, Orange, Taree and Port Macquarie. 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 Far West, Western NSW, Hunter New England and Mid North Coast 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 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 key health services operate within them. Staff told us about the challenges of delivering specialist care and other health services in remote areas, such as Broken Hill and Wilcannia, and the ongoing recruitment and retention issues that make it difficult to strengthen key workforces in rural and regional facilities.

We are also grateful to Maari Ma for hosting the Committee at the new Wilcannia Health and Wellbeing Centre, and to Charles Sturt University (CSU) for taking the Committee on a tour of its training facility at the Orange Rural Health Clinical School. The Wilcannia Health and

Wellbeing Centre will become a vital component of the delivery of Aboriginal health services in Wilcannia and nearby communities. The centre fills a gap in the provision of holistic care, and allows First Nations communities to access trusted care outside of a hospital setting. The Orange Rural Health Clinical School is a similarly impressive facility, and a critical element in the rural study-career pathway. The Committee is confident that CSU's training facility will continue to support graduates in preparing for work in a rural hospital, and providing a high standard of care to remote, rural and regional communities. Despite the crisis in regional health care, it was heartening to see facilities such as these working to improve the delivery of health services and specialist care.

The Committee also had the opportunity to meet privately with health stakeholders in a series of roundtable events. These included specialists, visiting medical officers, midwives, nurses, allied health professionals, hospital staff, senior staff of Aboriginal medical services, local council representatives, and staff from other non-government organisations. The Committee thanks you for sharing your experiences of the remote, rural and regional health system in NSW, and for your dedication to your communities, in the face of enduring challenges. We are immensely grateful to you for your contributions to this inquiry.

Appendix Five – Witnesses

28 May 2024
Orange Ex-Services Club, Coral Sea Room, Orange, NSW

Witness	Position and Organisation
Mrs Jessica Brown	General Manager - Strategic Policy, Marathon Health Service
Mrs Jenny Hazelton	President, Orange Push for Palliative
Ms Janice Harris	Vice President, Orange Push for Palliative
Mr Joe Sullivan	Chairperson, Mudgee Health Council
Ms Judy Blackman	Secretary, Mudgee Health Council
Ms Helen Goodacre	President and Welfare Officer, Can Assist Orange
Ms Lita Matthews	Member, Can Assist Orange
Ms Maureen Field	Treasurer, Can Assist Forbes
Ms Anne Worrad	Mental Health OT, Ramsay Clinic Orange
Ms Julie Dignan	Director (Data and Quality), Lives Lived Well
Professor Megan Smith PhD GAICD	Executive Dean, Faculty of Science and Health, Charles Sturt University, Faculty of Science and Health
A/Prof Randall Greenberg	Associate Professor, Deputy Head of Clinical School, University of Sydney, School of Rural Health (Orange)
Cr Frances Kinghorne	Councillor, Orange City Council
Mr Scott Maunder	Director Community and Cultural Services, Orange City Council
Dr Jess Jennings	Mayor, Bathurst Regional Council
Mayor Neil Westcott	Mayor, Parkes Shire Council
Cr Ken Keith	Councillor, Parkes Shire Council
Dr Catherine Keniry	Senior Lecturer in Medicine and Head of Research Unit, Charles Sturt University, Faculty of Science and Health
A/Prof Francis Geronimo	Course Director and Associate Professor in Medicine, Charles Sturt University, Faculty of Science and Health
Ms Justine Brindle	School Manager, School of Rural Medicine, Charles Sturt University, Faculty of Science and Health
Dr Ross Wilson	Member, Bathurst Community Health Committee

Ms Melanie Meehan	Team Leader, Residential Services Wyla, Lives Lived Well
Dr Anna Noonan	Associate Lecturer, School of Rural Health, University of Sydney, School of Rural Health (Orange)
Ms Jess Silva	Program Manager Western NSW, Mission Australia
Ms Sarah MacInnes	Paediatric Occupational Therapist, SEED Paediatric Services
Ms Alyssa Fitzgerald	Business Development, Marathon Health Service
Ms Michelle Maunder	Co Director, SEED Paediatric Services

31 May 2024
Parliament House, Macquarie Room, Sydney, NSW

Witness	**Position and Organisation**
Ms Alison Weatherstone	ACM Chief Midwife, Australian College of Midwives ACM
Ms Rita Martin	Government and Community Relations Organiser Professional Services, NSW Nurses and Midwives' Association
Ms Jacqui Emery	CEO, Royal Far West
Mr Coda Danu-Asmara	Industrial Officer, Australian Paramedics Association (NSW)
Ms Aya Emery	Policy Officer, Australian College of Midwives ACM
Dr Vanessa Scarf PhD	NSW Branch Chair, Australian College of Midwives ACM
Dr Marcel Zimmet	Chief Medical Officer, Royal Far West
Ms Tania DiNicola	Delegate, Australian Paramedics Association (NSW)
Mr Gary Wilson	Delegate and Former Secretary, Australian Paramedics Association (NSW)
Ms Tanya Mitchell	ICPA-NSW President, Isolated Children's Parent's Association (ICPA)
Ms Britt Anderson	NSW Publicity Officer and Health and Wellbeing portfolio seconder , Isolated Children's Parent's Association (ICPA)
Ms Tara Russell	Executive Officer, Community Transport Organisation Ltd
Dr Jillian Farmer	CEO, A Better Culture
Ms Elyse Cain	Policy Lead, NSW Council of Social Service (NCOSS)
Mr Ben McAlpine	Director, Policy and Advocacy, NSW Council of Social Service (NCOSS)

Mr Alex Green	CEO, Arthritis NSW
Ms Kirsty Blades	CEO, Palliative Care New South Wales
Mrs Jill McGovern	Older Women's Network NSW
Ms Lorraine Penn	Board member, Older Women's Network NSW
Dr Vanessa Johnston	Director of Cancer Information and Support Services, Cancer Council NSW
Ms Brenna Smith	Manager Community, Cancer Information and Support Services, Cancer Council NSW
Mr Brad Gellert	Manager Policy and Advocacy, Cancer Council NSW
Mrs Meggan Harrison	Southern Highlands Cancer Centre
Dr Robin Williams	Chair of Western NSW Primary Health Network board, Western NSW Primary Health Network
New South Wales Nurses and Midwives' Association TBC	New South Wales Nurses and Midwives' Association
Professor Myfanwy Maple	Director, Manna Institute
Mr Michael Whaites	Assistant General Secretary, New South Wales Nurses and Midwives' Association
Ms Felicity Burns	President, Palliative Care New South Wales

03 June 2024
Parliament House, Jubilee Room, Sydney, NSW

Witness	**Position and Organisation**
Mr Richard Colbran	Chief Executive Officer, NSW Rural Doctors Network (RDN)
Professor Peter O'Mara	Chair, NSW Rural Doctors Network (RDN)
Mr Mike Edwards	Chief Operating Officer, NSW Rural Doctors Network (RDN)
Dr Lilach Leibenson	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
Ms Fiona Davies	Chief Executive Officer, AMA New South Wales
Dr Rachel Christmas	President, GP VMO Obstetrician, Temora NSW, Rural Doctors' Association of NSW
Cr Darriea Turley AM	President, Local Government NSW (LGNSW)
Ms Susanne (Susi) Tegen	Chief Executive Officer, National Rural Health Alliance
Mr David Reynolds	Chief Executive, Local Government NSW
Dr Rod Martin	College Councillor NSW, Australian College of Rural and Remote Medicine (ACRRM)
Dr Dan Halliday	President, Australian College of Rural and Remote Medicine (ACRRM)

Mr Luke Sloane	Deputy Secretary, Regional Health, NSW Health
Mr Richard Griffiths	Executive Director, Workforce Planning and Talent Development, Ministry of Health, NSW Health
Ms Geraldine Wilson	Executive Director, Centre for Aboriginal Health, NSW Health
Dr Brendan Flynn	Executive Director, Mental Health Branch, NSW Health
Dr Michael Bowden	Senior Clinical Advisor, Child & Youth Mental Health, Senior Child & Adolescent Psychiatrist , NSW Health
Professor Tracey O'Brien	Chief Executive, Cancer Institute, NSW Health
Dr Andrew Woods	Senior Clinical Advisor Obstetrics, NSW Health
Dr Helen Goodwin	Chief Paediatrician, NSW Health
Dr Paul Craven	Executive Director of children, young people, and families, medical workforce, and of networks and streams, HNE LHD, NSW Health
Dr Sarah Wenham	Palliative Care Physician , NSW Health
Dr Alam Yoosuff	Vice President, Rural Doctors' Association of NSW
Ms Margaret Deerain	Director, Policy and Strategy Development, National Rural Health Alliance
Dr Tony Sara	Secretary, Australian Salaried Medical Officers' Federation NSW
Dr Michelle Moyle	Assistant Secretary/Treasurer, Australian Salaried Medical Officers' Federation NSW
Mr Ian Lisser	Manager of Industrial Services and Senior IO, Australian Salaried Medical Officers' Federation NSW

Appendix Six – Extracts from minutes

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. ***

3. Correspondence
***

4. Forward work plan

4.1. Committee's 2024 work programme
The Committee discussed the next steps in its examination of the implementation of recommendations from the Portfolio Committee No. 2 report.
4.2. Adoption of a second inquiry
The Committee considered adopting an inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to delivery of specific health services and specialist care in remote, rural and regional NSW.
Resolved on the motion of Mr Barr, seconded Ms Doyle:

- That the Committee conduct an inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW, 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 12 April.
- 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.

4.3. Potential site visits

Committee considered future site visits, in relation to its 2024 work programme and asked the Secretariat to prepare some options for two site visits, to Orange (and surrounds) and Broken Hill (and surrounds).

Resolved on the motion of Ms Doyle, seconded Ms Thompson that the Committee, subject to funding approval from the Speaker, undertake up to four days of site visits in relation to the adopted inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to delivery of specific health services and specialist care in remote, rural and regional NSW.

The Chair adjourned the meeting at 9:52am.

5. ***

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. ***

3. Committee's second inquiry (PC2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW)

3.1. Extension of submission deadline

The Committee considered formally extending the deadline for submissions to Friday 26 April.

Resolved on the motion of Ms Saffin, seconded Mrs Williams that the Committee:

- extend the deadline for submissions until 26 April 2024 and write to any stakeholders previously notified, advising them of the extension
- that the Chair issue a media release announcing the extension of the deadline for submissions
- that the relevant details be updated on the Committee's webpage.

3.2. Site visits to Orange and surrounds

The Committee considered upcoming site visits to Orange and surrounds, with the possibility of an additional visit to the Manning Great Lakes area.

Moved on the motion of Mr Barr, seconded by Ms Saffin that the Committee, subject to funding approval from the Speaker, undertake an additional two days of site visits in relation to its inquiry into PC2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW.

The Chair informed the Committee that he has agreed to meet with the Member for Orange and the local medical staff council in the evening following the scheduled visits. Ms Saffin, Deputy Chair noted her interest in attending this meeting.

3.3. Site visits to Broken Hill and Wilcannia

The Committee discussed the upcoming site visits that were scheduled to commence on Monday 15 April.

***

4. Correspondence

****

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, Parliament House and via Webex

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. Committee's second inquiry (PC2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW)

2.1. Publication of submissions
The Committee considered the 65 submissions received for its second inquiry.

Resolved on the motion of Mrs Williams, seconded Ms Doyle, that:

- ***
- Submissions 6, 25 and 37 be accepted and published with redactions on the Committee's webpage; and
- Submissions 1-5, 8-9, 11-13, 15-21, 24, 27, 31-36, 38-45, 47-52 and 54-65 be accepted by the Committee and published in full on the Committee's webpage.

The Committee noted that the following stakeholders have been granted an extension past the submission deadline of 26 April 2024, but submissions have not yet been received:

- Dr Susan Velovski (member, Rural Doctors' Association of NSW),
- GenesisCare,
- Aboriginal Health and Medical Research Council.

2.2. Site visits to Orange and surrounds

The Committee discussed the upcoming site visits that are scheduled to commence on Monday 27 May.

The Committee discussed finishing the public hearing on Tuesday, 28 May at 3pm, and advising the local member of the Committee's schedule.

3. Correspondence

***

4. Additional information requested from NSW Health

The Committee noted information provided by NSW Health on facility profiles and health services data for Orange and neighbouring communities. The Committee requested that the secretariat recirculate this information prior to the upcoming site visit to Orange.

***

The Committee noted additional information has also been requested on the new maternity service operating at Glen Innes Hospital from NSW Health, following the Committee's site visit to the Hunter New England LHD in 2023, but has not been received yet.

5. Next meeting

The meeting adjourned at 2:48pm until the site visit on Monday, 27 May 2024.

MINUTES OF MEETING NO. 11

9:51 am, 28 May 2024
Coral Sea Room, Orange Ex-Services Club

Members present

Dr Joe McGirr (Chair), Ms Janelle Saffin (Deputy Chair), Mr Clayton Barr, Ms Liza Butler, Mrs Tanya Thomson, Ms Trish Doyle, The Hon Leslie Williams

Officers present

Leon Last, Matt Johnson, Madelaine Winkler, Sukhraj Goraya, Nicolle Gill, Karena Li

Apologies

Nil

Agenda item

Confirmation of minutes

Resolved, on the motion of Mr Barr, seconded by Ms Butler: that the minutes of the meeting of 20 May 2024 be confirmed.

1. Pre-hearing procedural resolutions

Committee to consider the notice of hearing and witnesses.

Resolved, on the motion of Mrs Thompson, seconded by Ms Doyle that:

- That the Committee invites the witnesses listed in the notice of the public hearing for Tuesday, 28 May 2024 to give evidence in relation to the inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW.
- That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 28 May 2024, 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 4pm, Friday 7 June 2024;
    - Secretariat to then circulate all proposed supplementary questions to Committee, with members to lodge any objections to the questions by Monday 10 June 2024.
- 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 10:00 am.

2. Public hearing

Witnesses and the public were admitted. The Chair opened the public hearing at 10:03am and made a short opening statement.

Mrs Jessica Brown, General Manager – Strategic Policy, and Ms Alyssa Fitzgerald, Group Manager – Partnerships and Growth, Marathon Health Service, were sworn and examined.

Mrs Brown made an opening statement. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

Mrs Jenny Hazelton, President, and Ms Janice Harris, Vice President, Orange Push for Palliative, were sworn and examined.

Mrs Hazelton made an opening statement. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

Mr Joe Sullivan, Chairperson, and Ms Judy Blackman, Secretary, Mudgee Health Council, were sworn and examined. Dr Ross Wilson, Member, Bathurst Community Health Committee, was affirmed and examined.

Mr Sullivan and Dr Wilson made opening statements. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair adjourned the hearing at 11:30 am.

The hearing resumed at 11:40 am.

Ms Helen Goodacre, President and Welfare Officer, and Ms Lita Matthews, Member, CanAssist Orange, were sworn and examined.
Ms Maureen Field, Treasurer, CanAssist Forbes, was affirmed and examined.
Ms Sarah MacInnes, Paediatric Occupational Therapist, and Ms Michelle Maunder, Co-Director, SEED Paediatric Services, were sworn and examined.

Ms Goodacre and Ms MacInness made opening statements. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

Ms Anne Worrad, Mental Health OT, Ramsay Clinic Orange, was sworn and examined.
Ms Julie Dignan, Director (Data and Quality), and Ms Melanie Meehan, Team Leader, Residential Services Wyla, Lives Lived Well, were affirmed and examined.
Ms Jess Silva, Program Manager Western NSW, Mission Australia was affirmed and examined.

Ms Worrad, Ms Dignan and Ms Silva made opening statements. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair adjourned the hearing at 12:54 pm.
The Chair resumed the hearing at 1:31 pm.

Professor Megan Smith, Executive Dean, Faculty of Science and Health, Dr Catherine Keniry, Senior Lecturer in Medicine and Head of Research Unit, Dr Francis Geronimo, Course Director and Associate Professor, and Ms Justine Brindle, School Manager, School of Rural Medicine, Charles Sturt University, Orange, were sworn and examined.
Associate Professor Randall Greenberg, Deputy Head of Clinical School and Dr Anna Noonan, Associate Lecturer, University of Sydney, School of Rural Health, Orange, were affirmed and examined.

Associate Professor Greenberg made an opening statement. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

Councillor Frances Kinghorne, and Mr Scott Maunder, Director Community and Cultural Services, Orange City Council, were affirmed and examined.
Mayor Neil Westcott, and Councillor Ken Keith, Parkes Shire Council were sworn and examined.
Dr Jess Jennings, Mayor, Bathurst Regional Council, was sworn and examined.

Councillor Kinghorne, Mayor Westcott and Dr Jennings made an opening statement. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

3. Next meeting
The meeting adjourned at 3:05 pm, until 8:55 am on Friday 31 May.

MINUTES OF MEETING NO. 12
8:56AM, 31 May 2024
Macquarie Room and via videoconference

Members present
Dr Joe McGirr (Chair), Ms Janelle Saffin (Deputy Chair; via videoconference), Mr Clayton Barr (via videoconference), Ms Liza Butler (via videoconference), Mrs Tanya Thompson (via videoconference), Ms Trish Doyle (via videoconference), The Hon Leslie Williams.

Officers present
Leon Last, Matt Johnson, Madelaine Winkler, Sukhraj Goraya, Nicolle Gill and Karena Li

Agenda item

1. Confirmation of minutes
Resolved, on the motion of Ms Doyle, seconded by Mr Barr: That the minutes of the meeting of 28 May 2024 be confirmed.

2. Pre-hearing procedural resolutions
The Committee considered the notice of hearing and witnesses.
Resolved, on the motion of Mrs Williams, seconded by Mr Barr that:

- That the Committee invites the witnesses listed in the notice of the public hearing for Friday, 31 May 2024 to give evidence in relation to the inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW.
- That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 31 May 2024, 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 7 June 2024;
    - Secretariat to then circulate all proposed supplementary questions to Committee, with members to lodge any objections to the questions by 5pm, Tuesday 11 June 2024.

- 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 9:00 am.

3. Public hearing

Witnesses and the public were admitted. The Chair opened the public hearing at 9.06am and made a short opening statement.

Ms Alison Weatherstone, Chief Midwife, Dr Vanessa Scarf, NSW Branch Chair, and Ms Aya Emery, Policy Officer, Australian College of Midwives, were affirmed and examined via videoconference.
Ms Jacqui Emery, Chief Executive Officer, Royal Far West, was affirmed and examined.
Dr Marcel Zimmet, Chief Medical Officer, Royal Far West, was sworn and examined.
Mr Michael Whaites, Assistant General Secretary, New South Wales Nurses and Midwives' Association, was affirmed and examined.
Ms Aya Emery, Ms Jacqui Emery and Mr Whaites each made an opening statement. The Committee questioned the witnesses.
Mr Michael Whaites tendered a document.
Evidence concluded and the witnesses withdrew.

Mr Coda Danu-Asmara, Industrial Officer, Australian Paramedics Association (NSW), was affirmed and examined.
Ms Tania DiNicola, Delegate, Australian Paramedics Association (NSW), was affirmed and examined via videoconference.
Mr Gary Wilson, Delegate and Former Secretary, Australian Paramedics Association (NSW), was sworn and examined.
Ms Tanya Mitchell, President, and Ms Britt Anderson, NSW Publicity Officer and Health and Wellbeing portfolio seconder, Isolated Children's Parent's Association, were affirmed and examined via videoconference.
Ms Tara Russell, Executive Officer, Community Transport Organisation Ltd., was sworn and examined.
Mr Wilson, Ms Russell and Ms Mitchell each made an opening statement.
The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair adjourned the hearing at 10:59 am.

The Committee held a brief deliberative meeting from 11.01 am to 11.08 am.

The Chair resumed the hearing at 12:48 pm.

Mr Ben McAlpine, Director, Policy and Advocacy, and Ms Elyse Cain, Policy Lead, NSW Council of Social Service, was affirmed and examined.

Professor Myfanwy Maple, Director, Manna Institute, was affirmed and examined via videoconference.
Dr Jillian Farmer, Chief Executive Officer, A Better Culture, was affirmed and examined via videoconference.
Mr McAlpine, Professor Maple and Dr Farmer each made an opening statement.
The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

Mr Alex Green, Chief Executive Officer, Arthritis NSW, was affirmed and examined.
Ms Kirsty Blades, Chief Executive Officer, Palliative Care New South Wales, was affirmed and examined.
Ms Felicity Burns, President, Palliative Care New South Wales, was affirmed and examined via videoconference.
Ms Lorraine Penn, Board member, Older Women's Network NSW, was affirmed and examined via videoconference.
Mrs Jill McGovern, Older Women's Network NSW, was affirmed and examined via teleconference.
Mr Green, Ms Blades and Ms Penn each made an opening statement.
The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair adjourned the hearing at 2:13 pm.

The Chair resumed the hearing at 2:31 pm.

Mrs Meggan Harrison, Southern Highlands Cancer Centre, was affirmed and examined.
Dr Vanessa Johnston, Director of Cancer Information and Support Services, Ms Brenna Smith, Manager Community, Cancer Information and Support Services, and Mr Brad Gellert, Manager Policy and Advocacy, Cancer Council New South Wales, were affirmed and examined via videoconference.
Mrs Harrison and Dr Johnston each made an opening statement.
The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The Chair adjourned the hearing at 3:17 pm.

The Chair resumed the hearing at 3:28 pm. The Chair stated that he was previously on the board of the Rural Doctors Network with Dr Williams.

Dr Robin Williams, Western NSW Primary Health Network, sworn and examined via videoconference. Dr Williams made an opening statement.
The Committee questioned the witness. Evidence concluded and the witness withdrew.

The hearing concluded at 4:05 pm.

4. Post-hearing deliberative meeting

The Committee commenced a deliberative meeting at 4:06 pm.

4.1. Publication orders
The Committee considered the transcript of the public evidence from the hearings held today and on Tuesday 28 May (Orange).
Resolved, on the motion of Mr Barr, seconded by Ms Doyle: That the corrected transcripts of public evidence given on Tuesday 28 May and Friday, 31 May be authorised for publication and uploaded on the Committee's webpage.

4.2. Consideration of tendered documents
The Committee noted that the secretariat will review the document tendered by Councillor Neil Westcott, Mayor, Parkes Shire Council, on Tuesday 28 May 2024.

The Committee considered the document tendered during the hearing.

***

5. Next meeting
The meeting adjourned at 4.08 pm, until 8:45 am on Monday 3 June in the Jubilee Room.

MINUTES OF MEETING NO.13
9:00 am, 3 June 2024
Jubilee Room, Parliament House

Members present
Dr Joe McGirr (Chair), Ms Janelle Saffin (Deputy Chair), Ms Liza Butler, Ms Trish Doyle, Mrs Tanya Thompson.

Officers present
Sam Griffith, Leon Last, Matt Johnson, Sukhraj Goraya, Karena Li and Nicolle Gill

Apologies
The Hon Leslie Williams, Mr Clayton Barr.

Agenda item

1. Pre-hearing procedural resolutions
The Committee considered the notice of hearing and witnesses.
The Chair informed the Committee that he has a personal relationship with Dr Tony Sara and Dr Michelle Moyle who are appearing before the Committee today.

Resolved on the motion of Ms Doyle, seconded by Mrs Thompson:

- That the Committee invites the witnesses listed in the notice of the public hearing for Monday, 3 June 2024 to give evidence in relation to the inquiry into the

implementation of Portfolio Committee No. 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW.

- That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 3 June 2024, 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 7 June 2024;
    - Secretariat to then circulate all proposed supplementary questions to Committee, with members to lodge any objections to the questions by 5pm, Tuesday 11 June 2024.
- 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 9:01am.

2. Public hearing

Witnesses and the public were admitted. The Chair opened the public hearing at 9:02am and made a short opening statement.

Professor Peter O'Mara, Chair, Rural Doctors Network, was sworn and examined via videoconference.
Mr Richard Colbran, Chief Executive Officer, and Mr Mike Edwards, Chief Operating Officer, Rural Doctors Network, were sworn and examined.
Dr Lilach Leibenson, Royal Australian and New Zealand College of Obstetricians and Gynaecologists was affirmed and examined.
Dr Tony Sara, Secretary, and Dr Michelle Moyle, Assistant Secretary and Treasurer, Australian Salaried Medical Officers' Federation NSW, were sworn and examined.
Mr Ian Lisser, Manager of Industrial Services and Senior Industrial Officer, Australian Salaried Medical Officers' Federation NSW, was affirmed and examined.

Dr Moyle, Mr Colbran and Dr Leibenson each made an opening statement. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The hearing adjourned at 10:02am.

The hearing adjourned at 10:07am.

Ms Fiona Davies, Chief Executive Officer, Australian Medical Association (NSW), was affirmed and examined.
Dr Rachel Christmas, President, and Dr Alam Yoosuff, Vice President, Rural Doctors' Association of NSW, both appearing via videoconference, were affirmed and examined.

Ms Davies and Dr Christmas each made an opening statement. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The hearing adjourned at 10:53am.

The hearing resumed at 11:05am.

Councillor Darriea Turley, President, Local Government NSW, was affirmed and examined.
Mr David Reynolds, Chief Executive, Local Government NSW, was sworn and examined.

Cr Turley made an opening statement. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

Ms Susanne Tegan, Chief Executive, and Ms Margaret Deerain, Director, Policy and Strategy Development, National Rural Health Alliance, were sworn and examined.
Dr Rod Martin, College Councillor NSW, Australian College of Rural and Remote Medicine, , was affirmed and examined via videoconference.

Ms Tegen and Dr Martin each made an opening statement. The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The hearing adjourned at 12:15pm.

The hearing resumed at 12:52pm.

Mr Luke Sloane, Deputy Secretary, Regional Health and Mr Richard Griffiths, Executive Director, Workforce Planning and Talent Development, NSW Health, were sworn and examined.

Dr Sarah Wenham, Palliative Care Physician, NSW Health was sworn and examined via videoconference.

Ms Geraldine Wilson, Executive Director, Centre for Aboriginal Health, Dr Brendan Flynn, Executive Director, Mental Health Branch, and Dr Michael Bowden, Senior Clinical Advisor, Child & Youth Mental Health, Senior Child & Adolescent Psychiatrist, were affirmed and examined.

Professor Tracey O'Brien, Chief Executive, Cancer Institute, Dr Andrew Woods, Senior Clinical Advisor Obstetrics, Dr Helen Goodwin, Chief Paediatrician, and Dr Paul Craven, Executive

Director of Children, Young people, and Families, Medical Workforce, and Networks and Streams, Hunter New England Local Health District, NSW Health, were affirmed and examined via videoconference.

The Committee questioned the witnesses. Evidence concluded and the witnesses withdrew.

The hearing concluded at 2:43pm.

3. Post-hearing deliberative meeting
The Chair resumed the meeting at 2:54pm.

3.1. Publication orders
The Committee considered the publication of the transcript of today's public evidence.
Resolved on the motion of Ms Doyle, seconded by Mrs Thompson, That the corrected transcript of public evidence given today be authorised for publication and uploaded on the Committee's webpage.

3.2. Acceptance and publication of tendered documents
The Committee considered the document received at its public hearing on Tuesday 28 May.

***

4. Next meeting
The meeting adjourned at 2:55pm until a time and place to be determined.

MINUTES OF MEETING NO.14
2:03 pm, 2 August 2024
Room 1136 and via Webex

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. ***

3. Inquiry into PC2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW

Publication of submissions
The Committee considered late submissions for publication.
Resolved, on the motion of Mr Barr, seconded by Ms Butler:

- That submission 32a and 66 be accepted by the Committee and published in full on the Committee's webpage.
- That submission 67 be accepted by the Committee and published on the Committee's webpage with the name of a third party redacted.
- ***

Answers to questions on notice and supplementary questions
The Committee considered publication of answers to questions on notice and supplementary questions received from the following organisations:

- Dr Anna Noonan, School of Rural Health, University of Sydney, answer to supplementary question, received 19 June 2024.
- Mr Peter List, on behalf of NSW Health, answers to supplementary questions and questions on notice, received 24 June 2024.
- Susi Tegen, National Rural Health Alliance, answer to question on notice, received 25 June 2024.
- Cr Darriea Turley AM, Local Government NSW (LGNSW), answers to questions on notice, received 25 June 2024.
- Ms Izzy Angeli, on behalf of Australian Medical Association NSW, answer to supplementary question, received 27 June 2024.
- Mr Coda Danu-Asmara, Australian Paramedics Association NSW (APA NSW), answers to supplementary questions, received 28 June 2024.
- Dr Gillian Gibson, on behalf of Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), answers to questions on notice and supplementary questions, received 28 June 2024.
- Lily Doggett, on behalf of Rural Doctors Network, answers to questions on notice, received 2 July 2024.

Resolved, on the motion of Mr Barr, seconded by Mrs Williams:

- That the Committee accept the answers to questions on notice from LGNSW and publish them on its webpage with reference to 'Active Care Network' on page 9 redacted.
- ***

- That the Committee accept all other answers to questions on notice and supplementary questions listed above and publish them on its webpage, with contact details redacted.

Witness letters to clarify evidence
The Committee considered the following letters received from witnesses seeking to clarify evidence:

- Dr Jillann Farmer, CEO, A Better Culture, received on 6 June 2024.
- Dr Richard Colbran, CEO, Rural Doctors Network, received on 13 June 2024.
- Ms Geraldine Wilson, Executive Director, Centre for Aboriginal Health, NSW Health, received on 20 June 2024.

Resolved, on the motion of Mrs Williams, seconded by Mr Barr:
That the Committee accept and publish the witness correction letters from Ms Geraldine Wilson and Dr Richard Colbran on its webpage and footnote the transcript to link to these letters of clarification.

4. Correspondence
***

5. General business
The Committee discussed a potential itinerary for the upcoming Manning Great Lakes site visit scheduled for 26 and 27 August 2024.

***

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.

MINUTES OF MEETING NO.15
10:01 am, Wednesday 11 September 2024
Webex

Members present
Via Webex: Dr Joe McGirr (Chair), Ms Liza Butler, Ms Trish Doyle, and The Hon Leslie Williams.

Apologies

Ms Janelle Saffin (Deputy Chair), Mrs Tanya Thompson, and Mr Clayton Barr.

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 Doyle, seconded by Ms Butler: That the minutes of the meeting of 2 August 2024 be confirmed.

2. ***

3. Inquiry into PC2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW
Documents tendered during site visits
The Committee noted the following documents received during its visits to the Manning Great Lakes area:

- Hunter New England Health District organisational structure and 'Chapter 9: Staffing Levels and Structure for the Provision of Clinical Pharmacy Services', provided by Ms Laura Boyce, Health Services Union, on 26 August 2024.
- '16.2 Development activity & assessment performance (April – June 2024)' and '16.8 Economic and destination development activity biannual update', provided by Mr Alan Tickle, Manning Great Lakes Community Health Action Group, on 27 August 2024.
- 'Manning Great Lakes Community Health Action Group Recommendations for Items of Importance to be included in CSP Meeting held at Manning Base Hospital', provided by Ms Carmel Bartlett, Manning Great Lakes Community Health Action Group, on 27 August 2024.

4. Correspondence
***

5. Next meeting
The meeting adjourned at 10:06am, until a time and date to be determined.

MINUTES OF MEETING NO.16
3.01 pm, 29 November 2024
Room 1136 and via Webex

Members present
Dr Joe McGirr (Chair) (via Webex)**,** Ms Janelle Saffin (Deputy Chair) (via Webex)**,** Mr Clayton Barr (via Webex), Ms Liza Butler (via Webex), Ms Trish Doyle (via Webex), Mrs Tanya Thompson and The Hon. Leslie Williams (via Webex).

Officers present
Matthew Johnson, Carly McKenna, Sukhraj Goraya, Madelaine Winkler and Karena Li.

Agenda item

1. Confirmation of minutes
Resolved on the motion of Ms Doyle: That the minutes of the meeting of 11 September 2024 be confirmed.

2. ***

3. Correspondence
***

4. Rural Health Inquiry Progress Report
The Committee noted that NSW Health published its Rural Health Inquiry Progress Report on 17 September 2024.

5. Committee's second inquiry (PC2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW)
The Committee noted that a report deliberative will be scheduled in early 2025 to consider the Committee's second report.

6. General business
***

7. Next meeting
The meeting adjourned at 3:17pm until 8:45am on 12 December at Parliament House.

MINUTES OF MEETING NO.17
****

MINUTES OF MEETING NO.18
****

UNCONFIRMED MINUTES OF MEETING NO.19
9:01 am, 17 March 2025
Room 1136 and via Webex

Members present

Dr Joe McGirr (Chair), Mr Clayton Barr, Ms Liza Butler (via Webex), Mr Justin Clancy, Ms Trish Doyle (via Webex) and Mrs Tanya Thompson

Apologies
Ms Janelle Saffin (Deputy Chair)

Officers Present

Matthew Johnson, Carly McKenna, Sukhraj Goraya, Joan Douce, Yann Pearson and Nicolle Gill.

Agenda item

1. Confirmation of minutes

Resolved, on the motion of Mrs Thompson: That the minutes of the meetings of 12 December and 13 December 2024 be confirmed.

2. Membership changes

The Committee noted:

- the extract from the Legislative Assembly Votes and Proceedings, no 91, entry no 6, advising of the resignation of Mrs Leslie Williams
- the extract from the Legislative Assembly Votes and Proceedings, no 94, entry no 10, appointing Mr Justin Clancy MP to the Committee, in place of Mrs Williams:

> **6 ELECTORAL DISTRICT OF PORT MACQUARIE**
>
> The Speaker advised the House that on 31 January 2025 he had received a letter from Leslie Gladys Williams resigning her seat as member for the electoral district of Port Macquarie.
>
> **10 COMMITTEE MEMBERSHIP**
>
> (2) Justin Clancy be appointed to serve on the Select Committee on Remote, Rural and Regional Health.

3. NSW Government response to inquiry into the implementation of PC2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health

3.1. NSW Government response

The Committee discussed the NSW Government responses to the Committee's report on the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health.

4. Inquiry into the implementation of PC2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW

4.1. Resolution permitting recording of meeting

Resolved, on the motion of Ms Doyle: 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 once the report is tabled.

4.2. Consideration of Chair's draft report

Resolved, on the motion of Mrs Thompson: That the draft report be considered chapter by chapter.

The Committee considered Chapter One of the report.

Resolved, on the motion of Mr Barr: That the word 'students' in the second dot point of Recommendation 2 are omitted and replaced with the words 'specialists and rural generalists'.

Resolved, on the motion of Mr Barr: That Recommendation 4 of the report be amended to insert the words 'NSW Health work with' before 'all rural and regional' and the word 'to' be inserted before the word 'prioritise'.

Resolved, on the motion of Mr Clancy: That the following sentence be omitted from Recommendation 4: 'This should include consideration of removing restrictions on visiting rights for privately practicing midwives, where relevant.'

Resolved on the motion of Mr Clancy: That a new recommendation, Recommendation 5, be inserted after Recommendation 4 that reads: 'That NSW Health work with all rural and regional Local Health Districts to actively consider removing restrictions on visiting rights for privately practising midwives, where these restrictions are in place.'

Resolved, on the motion of Mr Barr: That Chapter One, as amended, stand as part of the report.

The Committee considered Chapter Two of the report.

Resolved, on the motion of Mr Clancy: That Chapter Two stand as part of the report.

The Committee considered Chapter Three of the report.

Resolved, on the motion of Mrs Thompson: That Chapter Three stand as part of the report.

The Committee considered Chapter Four of the report.

Resolved, on the motion of Mr Clancy: That Chapter Four stand as part of the report.

The Committee considered Chapter Five of the report.

Resolved, on the motion of Ms Doyle: That Chapter Five stand as part of the report.

The Committee considered Chapter Six of the report.

Resolved, on the motion of Ms Butler: That Chapter Six stand as part of the report.

The Committee considered Chapter Seven of the report.

Resolved, on the motion of Mr Clancy: That Recommendation 27 be amended to insert the words [This update] 'should include information on the numbers and locations of Intensive Care Paramedics and Extended Care Paramedics.'

Resolved, on the motion of Mrs Thompson: That Chapter Seven, as amended, stand as part of the report.

Resolved, on the motion of Ms Doyle:

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.

5. ***

6. ***

7. ***

8. General Business

The Committee discussed its forward work plan.

9. Next meeting

The meeting adjourned at 10:51am until 12 May 2025.