REPORT ON PROCEEDINGS BEFORE

LEGISLATIVE ASSEMBLY SELECT COMMITTEE ON REMOTE, RURAL AND REGIONAL HEALTH

INQUIRY INTO THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO CROSS-JURISDICTIONAL HEALTH REFORM AND GOVERNMENT CONSULTATION WITH REMOTE, RURAL AND REGIONAL COMMUNITIES

At Macquarie Room, Parliament House, Sydney on Thursday 12 December 2024

The Committee met at 9:00.

PRESENT

Dr Joe McGirr (Chair)

Ms Trish Doyle
Ms Janelle Saffin (Deputy Chair)

PRESENT VIA VIDEOCONFERENCE

Mr Clayton Barr
Ms Liza ButlerMs Liza Butler
Mrs Tanya Thompson
Mrs Leslie Williams

The CHAIR: Good morning, everyone. Welcome to today's public hearing of the Legislative Assembly Select Committee on Remote, Rural and Regional Health inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities. I am Dr Joe McGirr, the member for Wagga Wagga and Chair of the Committee. With me today in the Macquarie Room here at Parliament I have Ms Trish Doyle, the member for Blue Mountains, and we are expecting Deputy Chair Ms Janelle Saffin, the member for Lismore, shortly. The following Committee members are joining us online: Mr Clayton Barr, the member for Cessnock; Ms Liza Butler, the member for South Coast; and Mrs Tanya Thompson, the member for Myall Lakes.

The hearing is being broadcast to the public via the Parliament's website. We have a combination of witnesses appearing in person and via videoconference today. Before we commence, I acknowledge the Gadigal people, who are the traditional custodians of the lands on which we are meeting today. I pay my respects to Elders past and present of the Eora nation and extend that respect to other Aboriginal and Torres Strait Islander people who are present today or watching proceedings via the website. I thank everyone who is appearing before the Committee today. I declare the hearing open.

Ms MONIKA WHEELER, Chief Executive Officer, Healthy North Coast, before the Committee via videoconference, affirmed and examined

Dr ADRIAN GILLILAND, GP and Chair, Healthy North Coast, before the Committee via videoconference, sworn and examined

Mr STEWART GORDON, Chief Executive Officer, Murrumbidgee Primary Health Network, before the Committee via videoconference, affirmed and examined

Ms NARELLE MILLS, Executive Integration and Partnerships, Murrumbidgee Primary Health Network, before the Committee via videoconference, affirmed and examined

Ms MELISSA COLLINS, Executive Policy, Strategy and Innovation, Murrumbidgee Primary Health Network, before the Committee via videoconference, affirmed and examined

Mr BRAD PORTER, Chief Executive Officer, Western NSW Primary Health Network, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome representatives from the Murrumbidgee Primary Health Network, Healthy North Coast, which delivers the North Coast Primary Health Network program, and the Western NSW Primary Health Network. Can you each please confirm that you've been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

MONIKA WHEELER: Yes.

ADRIAN GILLILAND: Yes.

STEWART GORDON: Yes.

NARELLE MILLS: Yes.

MELISSA COLLINS: Yes.

BRAD PORTER: Yes.

The CHAIR: Before we get started, I ask all witnesses and Committee members to state their name before asking or answering a question. That will assist Hansard in recording the evidence today. Would any of the witnesses like to make a brief opening statement, limited to a couple of minutes? I suggest one statement from each organisation. Do any of the organisations wish to make an opening statement?

BRAD PORTER: Yes, Chair. Good morning, Chair, and members of the Committee. Thank you for the opportunity to appear here before you today. Western NSW Primary Health Network (PHN) serves a vast region encompassing some of the most remote, rural and regional communities in New South Wales—53.5 per cent of the State. These communities face unique challenges, including limited access to healthcare services, significant workforce shortages and a growing burden of chronic disease.

Prevention is better than cure, but we are so far behind. We are committed to do more around empowering people through increased health literacy. Our role is to address these inequities by commissioning services that meet local needs, supporting innovation and fostering stronger partnerships across the health system with Local Health Districts (LHDs), primary care providers and service providers. I have pledged, with my other health chiefs in the region, to do that through joint planning and governance.

Importantly, we are committed to amplifying the voices of our communities and of First Nations peoples, who represent a significant part of our region, to ensure their voices shape the solutions that are delivered. As the new chief executive officer of the Western NSW PHN, I look forward to discussing how we can work collaboratively to strengthen primary healthcare delivery and funding in our region to see improved health outcomes for those who need it most, giving better quality of life and expectancy and contributing to thriving regional communities. Thank you, Chair.

STEWART GORDON: Thanks for the opportunity to appear today at this public hearing. My name is Stewart Gordon. I am the CEO of Murrumbidgee Primary Health Network. The Murrumbidgee Primary Health Network, through its parent company, Firsthealth Limited, has a 30-year history of delivering health services and programs in the Murrumbidgee. At the outset, I would like to acknowledge the progress against the 44 recommendations. However, I note there remains significant work to be done to improve the access to quality and timely health care for rural and remote communities in New South Wales.

In our view, of most urgency are the recommendations underpinning the collaborative planning and delivery of an integrated health system between local health districts and primary health networks. Having said that, the strong relationship between the primary health network here in the Murrumbidgee and the local health district means we are well placed to progress this work into the future. In fact, as recently as Tuesday this week my PHN and the Murrumbidgee Local Health District undertook further work to hardwire in collaborative ways of working between our respective organisations—noting, however, that the availability, pooling and commitment of ongoing funding for this specific purpose is required to ensure solutions are implemented.

It is our belief that a one-health-system approach is critical to delivering timely, efficient and coordinated health care to rural communities. It is about joint health needs assessments to inform joint health planning and properly harnessing health consumer voices through Local Health Advisory Committee (LHAC) feedback processes. In fact, rural areas are perfectly placed to action this approach to working because we can articulate our place-based approach, we know the players in the system in order to solve the problem and, if done well, we can demonstrate the local impact of collaborative working. We thank you for your consideration of our submission and interest in hearing more from us today.

ADRIAN GILLILAND: I'll be speaking on behalf of Healthy North Coast. I'd like to thank Leslie Williams, MP for Port Macquarie, and Janelle Saffin, MP for Lismore, for encouraging Healthy North Coast to make a submission. Both Leslie and Janelle are strong advocates for better health care in our local communities. As well as Australia's 31 primary healthcare networks funded by the Australian Government, Healthy North Coast works to streamline health services, particularly for those at risk of poor health outcomes, and coordinate care so people can receive the right care, in the right place, at the right time. Our catchment covers from Tweed Heads to Port Macquarie. As the Chair of Healthy North Coast and a shared GP owner of a large practice in Coffs Harbour, I believe a radical shift is needed to prioritise preventative primary healthcare services so that communities are supported to enjoy optimal health and wellbeing and there is reduced pressure on hospital services.

In relation to the progress of and issues related to the implementation of Portfolio Committee No. 2 recommendations relating to health outcomes and access to health and hospital services, we believe there have been positive steps forward but there are many more to go. At Healthy North Coast we believe that a whole-of-system vision needs to be pursued which sees acute primary care and community centres working and communicating collaboratively, overcoming traditional fragmentation driven through funding systems and incentives, and delivering high-value care that improves health outcomes. We believe examples from the North Coast provide positive evidence of progress and positive change. Scaling examples like this, which also exist in many other parts of the State, should be considered for statewide expansion and rolled out to ensure sustainable and long-lasting change. Thank you to the Committee.

The CHAIR: Thank you all. I will have the first question. It's to each of you in turn, and you've touched on it in your opening statements. It's exploring in depth how well PHNs and the regional local health districts currently work together to deliver healthcare services and initiatives. In particular, has this improved in recent years? The background from that is a concern the Committee has that working together hasn't been as effective as it might have been across the State. I might go in the order of the original statements, so we might start with Western and then I will go to Murrumbidgee and then Healthy North Coast.

BRAD PORTER: I can confirm that I've been in the position now for five months and we have established in that time some local governance. Our two boards of the LHD and the PHN, although it's not a governing body, do now regularly meet every quarter, with representatives from each board and with the CEOs. That's one aspect around governance. But the other important initiative that myself and CEO Mr Mark Spittal of the Western LHD have introduced is what we're calling "healthy communities". We cover 27 local government areas and we know that local governments, although they don't have a remit for health services, are very interested in what we, as State and Federal funders, are doing in the health space.

We've created programs. We're doing Warrumbungle Shire at the start, so it's called "Healthy Warrumbungle". We're jointly going into that community, mapping and planning out what services are provided; co-designing with local communities; talking to them about what's working well and what's not working well; and then, between us and our funding streams between the two organisations, ensuring that we're working to fill any gaps. Of course, from a PHN point of view, we're very focused on that primary and preventative care space. As we've pulled this together with a steering committee and terms of reference, we hope to continue to replicate that across the 27 local government areas that are covered in western New South Wales, both with Western NSW Local Health District and Far West Local Health District.

STEWART GORDON: The Murrumbidgee Primary Health Network and the local health district boundaries align perfectly within our region, and we have a very strong relationship and way of working with the local health district. As we've talked about previously, Dr McGirr, that is very much relationship based. The chief

executive and executive team for the local health district and the primary health network's executive team work very closely on multiple projects and initiatives. That is also underpinned by some very deliberate and strong governance, and that's articulated in a collaborative agreement that's been signed between both of our entities. In short, the objects of that agreement are about enhancing collaboration; identifying, reviewing, developing and implementing models of care; and facilitating the joint information sharing between the organisations. I will stop there, Dr McGirr. If you require any further examples of some of the projects and initiatives we have underway, we're very happy to provide those.

The CHAIR: Actually, it would be good to hear some examples. But it is encouraging to hear arrangements about governance. It's puzzling that these arrangements of governance are now emerging, because I think the PHNs have been in place for quite some time. It's good to see that there is a focus on governance, but some examples of actual collaboration would be really good. It could be Ms Mills, as well, to answer that question, not just yourself, from Murrumbidgee. When we come to Healthy North Coast, that would be good as well.

STEWART GORDON: Thanks, Dr McGirr. I'll refer to you, Narelle, to handle that one.

NARELLE MILLS: Thanks, Stewart, and thanks, Chair. Probably one to really highlight is Collaborative Commissioning. The Murrumbidgee region has been one of five areas across New South Wales that has received funding through the Collaborative Commissioning approach through the Ministry [of Health]. We commenced on that Collaborative Commissioning journey back in 2019 and have been working with the LHD, again with that joint governance, around in terms of a core funding source or funding from the Ministry. That piece of work, I think, really demonstrates how we can make improvements at a regional level by working together. What I mean by that is that that particular piece of work allowed us to come together across the PHN, primary care and acute care services and look at what were the needs across our region and where were the wicked problems for us in our region.

We're one of the highest regions for hospital admissions for people with chronic obstructive pulmonary disease (COPD) and chronic heart failure (CHF). And so we were able to identify that that's an area that we really wanted to try to tackle together. We had done work prior to that—little bits and pieces of projects that really were not making a dent in the system and in those presentations. By coming together under that Collaborative Commissioning model, one, we could jointly identify the needs, and then, two, we could actually track the patient journey across the system, regardless of whether it's a primary care service that they're accessing, or acute care, or community. Again, we were able to map that out. Through doing that process, we were then able to identify where are the gaps that exist across that patient journey.

We've designed a care pathway for people with COPD and CHF, starting from being in community and ensuring that we're identifying people early on and getting accurate diagnoses, through to better management in community—when people do go into hospital and come back out again, making sure they've got access to support in community, rehab et cetera. We were able to look at where the gaps were together and then make joint decisions together around where we wanted to allocate that funding to build the system so we had a strong care pathway. We've been working on that for—I think it was 12 months to design that model and then three years of implementation, and we're coming up to our third year of implementation.

The results, at the moment, start to show some good trends in hospital admissions for COPD. I think that the challenge with that whole pathway is, again, that we're working under very limited funding arrangements. We're expecting, in the next 12 months, that that whole program will finish. We'll no longer have seed funding to support it. And so the challenge for us, as a collaborative group between the PHN and the LHD, is to look at sustainability now and how we make that work together. I guess that's probably the challenging part. It's easy when you've got a big bucket of money and you can try to set things up and make a difference. But with a lot of these things, the funding comes to an end and a lot of that good work starts to drop off. Three years is not long enough to get sustainable system change.

The CHAIR: Have you got some data on results from that project? You said there were some trends.

NARELLE MILLS: We've started to monitor the COPD admissions. We've got some data that we could possibly pull together to share with you. There is a formal evaluation of all collaborative commissioning projects across the five different sites through the George Institute. That evaluation will be available as well. Dr McGirr, if you're interested in any sort of preliminary data, we can try to pull that together and send it to you.

The CHAIR: We'll note that as a supplementary question and ask you to come back to us on that. I'm conscious of time, so if I cut people off, please forgive me. I'll just move to Healthy North Coast to comment on the question of how well you work with the LHD. Do you have examples of where that's worked or problems where it has not?

ADRIAN GILLILAND: I'll start by talking about the governance side of things and then I'll hand over to Monika to talk about actual examples. Healthy North Coast has been working for a long time with our two LHDs. We share boundaries with the Northern NSW and Mid North Coast LHDs. We've had joint board meetings for quite some time and some joint initiatives. We've always had trouble, as Narelle said, when the funding runs out, and also around ongoing funding and how we're going to continue with it, in particular when the rubber hits the road. In December 2023, we signed a formal memorandum of understanding between ourselves and our two LHDS, which was launched by Rose Jackson in June of this year with a formal launch. Within that MOU, all the LHDs are committed to the joint statement, which is a way of working together.

We also have some governance and escalation things in place. We have a statement of works. The three chief executives meet together on a quarterly basis and on a regular basis to work through all of the joint initiatives. If there are issues that arise due to disagreements between the CEOs, we have an escalation forum where it can go up to the boards and also to the chairs to resolve any issues that might arise. We think that's been working really well so far. We're really pleased with the progress thus far. I'll hand over to Monika to talk about how that works in the real world.

MONIKA WHEELER: I think it's a fair comment to ask why it has taken so long for the governance to take shape until now. What I would say is that one of the challenges locally is that there is no actual requirement from NSW Health local health districts to have shared governance with their primary health networks. There is some requirement for PHNs in a limited number of our funding agreements to have shared governance with local health districts, but that's not reciprocated currently in the NSW Health activity agreements with the local health districts. I will give you a specific example. I guess my point is that it's not for want of trying that these relationships have taken as long as they have to take shape. What I would observe, having worked in the North Coast PHN for many years now, is that largely what that means is that it is personality driven. If you have local health district and PHN CEOs and board members who are very keen to progress an integrated approach to shared governance, then it happens. But as soon as those personalities change, so too does the shared governance.

I think if we're looking at how to create a health system, particularly in rural communities that need both primary health care and acute care services working as one, we need to make sure that that is a requirement and it's not based on personalities that are in positions at any given time. In our region, we have certainly worked very closely with the local health district over the course of the nearly 10 years of the PHN being in existence. We have many examples of case studies where that has worked really well. What I would say is that as personalities have changed over the course of the last decade, so too have those collaborations.

An example I could provide of a program that has worked very well that I think we could quite safely say has saved health dollars over the years is HealthPathways. That exists in all regions in New South Wales, but our region was one of the first regions to set up that program. HealthPathways provides a single point of truth for all health practitioners across the North Coast, where they can see not only diagnosis and treatment advice, but also what the referral pathways are locally. HealthPathways is a really great example of where it can be used as a way to troubleshoot local issues that exist between a hospital system and, particularly, the local general practice services.

I will give you a great example of some inroads that we've made just recently in regards to one of those local issues, which is around paediatric access for attention-deficit/hyperactivity disorder (ADHD) treatment. I am sure the Committee is well aware that ADHD diagnoses have gone through the roof in recent times. The impact of that is that there are very, very long waitlists for paediatric outpatient services across all of New South Wales. We've certainly seen that acutely in our region, where some children—some very high-needs children, Aboriginal children—are waiting some two to three years in places like the Clarence Valley before they can see a paediatrician. If you can't pay, it just means that you may need to wait two, three or even four years. For a child who has significant issues, whether that's hearing loss or developmental delays, waiting two or three years is an incredible amount of time to lose learning, to lose development and so many other important opportunities in those early years of life.

What we have been able to negotiate with our paediatricians in both Northern NSW and the Mid North Coast is an innovative new shared care pathway with general practice, where we will have HealthPathways as the single point of truth for how the pathway will work. Basically, what it will allow is for paediatricians to provide coaching and support to our local general practice community who are willing to take on ADHD clients, who they will then manage in a general practice setting, with the support and guidance of local paediatricians. That will reduce paediatric waitlist times and will mean that the kids who really need to get in to see paediatricians will get that access in a more timely manner. It will also mean that general practitioners will feel more supported in having an acute care specialist colleague who they can call and touch base with very easily—that is quite difficult at the moment because they are so busy—meaning that the care that they deliver in a general practice setting is going to

be of a higher quality and they are going to feel more confident to deliver that care in a safe setting to their scope of practice. That's a good one that I'd like to put on the record.

The CHAIR: Ms Wheeler, before we go on to the next question, I just want to clarify, what was the LHD's contribution to that project?

MONIKA WHEELER: The LHD's contribution is that they will be hosting a staff member who will help coordinate this shared care pathway. The primary health network will be providing the large bulk of the funding for that coordinator role, but they will be the ones who will be doing the leg work within the LHD system.

The CHAIR: It sounds to me as though it's a very worthwhile project but, to be frank, it sounds like it's a PHN project and you're basically driving it, and the LHD is fitting it in.

MONIKA WHEELER: It was actually paediatrician-led, I must admit. It's a partnership initiative. Our local paediatricians came to us in—I wouldn't say a state of crisis, that might be too extreme, but certainly really concerned that they are not able to see the amount of children who are on their waitlists. They wanted to find an alternative solution. I don't think it's fair to say it's just the PHN. I think it has been a collaborative initiative. Certainly, it's endorsed and supported by management in the local health districts.

The CHAIR: I accept that the paediatricians would have approached you. I'm not convinced that is quite the same as the LHD. But I take your point. Thank you for that. That was a great example.

Ms LIZA BUTLER: Thank you, everyone, for joining us today. Moving on from the local health districts, I would like to talk about recommendation 42, the Local Health Advisory Committees. Can you tell us to what extent PHNs collaborate with Local Health Advisory Committees, and are the local committees utilised effectively in your region? How do you measure that they are being used effectively?

The CHAIR: Who would like to go first?

BRAD PORTER: We might stick to the same order, Chair.

The CHAIR: We will start with Western and then Murrumbidgee and then Healthy North Coast. Anyone from either group can answer.

BRAD PORTER: My understanding is PHNs have a legislative requirement to have their own advisory council. In Western, we have two community advisory groups that cover Far West Local Health District and Western NSW Local Health District. We also have two clinical advisory councils, both covering those two LHDs, made up of GPs and clinicians. And then we have a fifth advisory group of First Nations that covers the whole region. That's within the PHN and the legislative requirement. I would say that so far we don't have any interactions with the LHD advisory committees. Given the people on our advisory committees, there is some crossover, so lots of information flows to us via our members who have also often either been involved previously or are currently involved in the local health district advisory committees.

STEWART GORDON: Murrumbidgee Primary Health Network and the Murrumbidgee LHD jointly manage and support around 30 active Local Health Advisory Committees, so we have a very integrated approach. These volunteer health advocates provide grassroots input into local health issues which inform our health needs assessment and our local planning. We run biannual joint Local Health Advisory Committee forums with our LHD, and we jointly fund those events as well. That's, I suppose, at a high level. With regard to specific issues, I will now refer to my colleague, Narelle Mills, to provide further detail for you.

NARELLE MILLS: As Stewart mentioned, we run the twice-yearly LHAC forums. We jointly facilitate LHAC recruitment drives together, so they are co-badged in terms of that recruitment drive. Every two years we do a joint planning session with each of the Local Health Advisory Committees. That's attended by representatives of the PHN and the LHD, and we visit with each of those LHACs and provide them with the health needs assessment data and work with them around identifying local issues and local projects that they can work on. Importantly for us, when we structured or set up our Community Advisory Committees that we are required to have as a PHN—those LHACs—we then facilitate sector LHAC chair meetings and we run that quarterly with each of our LHAC chairs. And then we have a representative from each of those sectors that sit on our Community Advisory Committee. That then ensures that there's a pathway of community issues being raised at the Local Health Advisory Committees coming up through to our Community Advisory Committee and straight to our board. If there are any other questions, I'm happy to answer them.

The CHAIR: Ms Collins, I don't want to leave you out. If you wish to make a comment, please feel free to do so.

MELISSA COLLINS: I'm happy to defer to Narelle in this case.

MONIKA WHEELER: The updated health advisory councils that both northern New South Wales and Mid North Coast LHDs run have certainly included some involvement from us. I've been lucky to actually have a tour of the Bonalbo multipurpose centre with some of the advisory council members from that community and hear some of the concerns that they have about ongoing health service availability there, and also in Coraki, where there have been longstanding concerns about health care access. Our staff regularly attend the health advisory forums and discuss issues that the committee is interested in. What I would say, though, is that in our region, Healthy North Coast still has a clinical advisory council and a community advisory council that sits separate to the LHD forums. Potentially, in the future, that's something that we need to look at in terms of having shared healthcare advice coming from the community.

I would say, though, just in addition to those comments, that one of the most important things, in addition to having almost representatives bodies, I guess, representing consumers, is just making sure that a consumer voice is embedded in healthcare service design and evaluation. I do see that that has evolved a lot in the local health district space, and certainly in the services that we commission also. But there's still a long way to go there in making sure that a consumer voice is really driving improvements and changes in all healthcare services—we're not there yet, I think there have been improvements, but it's not standard practice—that it really drives the detail of reform and change.

The CHAIR: Just to clarify, back to Murrumbidgee, it's the LHD and the PHN who jointly fund and sponsor those Local Health Advisory Committees?

NARELLE MILLS: We jointly manage them. In terms of funding, the local health district provides, I think, some small grants through the LHD for those Local Health Advisory Committees. We'd probably need to clarify what that exactly looks like. We, as a PHN, offer grants from time to time out to those Local Health Advisory Committees.

The CHAIR: I wasn't thinking of grants so much as the infrastructure and the support because they don't happen for free—you need people to organise meetings, venues and so on.

Ms LIZA BUTLER: Was it the biannual forums that you jointly fund? That's in my notes that I wrote down.

NARELLE MILLS: Yes, we jointly fund the forums. We have a staff member within the PHN who has responsibility for Local Health Advisory Committees. That person works closely with the person in the local health district who has responsibility for Local Health Advisory Committees. They meet regularly to oversee how those LHACs operate. When the LHACs meet, we have a staff member from the PHN that attends the Local Health Advisory Committee meetings on a regular basis. That's spread across quite a number of our staff; we share that responsibility. We have probably around 20 staff that may have an LHAC that they go along and attend, along with the local health district representative.

The CHAIR: That's quite impressive, I have to say.

Mrs TANYA THOMPSON: Thank you to everyone for your time today at this hearing. I would like to go to recommendation 8 and ask you all if you feel NSW Health has supported the growth and development of the primary health sector in remote, rural and regional areas of New South Wales?

The CHAIR: Who would like to start? We could do the same order again, if you like, Mr Porter.

BRAD PORTER: I'm not sure I have any direct response to that. I guess my understanding is that there are some joint funding models that are coming starting to come in in the mental health space et cetera in terms of joint funding across the two funding streams of Federal and State. My colleagues may be able to—NSW Health is really quite reluctant to step in and provide direct funding to primary health care. Obviously, the majority of funding for that process comes through the Federal Government through MBS and through incentive payments. I'm not aware of any direct support that's coming from NSW Health into the primary healthcare space. In saying that, due to the workforce crisis in Western NSW, there are a number of 19 (2) exemptions being applied for by the LHD. It's 19 (2) exemptions, for those probably all aware, where there is the need for the local health district to provide primary care services in a Multipurpose Service (MPS) or an emergency department and their ability to claim Medicare to see that low-acuity patient.

STEWART GORDON: At a strategic level, I think the smaller the community, the more focused the community needs to be of primary health care as a model of care. My view is that there's a lot more opportunity, particularly in those very small towns, for there to be less delineation between hospital-based care and primary health care. A more joined-up approach is absolutely what is required in those small towns. With regard to single employer models, the Murrumbidgee was the beginnings of those models for New South Wales, is my

understanding. And that, again, is an example of how actually having our staff work across the hospital and primary care sector—which is absolutely important, particularly the smaller the town—goes.

I think there's an absolute opportunity for us to really lean into the way in which we address the thin-markets issue. There is thin-markets funding out there. Unfortunately, the way it rolls at the moment, my understanding is that services need to fall over before that funding can be accessed. It would only be common sense for us to be able to get in early and prevent services from falling over by having ready access to that money prior to a crisis. That's all from my perspective. Narelle or Melissa, do you have anything to add to that?

NARELLE MILLS: I think the only other one I would highlight is the Collaborative Care initiative. I know that New South Wales has picked up on some funding to help roll out Collaborative Care through the Rural Doctors Network and have started to grow the—there were I think five sites to begin with that the Ministry is now investing in for the Murrumbidgee region. We were one of the first sites with the Snowy Valleys Collaborative Care project. We're now working with NSW Health and with the Rural Doctors Network to look at Collaborative Care in one of our other communities of Leeton. It's great to see that investment and that approach to really local-based identification of needs and how we can work together at that community level to make improvements. Again, I'll just caveat that with it's a two-year funding project. Again, comes and goes and it's really hard to make system changes in such short time frames.

MONIKA WHEELER: I think in our region there would be very limited examples of where the local health districts or the Ministry have invested in the primary healthcare sector, workforce support or other initiatives. I think it would be fair to say that they see that as our job—and other funded Commonwealth agencies like the rural workforce agencies, the rural training hubs and so on. With the exception of the broader statewide rollout of the single employer model, the only example I can think of where NSW Health services have supported primary healthcare workforce development would be where they have released specialists to come and give training to local GPs and allied health professionals. We have a clinical society model in our region, which is an interdisciplinary primary healthcare education forum that exists in eight catchments in our region. That's where a lot of the specialists will come to deliver education, which is very valuable and certainly welcomed by primary health care, but that would be the extent at this point, I would say.

Mr CLAYTON BARR: Along a similar vein, could you help us fact check something? In a recent progress report, NSW Health noted that LHDs "have supported PHNs to develop regional place-based needs assessments". Has that happened in your respective districts? Is that a true statement for them to be making?

BRAD PORTER: Certainly in Western NSW, we've just completed our primary health care three-year health needs assessment. The collaboration that's occurred with the LHD and their executive manager of planning and strategic priorities and her team has been very much embedded with us—so, yes, that has occurred. Our data people and their data people have worked hand in hand to release what they call the "state of the nation" or "state of the region" report, and then the PHN takes that from an acute healthcare setting and uses much of that information to apply it to our own health needs assessment, which obviously goes much further into social determinants of health in the primary healthcare setting. So, yes, I can confirm that has happened in Western.

STEWART GORDON: We too have just completed our health needs assessment for its three-yearly update. With regard to the extent to which the LHD is involved in that process, as we mentioned before, we do have a lot of qualitative data, which feeds into that process via the LHAC process—so hearing what's going on on the ground and then filtering that into our health needs assessment. It puts, can we say, qualitative meat around the quantitative bones of the data that we're able to extract and put into that piece of work. I think there is, however, absolute opportunity for there to be legislative change in order for us to better share data between LHDs and PHNs to be able to produce a true joint regional needs assessment, which actually then lets us inform our joint regional planning approach. If we were able to have that free flow of information exchange between the entities in order for us to be able to produce such a document, that would then give us that proper helicopter view of what's going on in our region to be able to inform health planning.

Mr CLAYTON BARR: What prevents that?

STEWART GORDON: I understand that there are issues with regards to data sharing between entities and also with regard to—I'm sorry, I've just gone blank. There are issues in regard to information exchange in order to be able to do that from a privacy perspective as well. But I'm happy for anyone else to jump in and help me out here.

MONIKA WHEELER: I think, Stewart, that there are some issues with the privacy legislation that make it difficult for NSW Health. But, in saying that, every local health district CEO—I understand, and this would need to be double-checked—has the ability to release any data that they believe is appropriate to release for the benefit of the community. Within that, of course, ethics committees that exist in every local health district, I'm

sure, would need to have some role. There are some fairly rigorous controls around how that data is released and shared. I think it's something that needs to be addressed, though, if we're actually going to move to genuine shared planning across both primary and acute care. I do understand that this is something that the Ministry has looked at, but I'm not aware of much progress that has happened recently. What I would say is, as we articulated in our submission to this inquiry, we really need to see the full implementation of the NSW Health and New South Wales PHN's joint statement, which does articulate the steps that we need to take to implement shared planning across all districts across New South Wales.

That's really the priority that we need to see at a statewide level take shape, so that every region is supported with that authority to plan locally with their colleagues. On the North Coast, we have ambitions for shared planning in our MOU that Adrian mentioned, which was launched in July. We have identified a time line for how we will be exploring shared planning resources, shared data-sharing agreements and doing joint needs assessments. In terms of evidence of NSW Health already having committed funding towards shared planning, I'm aware of one instance where that has happened in Hunter New England and Central Coast. They have conducted a joint health needs assessment together. I'm not aware of others, but it doesn't mean that they don't exist. That's just my understanding.

Mr CLAYTON BARR: Ms Wheeler, do I take it from that that the LHD that you work with has not supported the PHN to develop a regional placed-based needs assessment?

MONIKA WHEELER: Correct, but we have ambitions and shared goals to do that. We just haven't done it yet. What we have achieved is a mental health joint regional plan, but not a whole-of-region, population-wide needs assessment.

The CHAIR: Ms Wheeler, can I follow up on a very important comment you made about the NSW Health joint statement and the full implementation of that. Perhaps you could explain in more detail what has been the process for that and where it is up to from your perspective, and then I will get some commentary from the other PHNs. That is quite an important issue that you've raised.

MONIKA WHEELER: Yes, the joint statement was a collaborative piece of work that started some years ago as a principal document that sets out how do we intend to work together as both the acute and primary healthcare system funded by two different streams of government. In that, there were some excellent principles that set out three priority areas: focusing on care in the community, establishing regional planning processes and governance, and data and outcomes. From those three key priority areas, a couple of years back—it must have been 2022—there were some implementation plans that were developed. What we are really looking forward to seeing next now is the implementation of those plans. We are very keen, as New South Wales PHNs, to support that work, and there are active conversations going on at the moment with NSW Health around that. But there has been a delay since the implementation plans were developed and where we are today. We would certainly say that that should be a priority. It is certainly something we have said publicly many times. We are certainly ready and willing to support that.

The CHAIR: Any comment from Murrumbidgee or Western on that important joint statement?

BRAD PORTER: From Western's point of view, in practice we are implementing that. Besides our health needs assessment, which has been done separately—because it has two different areas of focus, in primary care and acute care—we are embarking on a supplementary First Nations health needs assessment. That will absolutely be done jointly across the whole region, being Far West and Western, and with the LHD and the PHN involving First Nations people, of course. In the last two months I've met with both of the regional assemblies in Murdi Paaki and the Three Rivers Regional Assembly, which are key Aboriginal people who are representing all facets of Aboriginal affairs, not just health. They both have two health accords, where they have consulted with mob and community about their health, so that then gets fed back into the qualitative data about what are the specific issues about Closing the Gap. That's in a practical sense. I'll leave it at that.

The CHAIR: Anything from Murrumbidgee?

STEWART GORDON: Just quickly, Dr McGirr. In addition to the value proposition of a joint regional needs assessment, I think another good example of joint regional planning is the approach being taken in the Murrumbidgee by the PHN and the Murrumbidgee LHD as a member of our Murrumbidgee Health and Knowledge Precinct, and the development and implementation of a regional planning framework within that construct, which is underway at the moment. That planning framework will provide us with a repeatable approach to identifying local problems, thinking about what the evidence is in order to be able to address those problems, including who needs to be included around the table, and then measuring the impact of what we do.

The CHAIR: I'm glad you raised the issue of the Health and Knowledge Precinct, which is something I've been working on and supportive of. We have a session tomorrow where we are going to explore that in more

detail, but I think raising that here in the context of a regional framework and an actual mechanism to allow that to happen is quite important. Thank you for that.

Ms TRISH DOYLE: Hello, everyone. Thank you for joining us today and sharing some of your insights. A particular hello to Monika Wheeler. We worked together many moons ago. Thank you for what you do in representing your areas and for your expertise. Even though I did grow up in the Riverina—hello to the Murrumbidgee crew—I am going to direct a question to Healthy North Coast. Your submission refers to North Coast Health Connect as a particular model that aims to provide free, same-day access to GPs and pharmacies across the region. How does that model work when we are hearing across the State that there is limited GP availability? How do you integrate that with access to urgent care services? Tell us a little bit about that model if you can, please.

MONIKA WHEELER: Thanks, Trish. It's so nice to see you after so many years. We have developed North Coast Health Connect over many years—in fact, before the urgent care program was alive and in the implementation phase. We developed that program because in our region we were seeing quite high numbers of people using the emergency department in those category 4s and 5s—so what they call low emergency ED presentations—which can sometimes be appropriate to be seen in a general practice setting. Because we had such high rates—we had some of the worst rates in Australia—we started a process of trying to unpack how do we ensure that people get access to primary health care.

We went through quite an extensive co-design process where local consumers, clinicians and other stakeholders suggested that we needed to have the ability to have access to health care wherever you are—so some sort of digital health service, but a digital health service that was connected to local face-to-face primary healthcare services. From that, we initiated what we now call North Coast Health Connect. What we have been able to explore through this new service model is that there is capacity within general practices—some general practices; not all—where perhaps they have a new registrar who has just started, like a GP in training, and they don't have enough patients for that registrar to see. That particular practice might be an excellent participant in being able to offer quarantined appointments through a centralised booking service.

That is exactly what we have offered through North Coast Health Connect. We have 25 general practices that quarantine a number of GP appointments every week for us through a digital triage line that we run centrally across the whole region, and then we subsidise that practice to offer those appointments for free. From the implementation of this program, what we've been able to understand is that general practices are willing to participate in a centralised booking system like this—which hasn't been done before—if they have the capacity, of course. What this has exposed is that, unlike local health district services, which are very organised from a centralised administration perspective, general practices are all individual private businesses.

The way that they make appointments available is very much determined by their GP owners and perhaps their practice management policies. What that appears to the community is that, potentially, there are no appointments in your local community because those GP owners have decided that they don't have capacity. But, in fact, engaging general practices in a centralised booking system is possible and is acceptable. North Coast Health Connect has been able to really open up a whole range of different GP appointments that just weren't there before. We do think that it has relevance for rural and remote communities where an urgent care service just might not be appropriate. We might not have a population that can actually service a seven-days-a-week, eight-to-eight type service. But there might be members of the communities who still can't get access to those local general practices in our current state. This model—we call it a distributed model of urgent care—is I think something for consideration in rural communities where an urgent care service just would never have the throughput that would make it viable.

Ms TRISH DOYLE: Sounds like a great model.

Ms JANELLE SAFFIN: Monika and Adrian, you can take this on notice. The MOU—is it possible for us to see that? We'd like to know more about how it works in practice. Adrian, in your opening statement you said we need a radical shift. We don't have time now to hear what that means but I'm really interested. Maybe that might be a conversation we can have offline.

The CHAIR: Perhaps a couple of minutes on the radical shift.

Ms JANELLE SAFFIN: Is that okay?

The CHAIR: Yes, because I'm interested in that too.

ADRIAN GILLILAND: I think the radical shift is a bigger problem than something we can necessarily fix this time. But what we're seeing is that, as a percentage of total healthcare funding, the amount that goes into primary and preventative care is reducing as a total percentage of our GDP, and more and more is going into acute

hospital services, which are predominantly in cities. We're definitely not servicing our regional areas. We're not doing the preventative and the primary care work to actually keep people out of hospital and manage their chronic disease. We see more and more people with chronic disease. A lot of things can be managed if we manage them in time before they get into the hospital system. We're just not seeing the investment in primary and preventative care because the acute care sector really has lots of nice, new, shiny things which they can turn around quickly, whereas primary and preventative care takes a long time. If you look at all the evidence, it shows that by investing in primary care, you get double your value for money than what you do in the acute care sector.

Ms JANELLE SAFFIN: We might drill down more on that later. Thank you. That is great, a good steer.

The CHAIR: Thank you all for appearing before the Committee today. It has been a rich discussion and I really appreciate you taking the time. You'll be provided with a copy of the transcript of your evidence for corrections and any questions taken on notice from today. There were a couple. We also may send you some further questions in writing. Your replies will form part of the evidence and be made public. Would you be happy to provide written replies to any further questions? I think everyone has agreed.

(The witnesses withdrew.)

Ms SUSANNE TEGEN, Chief Executive Officer, National Rural Health Alliance, before the Committee via videoconference, sworn and examined

Ms MARGARET DEERAIN, Director, Policy and Strategy Development, National Rural Health Alliance, before the Committee via videoconference, sworn and examined

Mr RICHARD COLBRAN, Chief Executive Officer, Rural Doctors Network, sworn and examined

Mr MIKE EDWARDS, Chief Operating Officer, Rural Doctors Network, affirmed and examined

Ms ANNETTE LENSTRA, Sector Advancement Manager, Rural Doctors Network, affirmed and examined

Dr RACHEL CHRISTMAS, General Practitioner, Visiting Medical Officer Obstetrician, and President of Rural Doctors' Association NSW, before the Committee via videoconference, affirmed and examined

Dr SUE VELOVSKI, General Surgeon, and Committee Member of Rural Doctors' Association NSW, before the Committee via videoconference, sworn and examined

The CHAIR: I now welcome our next witnesses. For those witnesses appearing in person today, please be aware that staff will be taking photos throughout the hearing. If you have got any concerns, let us know. Can each of you online and in the room please confirm that you have been issued with the Committee's terms of reference and information about the standing orders related to the examination of witnesses? Everyone is nodding in the room and everyone is nodding online. Before we begin questioning, there is an opportunity for each organisation to make a brief opening statement of a couple of minutes. We will start with the Rural Doctors Network in the room and then we'll go to the Rural Doctors' Association and then the National Rural Health Alliance.

RICHARD COLBRAN: Thank you, Dr McGirr. On behalf of the Rural Doctors Network, I would like to once again thank the Committee for its work and also the opportunity to participate today. The notion of integration across our systems is very important and one that we've responded to in each of our responses to this Committee. I will also acknowledge RDN's chair, Professor Peter O'Mara, a proud Wiradjuri man. He is unable to be here today. He was in the last session we held, and he sends his apologies. I'd also like to acknowledge the traditional lands across all of New South Wales that we all work to support and the leaders of our First Nations peoples. A critical part of our conversation today—when we're thinking about integrating the sector—is to understand the notion of Aboriginal health and ways of working and also the opportunity to ensure that Aboriginal community-controlled health organisations are also considered within the integration story.

A lot of the work that RDN has done and prepared for this Committee over the last couple of years has related to the notion of integration of our system and we feel well positioned today to be able to continue to support that discussion and provide examples as well. At the heart of all of that work in RDN's 35 years, which we've been able to share with you previously, is the notion of thinking about community and having a community-first perspective but also bringing science and methodology to the way that we work with community and partner with those communities as well. On that note, the final piece we'd like to mention is just how important the idea of working with local stakeholders and understanding local needs and the nuancing of local needs is in the way that we deliver our services and creating access to care. Thank you very much.

RACHEL CHRISTMAS: Thank you for the opportunity to present today. There are cross-jurisdictional challenges that continue within New South Wales. There are a few challenges; there are also some good things happening. I think the challenges relate to disaster relief coordination; the incentives for GP registrars moving out into regional areas—and this has been happening across other States and not so much New South Wales; provision of community primary care services where there are gaps not provided by State services and through collaborative commissioning models; and I think there are risks of duplication and fragmentation and reactive programs happening. We need to be very careful that longstanding arrangements are not upset and that we continue to provide services locally where we have good responses to local needs.

[Inaudible] been seen in the single employer models across the State with RG training. There is scope for wider application of this. However, this is moving in a positive direction. There are junior doctor training opportunities within rural hospitals, and funding for that has increased through the John Flynn program. However, this is again being challenged—and as well with the rural generalist pathway—in opportunities not being fully taken up in LHDs. There is that breakdown at an LHD level about positions being made available, despite the funding being given for those positions.

The challenges that are existing within NSW Health are ensuring that those positions are actually filled appropriately, the funding is being used and that those positions aren't being pushed off elsewhere back into base hospitals for position-filling. But, overall, we are hearing that there are record numbers recruited to rural health,

and this is good. I would like to know what that breakdown is in terms of rural, remote and regional—because I think there is a tendency to put that all in the one basket—and to know how the incentives are actually bringing new people into rural medicine and rural health provision not just in medicine. How is that movement into that sector going? Where are they coming from? Are they actually coming from the private sector, rurally, into the public sector, or is it actually bringing new recruitment in from elsewhere? That breakdown would be interesting to see.

SUSANNE TEGEN: Good morning, Committee Chair and members. On behalf of the National Rural Health Alliance—its 52 members and the communities we serve—we welcome the opportunity to present again as part of this broad inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities in New South Wales. I will take this opportunity to highlight the key issues in our submission as they relate to the terms of reference. The terms of reference, for one, relate to cross-jurisdictional cooperation between New South Wales and the Australian Government, which is incredibly important.

The *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* highlights people in rural and remote communities continuing to experience poorer health outcomes—indeed, dying 12 to 16 years earlier than urban individuals. A coordinated national approach is needed to address health disparities that encompass models of care able to function where workforce and infrastructure is limited. A shared plan of action focusing on equity of access for rural communities needs to be part of a schedule of a new National Health Reform Agreement with priority actions and milestones for rural, remote and regional New South Wales—and, indeed, Australia—including a funding formula for the equitable distribution of teaching, training and research funds. The Alliance supports these findings and calls for the recommended schedule to the next National Health Reform Agreement for Australia's jurisdictions to commit to a national rural health strategy.

Current approaches are not delivering coordinated or sustained solutions. A clear, coordinated and funded plan for rural communities through a national rural health strategy is needed. We cannot continue to stand on the sideline and say it's okay for underfunding and underservicing of our rural communities. Term (2) of the terms of reference refers to a collaboration between NSW Health and Australian government bodies. You referred, in your original plan, to the Rural Area Community Controlled Health Organisation (RACCHO) pilot with a view to evaluating it, refining it and rolling it out across New South Wales—and, indeed, other States taking it up and rolling it out across Australia. The RACCHO model is now called PRIM-HS, with community input and flexible funding. We are seeking a commitment from the Government to support a national rural health fund which rural primary health organisations can fund according to need, in particular for MM 4 to MM 7. Where markets have failed or there aren't any markets, we cannot accept the underfunding and under-supporting.

We need to improve communication between communities and health services, and develop place-based, flexible health plans. This term of reference correctly identifies the importance of sharing information, research and learning across rural health services. The Alliance would like to take this opportunity to emphasise its call for a funded rural health innovation and evidence hub. Why do we need this? We need it because we have trials and pilots that need to be shared across communities. We need to be able to adapt and adopt and learn from those things that have been funded in the past. Our call for a rural health innovation evidence hub is a concrete response to sharing of this information, and it is very much a community-developed approach.

Finally, we believe that if these policies and recommendations are actioned, the New South Wales Government will also have actioned your term of reference (4), which is for the New South Wales Government to action—to prioritise—the health of regional communities in Government decision-making, as we can no longer stand on the sideline and say it is okay for people in rural, remote and regional communities to die earlier, to receive less health funding, and to have budgets that do not reflect what urban individuals are receiving currently and in the past. Things have not changed over the last 30 years. These people are part of the Australian population. Thank you for the opportunity to provide input into your deliberation. Thank you for your bold strategies to hear rural Australians. The National Rural Health Alliance welcomes any collaboration with New South Wales parliamentarians, the New South Wales Government and senators and MPs from the Federal Government to genuinely come up with solutions to close the gap.

The CHAIR: Thank you very much. Members of the Committee have questions; I will lead. Each of you has actually touched on this area. I will start with the National Rural Health Alliance because you have most recently referenced the progress that the New South Wales and Australian governments have made in addressing this issue of thin markets and growing primary care in regional, rural and remote New South Wales. What progress has been made or is being made? I also recognise that there are issues around training the GP workforce that are going to be important; we will come to those questions later and there will be other issues.

But can we just start with this key issue, which really goes to the heart of how you provide services in remote and rural New South Wales. The National Rural Health Alliance touched on this in its opening statement. You talked about the national rural health strategy, innovation hubs and a fund. You also mentioned RACCHOs, which are now PRIM-HS, and you quite rightly point out that there was a recommendation about developing those. For each of the groups, could you just comment on any observations about progress by the two governments in addressing thin markets and growing primary health care in remote and rural communities?

SUSANNE TEGEN: There isn't a national rural health strategy. That allows any funding or any initiative to be put underneath the general expenditure and the general activities and it's hidden. So we can see certain bits of funding going to rural communities, but it's not population health based and it is not on an equity basis—yet. We need a national rural health strategy. We also need to have approaches which are locally based and population health needs based. Currently there are trials and pilots, but they're not being expanded. Communities know best what works in their regions. Under a national rural health strategy, the funding should go where the population health need is the greatest, and it needs to be separated from urban funding and urban programs. That's the first thing.

The second thing is that, from a training perspective, there have been some moves to more rural training and more rural students across all of the health professions—except, when there is an inability in the first year to fill those positions, the funding goes back to the city. So there should be a national rural health fund where the funding stays in the rural sector and it allows for flexibility of delivery and flexibility of reusing the funding in other ways of being able to train people in a rural setting. The third thing is that currently, with all the pilots and research and everything, nobody shares it. Nobody knows what is actually going on. If rural communities, local government, clinicians or universities are trying to find who's doing what, nobody knows what's going on, and they're being directed to websites which say very little.

We're suggesting that there should be an innovation hub for rural Australia and that it is linked with the *Australian Journal of Rural Health*, where there is a synthesis of what is being found, a sharing of information—a rural hub where people can share and learn—and the national rural health fund is reflecting what is needed at a local community level and is funding what the need is. In MMM 4, 5 and 6, we will see—and we've provided you with this data before—that there is a massive dip of funding and also of clinicians on the ground. Indeed, the clinicians that are on the ground are often paramedics because there is nothing else. They are small communities.

What is being done on a Federal and State level? It is piecemeal. It is often released to be funded only for two or three years. For example, the Innovative Models of Care (IMOC) grants—you were talking about the PRIM-HS. We know of several communities around Australia that have been funded through the Innovative Models of Care Program. They are excellent models. But we know it's finishing, and it is not allowed to be used for the increase in service delivery. Even though it's fantastic funding, it's only allowed to be used to have discussions and collaboration. But it's not allowed to be used for the things that people want to be using it for. We are doing some great things on the ground. They are short funded. They're not funding the things that people really want to do. But because they're having to seek funding for something that they would like to build on, we still have communities having to raise hundreds of thousands of dollars purely so they can keep their service.

The CHAIR: Thank you very much. I might go to the Rural Doctors Network, who are here in the Parliament with us. That question around what's being done on thin markets and growing primary care—I know your organisation has been involved in a number of Collaborative Care trials. Perhaps you could speak to us about what progress is being made and what opportunities there might be.

RICHARD COLBRAN: Thanks, Dr McGirr. I'll let Mike Edwards take this one. He's heavily involved in these discussions and has great experience in this work.

MIKE EDWARDS: Thanks, Richard. To answer the general question around observations, firstly, we have observed from the Federal Government perspective that there has been a reduction in specific levers or grants that were focused on rural, in terms of only being available for rural, because they're looking to address the wider primary care access issue. That has had impacts and continues to have impacts on the ability to provide services and workforce and to incentivise workforce to deliver in rural communities. We have observed, though, that the Federal Government and the State Government are both looking to create consistency in gathering data to create a validation of need across the country and in New South Wales. We've also seen that they are creating these thin market trials, and New South Wales was last out of the country to propose thin market trials. We've also seen the department specifically create sharing groups for the IMOC trials and other trials under the Rural Health Commissioner to look to spread the information across the country so that we can learn from each other, and we've participated in many of those groups.

More towards Collaborative Care—and I'll speak to the IMOC. Collaborative Care was an original notion that was developed in partnership with the Australian Government around four or five years ago, and it was based

on the fact that we could see a continual challenge in specifically providing town-based solutions. The town-based solutions, in trying to sustain a very distinct workforce—primarily a GP workforce in the most remote areas—were being challenged. The work required to provide that workforce was then being rotated over a couple of years. Where, years ago, you may have been able to provide a sustainable GP or allied health service, the rotation of those services continued to change over time, so much so that we would have to this every couple of years. We approached the Government to think about this differently, not to think about it from a thin market and a town-based view but to think about it from a subregional point of view—looking for the subregions, the towns within each of those areas, to leverage the strength of all those communities to create a sustainable solution for that community.

What was really important, and what Richard mentioned before, was creating a method around this. At that time, the Australian Government had asked nationally to come up with innovation—hence the Innovative Models of Care—and we took a slightly different approach. We said that, whilst innovation is excellent, what is required is all of the things that create collaboration in a very complex environment in rural, regional and remote New South Wales. It's all the things that sit below the visibility of governance and process. It's all the things that sit below that that are very important to create sustainable solutions, and that sits at the essence of Collaborative Care. In terms of that, we undertook five trial sites across rural New South Wales that had a consistent method applied across the top of it.

Around that time, the Government then released the Innovative Models of Care. I think we diverted a little bit, because the Australian Government then took a focus on the Innovative Models of Care and the outcomes of those models to then inform potential policy change. But the New South Wales Government took a very strong interest in the Collaborative Care method because it could see the synchronisation of public health and primary health coming together, and an independent broker navigating those complex coordination activities required across regions. I'll stop there because I'll allow more time, but I'm happy to go into more detail when required.

The CHAIR: Ms Saffin wanted to clarify a couple of items, Mr Edwards, before we go on to the Rural Doctors Association.

Ms JANELLE SAFFIN: You said that there had been grants available that were particularised to rural, and now that's gone. Can you give us a bit more of an example—one grant?

MIKE EDWARDS: There's a grant that looks to incentivise doctors to be put in rural communities, Modified Monash Model (MMM) 3-7. That grant is based on a Distributed Priority Area (DPA) classification where we can then apply certain incentivisations. Because they needed to address the metropolitan issues around primary care and attracting GPs, that has been extended to cover almost every single DPA area in New South Wales, which is essentially every location except for central Sydney and, perhaps, a couple of other locations. That means it has been diluted in terms of its effectiveness for rural area.

The CHAIR: I have a question for the Rural Doctors' Association around the actions by the Australian and New South Wales governments that you have seen to address this issue of thin markets and growing the primary care workforce in rural and remote areas.

RACHEL CHRISTMAS: That's a very, very complex area, as has already been eluded to. The Rural Doctors' Association isn't involved in funding any of this or providing these services. We are representing our rural doctors in rural communities. I think there is the danger of the fragmentation of care if we have too many people and too many moving parts within this space. We know that the duplication of services is also a risk because we have State-based services that are available through community health and so on in smaller areas, but we also have the private sphere, which falls more under the Federal funding. That's where it's quite difficult, because we have the opportunity, I think, for people to work across both spheres.

An example I can give to make this relevant would be if you have a smaller town, like a MMM 5 like where I live, you may have an occupational therapist who works in that town privately, but they may also have the scope to do some work in the hospital under a State-based program, being paid by the State. However, those jobs aren't flexible and that doesn't work because they don't have a full-time equivalent or they don't have a contract that actually reflects an ad hoc employment model within a local hospital or in a district sense. I think there are opportunities for collaborating in that public-private space, which is a really difficult intersection. That's where GP VMOs, like me, work. We know that is a really difficult spot.

When we are looking at funding for these services, we have PHNs involved. We also have other collaborative commissioning going on. That's usually been coordinated and looked into by the Rural Doctors Network, who do a very good job of being involved with communities at a very community level and district wide. We need to make sure there are local solutions for local problems. That's imperative. We can't have big top-down initiatives being applied at a local level. I think it's difficult for us as an organisation to comment on the

nitty-gritty of the funding models for that because that's actually carried out through different organisations than ours. But what we see on the ground is a risk of duplication and of things getting fragmented. We need to be very careful that things are streamlined and also that funding streams are not vulnerable to reviews where we lose funding. We have an initiative which might be investing in mental health and then within two years we lose that funding and then we don't know who we refer to. This is a vulnerability within funding models currently, where we don't know whether there's going to be consistency of services. That's something that's a challenge as well.

I have one more comment about the thin market. The single employer model has been a useful thing in allowing GPs to be paid by the State Government system to provide primary care in very challenging towns where there is no GP. The 4Ts within New South Wales are a good example of that. That has been a good initiative where that State-Federal collaboration has been shown to be effective. I think that was a really good move and there's a lot of potential for that to be applied in other areas across the State.

SUE VELOVSKI: Just following on from Dr Christmas, Susi and Mike, I think Susi mentioned a few points in relation to the relevant KPIs. Speaking as a specialist general surgeon in our rural-regional hospital, which is supporting rural MMM 4 to 6, there are a lot of KPIs that are metrocentric that don't fit rural and regional areas, but we have to abide by them under NSW Health guidelines. As Dr Christmas also said, the single employer model has been extremely positive, particularly we see the gold star in the Murrumbidgee. But other local health districts are not buying into that, for reasons of funding, we are told. We have young doctors who are very keen on the single employer model and keen on rural generalism who are leaving, for example, areas in northern New South Wales to go to Wagga. Their fortune is our misfortune. In just a few years, I have lost six really good residents to go to Wagga. They actually liked the Northern NSW Local Health District. That's our loss.

We've also seen, through the Rural Doctors' Association, three or four very good trained doctors and rural generalists with a special interest—for example, two in paediatrics—leave to go interstate to Queensland. We had a fantastic obstetrician rural generalist go to Karratha in WA because at the end of their training the job prospects were not available as they are in other health districts. In essence, we're using our funding to train very good rural generalists but then they're going elsewhere. That's a travesty.

In terms of Mike's submission and information, I think he talked about innovative models of care. Ms Saffin wanted an example. One of the examples I could give you is from our local health district in northern New South Wales. In 2016 all our GPs, surgeons and specialists got together at a meeting that we organised because we had concerns about futile models of care, futile medicine and futile surgery. We were expecting maybe five or six people, but we got 200; we had the whole community of doctors there. We did that off our own back in our own time. We discussed, with the help of medico-legal experts. It was lovely that the LHD jumped on that. I think there were innovative levels of models of care funding for two years. After that the funding for the CNC and the funding for the monthly MDT meetings—whole of hospital and whole of community—just disappeared.

The CHAIR: Could you just expand a bit on "futile". You had a meeting around futile models of care. That is what you said. Then a project emerged from that. Then two years later the funding stopped. Could you describe the project?

SUE VELOVSKI: Yes. For a couple of a years before—we teach our surgical trainees about frailty in surgery et cetera—we were seeing, occasionally, people languishing in the hospital system. GPs were not being involved. We really reiterated this. I set up a meeting. I knew if I called it "End of life care" no-one would come. But we actually called it "Your medico-legal obligations in 2016". In the NHS, for example, there are specialists being tried for medical manslaughter—knowing that someone is going to die but doing a procedure anyway. There have been discussions and information presented in Queensland Parliament under parliamentary privilege about how many patients anaesthetists thought wouldn't make it but they still operated. We used that evidence base to do a Q&A sort of Geoffrey Robertson hypothetical. We advertised. We did it all on our own. We went around to the GPs. My personal staff went around and we advertised it.

We hoped to get maybe 30 clinicians from our area. We actually ended up with standing room only and had over 200. We came up with some really good proposals, working collaboratively together. The next year we were asked to put it on again. But then we didn't realise as clinicians that there was funding and a paid end-of-life care project was activated. Apparently, there was funding each year by New South Wales, is what we were told—State Government for two years. But when that funding expired, all that good work ceased. We were doing monthly MD team meetings, and all our allied health team—all our clinicians, the GP whose patient it was, because we were trying to teach our junior doctors it is the GP that is the cog in the wheel, and they can tell you so much more information over the one phone call about the family, rural et cetera, et cetera. I'll not waste any more of your time, Dr McGirr.

The CHAIR: So it was a collaboration around improving end-of-life care by bringing a range of players together and emphasising and linking to the role of a general practitioner?

SUE VELOVSKI: Yes.

SUSANNE TEGEN: If I could quickly say something, what you will hear today and tomorrow, it basically is that there are some fantastic solutions on the ground—that we have clinicians that are really passionate and understand the population health need and the socio-economic need. We are continuing not to address the fact that we don't have a national rural health strategy, nor do we spend the underspend or allocate the underspend. If we have the underspend for those communities, you would have place-based solutions that would actually work. But rural, remote and regional New South Wales, like the rest of Australia, is having to beg and borrow and raise funds after people have paid their taxes, they've paid their Medicare levy, they've worked in the industries that are bringing in the income for Australia, and here we are. We actually need to address this disparity and inequality.

The CHAIR: Can I follow that up, with the permission of my fellow members? This is the $6.55 billion underspend because there aren't clinicians providing services in the way the Commonwealth funds services, because you've got to have clinicians there to fund the services.

SUSANNE TEGEN: It is not just not clinicians, though; it is just the way the money is spent. It is inflexible and it is not targeted. It doesn't allow for continuation.

The CHAIR: We are in the midst of the national rural health reform agreement. You have referenced the evaluation of that. I think, from your submission, and from what you've said, you're proposing that those funds that are currently not spent, whether it is inflexibilities or lack of services, or probably a combination of both—that somehow those funds are made available between the Commonwealth and State so that communities can access them for innovative models of care and to attract people to particularly remote and rural locations. Is that correct?

SUSANNE TEGEN: Correct.

The CHAIR: Does that link to the PRIM-HS model?

SUSANNE TEGEN: The PRIM-HS model, but also for infrastructure for expansion of services, for training, for housing for trainee students—all of those things. Let's just give people equity in access in the first place and stop having to get rural people to beg. Whether they are clinicians or community members, they should not have to beg. We are not expecting Woollahra or Randwick to beg. Why are we expecting rural people to beg?

Ms LIZA BUTLER: Thank you for your attendance today. I want to delve a bit more into workforce. We know that the New South Wales Government has a regional health strategic plan for workforce. There is a national medical workforce strategy from the Federal Government. We keep hearing that the implementation is not great. Do the State and Federal government plans have accountabilities, such as KPIs, that you're aware of? How do you report that back to the governments?

RICHARD COLBRAN: The workforce component is very, very important. It has formed a major part of the initial rural health inquiry and also the continued discussions of this Committee as well. The Rural Doctors Network is of the opinion that workforce should be everybody's business, not a particular agency. Anyone who is working in rural health must be able to demonstrate—or should be required to demonstrate—contribution to the development and retention of workforce. One of the critical components that is well known globally is the first piece about workforce needs to be about retention when it comes to remote and rural practice. What tends to happen is initiatives and policies that are launched often talk about incentives to bring people, but it forgets the wellbeing—the professional support—of those that are already committed and already working in remote and rural.

In terms of the question, in terms of what is working or how to take things forward, we would always be talking about to make sure very first of all we think about those that have already made the commitment to remote and rural practice, and that more should be done in that case. Dr Christmas spoke a little bit earlier about the fact about the New South Wales Government's recent announcements to incentivise attraction to rural practice. We would also like to see the accountability or the reporting of those outcomes to differentiate between those that have now moved into remote, those that have moved into rural and those that have moved into regional, as opposed to just one singular answer which is about regional.

The other component of that—and Dr Christmas alluded to this, which I appreciate, because it's interesting that you start to hear different people talk about similar things—is it is also about how many of the people that are reported through those campaigns or new announcements are actually new to remote and rural practice. We suspect, on the topic of integration, that there are many people working in private practice outside of the State health system. How many of the people that have been taking advantage of the New South Wales Government's announcements are actually new to rural as opposed to being mopped up from systems and ways of working outside the State health system?

Just finally, the piece about accountability I think is a very important topic for this Committee. Our memory and our reflection from the original rural health inquiry is that it talks a lot about accountability and transparency. We think that that continues to be very, very important for us to be looking for. Anyone who is participating and receiving Government funds need to be able to demonstrate a response to a coordinated or a targeted plan that relates to workforce. We would certainly recommend continuing to think in that way as well.

The CHAIR: Dr Christmas, would you like to make a comment there?

RACHEL CHRISTMAS: Yes. Workforce remains a big issue, as you can understand. I do agree with what Mr Colbran said about retention being a very big part of the responsibilities of the New South Wales and Federal governments. There are lots of rural doctors that I speak for in rural communities who are working very hard for a very long time. The difficulty here is they work in private practice and they work in the hospitals as contractors. From a NSW Health perspective, we are not employees; we are contractors. Therefore, we don't actually come under any support from NSW Health or the New South Wales Government in terms of incentivising us to stay, in terms of support for workforce.

If I leave my practice, the town loses a GP and the hospital loses a VMO. However, traditionally, LHDs have not taken any role in looking to recruit GPs to towns or to hospitals. This is an area where there is that breakdown in that State Government and Federal Government divide. Rural doctors need a lot of support. That includes things like locum relief so they can actually go on holidays. Those locums need to be able to provide GP services because it is often not the hospital work that's the problem; it's the load in general practice, which is a huge load which is not seen—it's not visible at a State level. That is a really important area where we are looking at retention of workforce and encouraging new people to join.

When junior doctors come out and join us as a registrar, doing their training in general practice, the workload is significant. It is not just in the hospital; it's a significant burden of general practice in that community. That needs a bipartisan Federal-State collaboration on how we support those communities—support those doctors and doctors in training to make it a career that is sustainable and supported both through their ongoing education and training and maintenance of skills. This needs to be coordinated and supported at all levels.

RICHARD COLBRAN: The point raised by Dr Christmas relating to VMOs, or visiting medical officers, is very, very important. If I may refer the Committee back to evidence given by Dr Tom Douch about 12 months ago, I think it was in this room in the workforce session. Dr Douch, a very experienced and long-serving GP in Young, spoke to the notion of the word "visiting" in the whole title of VMO making the doctor feel like they're actually a visitor rather than an integral part connected to the State health system. I think it's such a great case study to talk about when you think about integration, so I thought I'd just reflect that back here.

You might recall also that some of the things that we're talking about, these very special doctors, who are the GP proceduralists who are able to keep our hospitals open—and also our remote and rural practices. I think our data suggested that about ten years ago there were over 800 of these rural proceduralists. Today we're down under 180. These are the people who I call our national assets. They are the ones who are holding the system together and they are the ones who are bearing the brunt. The notion of generalists is very important. While we're obviously here mentioning doctors today, this relates to every practice and craft group within health: our nursing, allied health, midwives and Aboriginal health workers, all the way through to the administrators. The ability to retain people in this very complicated environment and celebrate them and let them thrive, both personally and in practice in their profession, is absolutely essential to the story to support rural health moving forward.

The CHAIR: I'm just going to flag a question on notice to you to expand on what you would recommend in terms of retention, just in the interests of time.

RICHARD COLBRAN: Thank you, I'll prepare for that.

SUE VELOVSKI: I concur with Mr Colbran and Dr Rachel Christmas. Some examples I can give. Every community is going to suffer a natural or unnatural disaster, but when we did in Lismore, we had some GP registrars come and then we didn't have any accommodation for them because of the floods, so they left—similarly with other registrars. Then other things like there are Commonwealth and State grants for specialists to go and upskill or learn a new skill—a small amount of a few thousand dollars—but the grants have been rejected for our rural and regional colleagues when we ask for back-funding to go for a locum to cover our clinics so that our long list of patients didn't have to wait because we were away for a week learning a new skill.

We were advised that the money could be used for accommodation and food, but not for locums. Most rural and remote doctors who want to upskill know plenty of people in the city who will billet them, for example, but I think it's really important. We work really hard and we know the waitlist of our patients, particularly cancer patients. We think very hard before we put in a submission for one week away from our family and community.

To be knocked back because that $10,000, which will barely cover a locum—that's the rejection. You think, "What's the point?" People just stop applying for those grants.

SUSANNE TEGEN: I just wanted to concur with Dr Christmas, Dr Velovski and Mr Colbran. We've heard of communities or individuals in communities in New South Wales—one where the nurses were actually not being paid very well in their community. Then they had two nurses who were brought in. They were fly-in fly-out, but they only had to work four days a week, and they were also receiving the cost of a course being covered at a university, which had really nothing to do with their day-to-day work. In addition to that, they had their accommodation paid. Yet the nurses on the ground and the doctors were having to work twice as long. They didn't have the same conditions. No wonder people were leaving. We just need to level the playing field. Whether they're private, whether they're public or working for a health department or they're working for local government—because local government has picked up the pieces—I think we need to level the playing field.

Ms TRISH DOYLE: Thank you all for participating today and for your insight and work on the ground. As a girl who came from the country, I think it is important for us to acknowledge and reiterate what we're hearing from you: that there are local solutions for local communities, and it can't come from the top down. Thank you also for being brutally honest; I hope you continue to do so. I'm going to direct a question to Dr Christmas from the Rural Doctors Association around your submission that notes that, although PHNs and LHDs are "collaborating" on the organisational paperwork, PHN work is often disconnected in a functional sense. Can you elaborate on that—and anyone else who wants to comment.

RACHEL CHRISTMAS: PHNs are very important in their relationship with general practice. However, there is some degree of collaboration. I know in my district, Murrumbidgee, there is a formal collaborative arrangement between the LHD and the PHN. But an example I will give you—duplication of services is one. We have a dietitian who comes in who's part of the PHN. She is under-subscribed because we also have a dietitian who works at the hospital who is also part-time and also has a private practice. We know that the one who comes to our practice from the PHN can't see people who either have a GP management plan temporary arrangement where someone has already used up all of their dietitian appointments so they can see them extra, or if they don't qualify for a GP management plan. You're looking confused. It is confusing.

They can see this one, but otherwise they can see the hospital one where they don't need a plan. Then I refer to a different online referral system, which is a central intake one. But if they don't want to see that one and they have a GP management plan with a team care arrangement, they can see the private one. Have you got that straight? Okay. That's an example of where we have confusing systems which rely on different funding, which is confusing to a GP. And then we may not have the same dietitian who comes in, or the provider changes because a contract is renewed. These things create confusion. We have three different referral pathways and three different indications to that a referral. Honestly, I've got better things to do in my day than work out who needs what—which person I need to send you to based on what requirement. You just need to see a dietitian, for goodness sake. This is where it's frustrating.

I also know that PHNs spend most of their budget on mental health service provision. It's interesting to know that, in the Murrumbidgee, I think it's around 40 per cent of the budget for Collaborating Commissioning is on mental health, yet we don't have a PHN mental health worker in our practice. We lost ours and we haven't got a replacement. Mental health is a huge problem. We don't have someone at the hospital who can see people because they were told to prioritise domestic violence counselling and so can't see generalist counselling. We have one psychologist who comes once a week who's oversubscribed and it's not a one-size-fits-all. We need to have a variety of different people.

This goes to show that, even though there is goodwill here, we are not necessarily getting the funding where it's needed for the services that we need as a community. It's been hamstrung by a requirement that our hospitals have to prioritise domestic violence when we see that we may need different priorities depending on what we're seeing. What we're finding is these things aren't talking. We're not looking overall at a strategy and how the funding models from Federal and State and the way the services provided are brought together into an easy system that someone like me, who thinks pretty simply, can negotiate easily.

Ms TRISH DOYLE: Does anyone else want to comment on that? Rural Doctors Network?

MIKE EDWARDS: Sure. I think PHNs and local health districts and the Ministry of Health are funded to achieve two different aims. Collaborative Care, that we mentioned before, sees that that's an important part of it. Richard mentioned before that it is everyone's business in terms of coming up with sustainable solutions in the region. That includes the universities and the Aboriginal Community Controlled Health Services, the councils—everyone. I think what you see in terms of that relationship is their ability to respond to what's visible, their funding arrangements, their governance structures and the processes they've got to then respond to. Collaborative Care tries to then bring together all of those invisible components. What's it going to take to understand community

need? What's it going to take to develop the trust between the stakeholders, who have very different priorities, to come together for a regional outcome or purpose? What's the distribution of power between all the different people that hold the funding? That very much alludes to Dr Christmas's comments around not being able to articulate or have the mental health needs in GP practices being met when it's being overridden by potential PHN needs to respond to a funding arrangement.

The CHAIR: I understand the separate funding streams and the separate purposes—I get that. But at the end of the day, they are both operating in a community. Frankly, those descriptions of different funding streams just strike me as an excuse. At the end of the day, you're both working in the same community. There should be a capacity for the LHD and the PHN, at least at the start—and I realise there are other organisations—to coordinate activities so that there's not duplication and gaps are filled. That's a comment from me. I'm a little bit frustrated, but I'll accept that.

SUSANNE TEGEN: Dr McGirr, that is really why we've developed, with stakeholders and communities, the PRIM-HS model, because it's not a practice as such. It is everyone sitting around the table—local government, the health workforce, the different PHNs, workforce agencies and industry—and then you look at that community. As I said, we are focusing mainly on MMM 4, 5 and 6. What they do is they sit around the table and go, "This is what we are funded for." That's why you need the transparency that Dr Colbran referred to before. You say, "Look, this is our population health need. This is what currently exists." You map it and then you say, "What is it that we need in this community to address our population? We've got the PALM workers coming in at a certain time of the year and we've got this many tourists coming in. What is it that we can actually deal with and what can we fund that will make a difference?" I'm not saying it's a solution for everything, but it develops the collaboration, the discussions and the sharing and resources. But you need the flexibility of funding and you need to have an independent chair to bring it all together, because the priorities of the stakeholders will always be at the front and centre.

The CHAIR: I think we might bring it to a close. I thank all of the witnesses for coming today, appearing before us and sharing your evidence. It has been very good. I think we flagged a number of questions that you're going to take on notice. You will be provided with a copy of the transcript of your evidence for corrections and questions on notice. We may send you further questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide written replies to any further questions? People appear happy to do that—thank you.

(The witnesses withdrew.)

(Short adjournment)

Dr IAN KAMERMAN, Representative, Royal Australian College of General Practitioners, affirmed and examined

Adjunct Associate Professor LEANNE BOASE, Chief Executive Officer, Australian College of Nurse Practitioners, before the Committee via videoconference, affirmed and examined

Mrs REBECCA SEDGMAN, Policy Advisor, Australian College of Nurse Practitioners, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome witnesses from the Royal Australian College of General Practitioners and the Australian College of Nurse Practitioners. For witnesses appearing in person today—that's you, Dr Kamerman—please be aware that staff will be taking photos throughout the hearing. If you have any concerns, please let us know. Can I confirm that witnesses have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

IAN KAMERMAN: Yes.

LEANNE BOASE: Yes.

REBECCA SEDGMAN: Yes.

The CHAIR: Would both organisations like to take the opportunity to make a brief opening statement?

IAN KAMERMAN: Not from me.

REBECCA SEDGMAN: On behalf of CEO Leanne Boase, the Australian College of Nurse Practitioners and our members, we would like to express our thanks to the Committee and the Chair for the opportunity to participate in the hearing. The Australian College of Nurse Practitioners represent nurse practitioners, advanced practice nurses and future nurse practitioners across Australia. As part of that, we also advocate for improved access to health care. To begin, I'd like to highlight our recommendations as provided via our submission and to extend on these recommendations throughout the hearing as required. The ACNP endorses, regarding recommendation 11, the development of the 10-year rural and remote medical and health workforce recruitment and retention strategy, also noting in this that the strategy should align with the National Nursing Workforce Strategy and the Nurse Practitioner Workforce Plan to ensure sustainable growth of nurse practitioner led or supported health services across regional and remote areas.

The CHAIR: I'll start off the questioning to both of you, and I'll start with the Australian College of Nurse Practitioners. You have in fact referenced the strategic workforce plans. I wonder if you're aware of collaborative work between the New South Wales and Commonwealth governments to design or implement strategic plans for New South Wales in regard to its regional health workforce?

REBECCA SEDGMAN: I might hand over to Leanne on this one. I haven't heard about that collaborative arrangement or how we can support that arrangement within the college. Leanne might have a bit more background on that.

LEANNE BOASE: Sure. I'm not aware of any direct or targeted work between the Federal Government and New South Wales in relation to this. However, through some of these larger pieces of work, probably most relevant—the one that I can speak to—is the Nurse Practitioner Workforce Plan. That does refer specifically to health service delivery by States and Territories and how that plan needs to be considered and incorporated in order to address healthcare needs in States and Territories. It does feed down from Federal into the States in regard to health Ministers and providing advice to health Ministers in different States and Territories. That's the only way that I can say the ACNP has been directly working on something between the Federal Government and the State of New South Wales.

The CHAIR: Is that a Commonwealth plan around the nurse practitioner workforce?

LEANNE BOASE: It is a Commonwealth plan, yes.

The CHAIR: Can you outline in a little more detail what the objectives of the plan are and what the expectations are on the States in regard to implementing it?

LEANNE BOASE: There are a couple of key points, I suppose. The workforce plan is not only about increasing the workforce; it's also about fully enabling it. There are a number of Federal legislative barriers and regulatory barriers around authorisations and certifications, where nurse practitioners are trained and ready to work but come across these barriers which limit their practice. In regard to States and Territories, we do tend to do things eight different ways, slightly, across the country. There's variation. It affects every health profession. What the Nurse Practitioner Workforce Plan is looking for is alignment of legislation, regulations and everything

that affects the practice of healthcare professionals—just seeking effort and work from all of those States and Territories in regard to alignment, not only with each other but also with the Federal workforce plan and the objectives in the Nurse Practitioner Workforce Plan. So it is putting some pressure towards the States.

Recently also the *Unleashing the Potential of our Health Workforce – Scope of Practice Review* referenced the same thing—again, not just for nurse practitioners but for all health professionals—highlighting the differences between States and Territories in legislation and the way health professionals can work, what they're permitted to do and what the barriers might be to their practice. I think this is one thing that we're seeing across a few plans from the Federal Government—the intention to start trying to produce, wherever possible, alignment and something that's more navigable for health professionals. Many health professionals in Australia work across borders too.

The CHAIR: To follow up on that, in terms of NSW Health and rural and regional health care, are there steps that the New South Wales Government should be taking to facilitate nurse practitioner roles in rural and regional areas?

LEANNE BOASE: Absolutely. Bec, did you want to talk to that?

REBECCA SEDGMAN: Yes, I think there were some goals or actions to be arranged in three time frames. The short-term goal was to remove the barriers, which we're trying to do through the Pharmaceutical Benefits Scheme (PBS) and Medicare Benefits Schedule (MBS). Then medium term, which is three to five years, was to grow and expand and build the workforce, but that needs some sort of explicit funding because the growth of the role has been so slow within Australia and within New South Wales. We were talking through this and how many nurse practitioners should be in the workforce currently after the model being around for over 25 years. We're sitting close to 3,000 when we should be around 20,000 nurse practitioners across the country and we're not sitting anywhere near that.

The problem with that is that there's no explicit funding of models directly for nurse practitioners, so these funding models from the Commonwealth need to be supported to grow the workforce. In that plan is the longer term goal for five to 10 years to increase access to NP care so that those who want to access a nurse practitioner have the ability. In that regional or remote area, sometimes a nurse practitioner is the only clinician in that area supporting health services and health service provision. If there are restrictions on their practice or restrictions on access for patients, this then hampers care provision. The plan basically is to support the growth, but the growth also needs funding in order to meet those higher targets of employment.

With that also comes education frameworks which can be supported alongside the medical colleagues and our allied health colleagues in interdisciplinary models of care so that, if there's a training program that's open to GPs, it should be open to allied health and open to nurse practitioners so that we're not doubling up on these frameworks of education—alongside that scholarship money to enable nurses in advanced practice models of care to also then educate themselves at that higher level to become NPs. That ongoing financial support, supporting roles out in the community, is key to this.

The CHAIR: I will go to Dr Kamerman now. The same question—it's around collaborative work between the Federal Government and the New South Wales Government in relation to strategic workforce planning. I'm particularly interested in that in relation to general practitioners, given that you're from the Royal Australian College of General Practitioners. The context here is that the Committee continues to hear of issues with primary care, shortages of primary care in rural and regional areas. In fact, we heard this morning in relation to rural generalists that 10 years ago there might have been 800 rural generalists but it's now less than 200 across the State. Certainly, that's evidence we've received. From the point of view of the college of general practitioners, what are you seeing on the ground in terms of addressing issues around the primary healthcare workforce?

IAN KAMERMAN: Thank you very much for the question, Dr McGirr. I think the major word within that question is "strategic". I would suggest there's probably no strategic planning that's undertaken between both levels of government. There are a whole lot of programs that exist and we could name them. There's the single employer model. There is the work that both governments are doing as far as rural generalist training programs undertaken by Health Education and Training Institute (HETI) to provide rural generalists within New South Wales. There is the John Flynn placement program that puts junior doctors within general practice, but none of these appear to be connected strategically to meet the goal of improving the workforce, at least not in a joined-up way.

One can look at—a good example is the rural generalist training model that HETI operates. A lot of people within the system would call that the pathway to nowhere because we're training doctors with high-level skills that are not able to find positions within the State and they're all moving interstate. This is a significant problem—

that we're using our own resources here and we've got doctors that want to stay here, but they're unable to find actual positions that use their skills.

The CHAIR: Why is that?

IAN KAMERMAN: There are a number of reasons. The first one is that, I'd have to say, there's a fair amount of resistance within LHDs to actually appoint doctors to these sorts of positions. I can name a number of towns—Kempsey being the first one that comes to mind—where we've got rural generalists who are quite keen to work there, there are obstetricians, but they're not afforded the ability to do so. The health service will not actually appoint them.

You've also got to think about the industrial models. I know the Select Committee did provide a whole lot of recommendations around the industrial model. I work with the Rural Doctors' Association—another one of my roles as far as developing industrial models for the employment of these doctors. It's bogged down within NSW Health trying to develop appropriate rates of pay for these doctors. We're nowhere near the rates of pay that are provided by other States. On top of this, if a new registrar is looking at where they're going to work—I mean, Victoria is offering $40,000 for a registrar to set up. Queensland is offering similar amounts. New South Wales is offering nothing.

If you look at the latest GP registrar numbers coming through, it's oversubscribed. It's oversubscribed at a national level but New South Wales, particularly western New South Wales and my region, which is the New England north-west—I work in Tamworth. Very few registrars are going there. Again, we think this is probably due to the incentives that various States are offering to attract registrars to work in their areas. We look at things like the John Flynn program, where you've got doctors that are keen to get general practice exposure. That's really good, but it needs to be enhanced significantly. Every doctor needs the opportunity to be able to get experience in general practice. At the moment, probably about 16 per cent of medical graduates are ending up in general practice, and Australia as a country needs roughly 40 per cent to enter general practice. We're not providing examples to the junior doctor workforces working within general practice.

We can look at the single employer model. The single employer model is all about—again, it was the Murrumbidgee model that started this. It's about locally developed models that enable junior doctors to actually be engaged within the New South Wales health system and work within general practice, as well as working within the hospital and maintaining their entitlements. I would say that the New South Wales model is close to a disaster because this is a statewide model. It doesn't allow any local adaptability. The whole strength of the Murrumbidgee model, the whole strength of the Riverland model, is about local clinicians, local non-GP specialists, local GPs, local practices and local health facilities getting together and working with these doctors. A statewide model doesn't allow any of that. There's no flexibility, and it's really hard to engage and encourage those doctors to stick within the system.

Ms TRISH DOYLE: Thank you. That's a very honest answer.

Ms JANELLE SAFFIN: I've got two questions for both colleges. Following on with Dr Kamerman, NSW Health notes that the Australian Government is responsible for GP training positions. You've alluded to some of this, and we know that some State funding has been approved for rural intern positions. That's in their progress report. Are you aware of this and how the funding will be used, and any other efforts made? I think you've answered it somewhat by your answer to Dr McGirr, but I just wanted to drill down on that in particular.

IAN KAMERMAN: I don't see how rural intern positions would necessarily immediately flow into general practice training. I think it is great that they've offered rural positions. I think it offers excellent skills and training. But often the issue is that the hospitals that they're working from largely do not have GPs working within the hospital. I'm a very old-fashioned and probably out-of-date GP. My model of practice is working within the community and working within the hospital in the same role, the same time. I used to work in larger hospitals. I work in smaller hospitals as well. There are no positions available or encouraged for GPs within the New South Wales hospital system, other than very small hospitals. Again, it means that these interns do not get exposed to what high-quality medicine a GP can provide within a public hospital system. And the relationships that GPs have with their patients over the long term can enhance their health outcomes as well.

Ms JANELLE SAFFIN: So should we have a lot more positions within the hospitals for GPs but with proper remuneration?

IAN KAMERMAN: I would thoroughly agree with that. We need to somehow bring GPs back in within the hospital system. But, of course, the problem is that there are not enough GPs to service the population within their own private rooms as well.

The CHAIR: There aren't, but you've got to start somewhere. There's always that chicken-and-egg argument, and we get that all the time, "Well, there's not enough." But you won't get enough unless you strategically act. I want to pick up on Ms Saffin's comment because it's quite important. Dr Kamerman, there are two aspects to this. One is bringing GPs back into hospitals. I would suggest that with rural generalist training and subsequent maintenance of skills, there is a great opportunity for rural generalists to provide anaesthetic and obstetric services in hospitals. That would provide exposure to trainees about what is possible from a career path. It would supplement the workforce. But I think there is a great resistance in some of our larger hospitals to having that. The second point is the John Flynn placements. Correct me if I'm wrong, but this is junior doctors undertaking a term in primary care during the first two years of their training so that they're not exposed to just hospital practice. That's a comment from me, more than anything. Am I picking up your points there accurately, Dr Kamerman?

IAN KAMERMAN: Yes, I think you're absolutely right as far as the John Flynn program. From a rural generalist perspective, I'd also point out that it's also the non-procedural specialities where we're losing doctors hand over fist. A lot of doctors have now done paediatric training in rural generalist. There are no positions available for a paediatric rural generalist. Those doctors that I'm aware of who have done the training and want to practice in paediatrics have all moved interstate.

The CHAIR: The same would apply for palliative care and mental health, where we have workforce shortages, and yet, for some reason, people with the skills aren't being encouraged to come into the hospitals. I'm sorry to butt in there. Back to you, Ms Saffin.

Ms JANELLE SAFFIN: That's fine. I just wanted to hear your thinking on that. Like you, I've been around when the doctors were there, so I've seen all different models operate. I just wanted to drill down. Thank you, Dr Kamerman. I'll move on to the Australian College of Nurse Practitioners. NSW Health noted it engaged with you and the Australian Government to address some of the barriers to creating and supporting nurse practitioner roles. At the beginning you made some reference to that, but can you comment on that, please? Again, that was in the progress report from NSW Health, so it would be good to hear from you.

LEANNE BOASE: I can speak to that in that we haven't actually seen any significant degree of progress on that. We haven't actually been further involved from that point, but we are, obviously, ready to discuss and contribute further, should that arise. But I'm unaware that that's progressed any further from that point.

Ms JANELLE SAFFIN: I read in the progress report that there was engagement. I'm not going to ask you directly. But, anyway, that's what it says in their progress report. But you're saying there's no progress?

LEANNE BOASE: There was engagement.

Ms JANELLE SAFFIN: What was the engagement? What form did it take?

LEANNE BOASE: We provided written feedback.

Ms JANELLE SAFFIN: On the barriers?

LEANNE BOASE: Yes.

Ms JANELLE SAFFIN: Did you make that available to our Committee—the barriers—in writing?

LEANNE BOASE: I can look back and provide that. I can certainly pull that out.

Ms JANELLE SAFFIN: That would be useful, thank you.

The CHAIR: Was that written feedback to NSW Health?

LEANNE BOASE: Yes.

The CHAIR: Have you had a response—further meetings, engagement, discussions?

LEANNE BOASE: No, not of any significance. I do apologise; we do a lot of work with a lot of different governments. But no significant engagement—no significant work since then.

The CHAIR: It would be helpful for the Committee to see that, and also when it went in, and so on.

LEANNE BOASE: Absolutely. We can look into that and provide it.

Ms TRISH DOYLE: My question is to you, Dr Kamerman, and thank you for your honesty. That's what our Committee needs to hear, to drill down to some of your views, your insights and your experiences around some of the recommendations. NSW Health notes that they've collaborated with you to address the social determinants of health—progress report, page 35. What, in your view, did this collaboration involve? Can we note that reaction?

IAN KAMERMAN: I might have to take that one on notice because, I must admit, I can't think of anything that the college has been formally involved with. I'd have to seek further advice.

Ms TRISH DOYLE: More generally, then, did you want to talk to working with NSW Health on a number of these recommendations as it pertains to meeting the recommendations and progress with the recommendations?

IAN KAMERMAN: I think that NSW Health—in the meetings that I've had with them—the issue often is around the social determinants of health, which, of course, is not necessarily within their control. I'm well aware that the Department of Premier and Cabinet does work across departments with local stakeholders within the regions. That's my personal experience. I do a lot of work in addiction medicine, and I see that social determinants of health and issues with that is one of the prime drivers of addiction within rural New South Wales—within Australia generally. One of the major issues why healthcare outcomes are less in rural areas is because of lack of access to transport, employment, accommodation and all those other sorts of drivers. It is a significant issue. I don't think the Ministry of Health is the only one who is going to be able to shoulder that responsibility.

Ms TRISH DOYLE: Fair enough.

The CHAIR: I do want to come back to the College of Nurse Practitioners, but Dr Kamerman, can I just ask you a question in relation to—and this is, perhaps, not what you were expecting—the sharing of patient medical records and the concept of the role of the general practitioner being important, and the handover of care from the hospital to the general practitioner being an important point in the care journey of a patient? I wonder if you can reflect from an oncologist point of view or from your own personal experience on developments in terms of, for example, making discharge summaries available to general practitioners and referral pathways into hospitals?

IAN KAMERMAN: I actually think it's improving. The issue is that general practice has its own well-developed electronic systems. NSW Health itself runs a whole lot of systems. I know they are moving towards a single digital patient record. One of the issues is, how much is general practice involved in those discussions and how well is it able to provide input to make sure that system is actually useful for those within the community, particularly those in general practice. Often, I find, and most of my colleagues would find, that the days of getting a phone call from a junior doctor about a patient who is being discharged are very rare. Occasionally I will have to ring to get confirmation of what exactly is going on. Often I will find patients in the community well before I receive the discharge summary or I have to chase up the discharge summary on My Health Record, which, of course, is a Federal program. It is very useful for that because at least NSW Health does dump everything into the patient's My Health Record.

In terms of me arranging patient admission or patient entry into the NSW Health system, obviously if it's an emergency and the patient needs to go to the emergency department, it's a matter of simple phone calls—I don't have an issue. I have a good relationship with the College for Emergency Medicine specialists. I think that would be the feeling across the State. Often, the issue is more about referral into outpatients. Outpatients is a never-ending list. Increasingly, they are using electronic systems, which may or may not capture all the data that you need to put in a referral. You get no feedback as to when the patient is going to be seen or the length of the waitlists.

The CHAIR: Do all of your patients have access to My Health Record and make it available?

IAN KAMERMAN: No, some people choose to opt out. At the moment, the system is a universal opt-in. You've actually got to take steps to opt out. Some have opted out and that obviously creates problems. But for those who opt in, it is a reasonable system.

The CHAIR: Do the discharge summaries go into that system when the patient leaves the hospital?

IAN KAMERMAN: When the discharge summary is written, which may or may not be when the patient leaves the hospital.

The CHAIR: It would obviously be hard for you to know if there is a delay because you don't know when the patient is leaving the hospital sometimes. They may not come to see you for some time. Then you can log in and see where the discharge summary is, but it may have been entered one, two or three weeks after they were discharged. It's hard for you to see with the timeliness of that.

IAN KAMERMAN: Occasionally, I will see the patient before the discharge summary is written.

The CHAIR: But only occasionally? That sounds like a significant improvement. That's good to hear, actually. I do have another follow-up question for the Australian College of Nurse Practitioners that is related to your earlier evidence, but it's drilling down a little bit more. There is the NSW Health Rural Nurse Practitioners

Framework. How does that relate to what you referred to earlier around the national Nurse Practitioner Workforce Plan? How do they interact?

LEANNE BOASE: I'm not actually familiar with it, which is a bit concerning. It would have been something that I would have liked to have been involved in the development of or be aware of. But that is actually not something we have been aware of. We haven't been a part of that.

REBECCA SEDGMAN: There is the rural generalist framework for GPs. There was a submission that was made about that. But not for the nursing sector.

LEANNE BOASE: Not that we're aware of.

Ms TRISH DOYLE: That's a worry.

LEANNE BOASE: It hasn't come to us for comment or feedback. To be honest, most frameworks like that would usually come to us. We are pretty widely consulted with and informed. But in this case, no.

The CHAIR: Thank you. We'll just have to check our framework.

Ms TRISH DOYLE: My next question is to the nurse practitioners. How can all levels of government, but particularly State and Federal, support nurse practitioners in regional, rural and remote areas? If you had to itemise your top three ways or approaches in terms of the support you require, what would they be?

LEANNE BOASE: I think there should be consistency with other health professions. It comes down a lot to funding as well. I think it's our approach to funding. We're very much about funding through the public sector, the State system or in primary care. Obviously one is State and one is Federal. Rural health doesn't work like that. As the representative from the RACGP was quite rightly saying, the GP will work and needs to do work across primary care in the general practice, if there is one, and in the community, but also in the hospital. What we want and what we need is health professionals who are able to work across both sectors. The funding has to work that way as well. You can't fund in silos because what you'll end up doing is having health professionals working siloed in different systems. That's not how people work or how health works. I think particularly for rural health, we have to find ways of blending our State and Federal funding systems. Unfortunately, like it or not, funding systems do end up siloing health professionals into certain areas of practice.

I would draw parallels with other health practitioners on this as well. It affects all of us. In the case of nurse practitioners and funding, yes, there are very significant known blocks within the MBS. They are felt particularly sharply in rural and remote areas as there are no incentive programs or anything tied to nurse practitioner services where they might be operating in their own practices or providing services to regions as, often, the only primary care provider in the area. Also, in the State system it is an ongoing battle to provide justification for the tools needed to establish a nurse practitioner role in NSW Health as well. Some areas' health services do it really, really well. They really do. There is some improvement there. I recently went to Hunter New England. They're developing fantastic models of implementing nurse practitioner roles. There is hope and it's not that everybody is doing a terrible job or anything like that. But we still have a way to go.

There's a lot of misunderstanding about nurse practitioner roles as well—that we're trying to replace GPs or we're substitutes or things like that. We are actually a profession in our own right. Just because we can do many of the same things, we may come to outcomes in a slightly different way. We're obviously nurses. But there's a bit of misunderstanding there. Just in declaration, I've worked rural, remote. I've worked in the model of the GP that works in the community, in their own GP clinic and in the hospital. I've been the nurse that provides some of the cover, so the GP is not doing 24/7—so I've been the advanced practice nurse that's provided that cover. As I became a nurse practitioner, that was very promising, that I might be able to work in the same way. The GPs were very, very keen for that to happen because they're exhausted. It's a tough role. It's a hard place to work. It's extremely rewarding, but only if you allow it to be in that they're not on call 24/7, they're not having to do everything unsupported, that they've got a better team to work with.

So we see the nurse practitioner role as potentially functioning in some of the same ways that that model—and that is a great model because the community connects really well with the health providers, and the health providers can have a life outside of work and function much more effectively and have a much more rewarding role. I speak from a lot of professional experience here, myself. Back in that community, the GP was largely funded by MBS, which wasn't always ideal, and also visiting fees into the hospital. There were two different sources of funding. I think we just have to find our way through better ways of funding services that reach across the Federal and State system. That would be my biggest, probably, objective.

The CHAIR: That's really quite profound.

LEANNE BOASE: A lot of the other things we can and will overcome.

Ms TRISH DOYLE: So consistency, funding—

LEANNE BOASE: Flexibility.

Ms TRISH DOYLE: —and not just for the nurse practitioners but for health professionals across all sectors rather than the siloed approach?

LEANNE BOASE: Yes.

The CHAIR: Just to clarify, when you were in that role, you were funded by the State system, by the sound of it?

LEANNE BOASE: I was. I was employed by the hospital and so if the GP clinic was closed, the community would come to the hospital for their urgent care needs, their primary care needs, their emergency needs. They would come to the emergency department that wasn't funded, and I would be either the nurse on call for the hospital or I would be the nurse looking after the acute ward in the hospital, and I would simply move physically up to the emergency department and take care of the patients. Now, I would do that in one of three ways: I would quickly identify I needed to call a doctor in; I would be able to manage the patient with a telephone consultation with the doctor; or I would handle the patient independently, depending on my experience, training and my authorisation. That's much the same for nurse practitioners and every other health provider. We should be able to escalate as we see appropriate and when we see appropriate.

But I was fully funded by the State in that role. When I become a nurse practitioner, though, I have the opportunity of also then going and working alongside the GPs in their practice and seeing patients in that context as well because the Medicare funding is there for that. But it's still a very siloed approach. There's always that interplay between "Am I better off financially seeing them in my GP clinic or am I better off financially seeing them in the hospital?" That's not something that health professionals should have to be thinking about because of the different ways of funding. It should be about when, where and how best to deliver the healthcare service to the person.

Again, the other thing that is emerging in Australia—it has been for quite some time—is nurse practitioner-owned clinics, particularly where there might not be a GP clinic. I always say, as someone who has owned GP clinics in the past, it is extraordinarily expensive to build a GP clinic and to operate one. It is similar for nurse practitioner clinics. It is very much a brave individual that will do that—build that infrastructure as a private business owner. We do have nurse practitioner clinics emerging, particularly in rural and remote areas. One that comes to mind is Mallee Border Health. That works around the border of Victoria and New South Wales up in the Mallee. They service a huge region of Victoria—north-west Victoria and South Australia. They are nurse practitioners that own the practice. They have a GP come in once a week to basically sign the paperwork that they are not authorised to sign. But they consult with all different types of health practitioners for their patients, remotely, to support them: medical specialists, GPs, allied health. They have a great network that they draw in through the very presence of their physical practice but also the community that they serve—they draw in a lot of other health professionals.

It is not a terribly financially stable model. Because it is a nurse practitioner-owned clinic, it doesn't get any practice incentives. A good example, too, of one of the things we've been working on is allowing practices like that to go through a rigorous accreditation process so that in the future they might be eligible for those types of supportive incentive programs. There is a lot of work we can do to think about what types of practices can survive in more regional or rural or remote areas and how we want them to work and how we want to fund them. I think there is a lot of work we could be doing.

Mr CLAYTON BARR: I want to go back to the NSW Health rural nurse practitioners framework. I am mindful that you are not familiar with the document. It was released early in 2023, so it's almost two years old. The purpose for the document—I will read this little part. It says:

> The framework complements current NP practice, regulatory, professional and educational requirements as outlined by Nursing and Midwifery Board of Australia …

That is a different organisation. Can you explain to me how they work and how you work, and how you are separate but similar?

LEANNE BOASE: The Nursing and Midwifery Board of Australia is one of the boards under AHPRA. They are the regulatory body. Like the Medical Board of Australia, the Paramedicine Board of Australia, they are the regulators of the profession under AHPRA. They, as the regulators, also implement the standards for practice and the standards for education. Specifically, in what we are talking to in relation to nurse practitioners, there are rigorous standards for the education of nurse practitioners in Australia that are implemented and endorsed by the

Nursing and Midwifery Board of Australia. We are the professional college for nurse practitioners. We inform policy and we support the growth of the profession as a professional college.

Mr CLAYTON BARR: Can I take Dr Kamerman back to something that he said earlier? Dr Kamerman, you were describing a scenario where sometimes when we get rural generalists that do further training in paediatrics et cetera, there's no position in NSW Health, or the LHDs don't have positions available for these people. Is that what you were saying? If that is what you were saying, why is that? Is that in some sort of flowchart of the employment of our teams, that there is no spot allocated to these types of role? We seem to be desperately short of, for example, paediatricians.

IAN KAMERMAN: Thank you very much for the question, Mr Barr. I thoroughly agree with you. It makes absolutely no sense that you can be an LHD that provides training for these doctors to get them through their advanced skills, to get the rural generalist qualification in paediatrics, and at the end of the day refuse to offer them a position within your LHD. I would love to ask the chief executives of the LHDs as to exactly why they are doing this because it makes absolutely no sense. Consequently, these people take positions in other States. Two that I know have gone to Queensland.

Mr CLAYTON BARR: Is that just a decision by an LHD about whether or not they're going to create a position and allocate the wage to that?

IAN KAMERMAN: I think Dr McGirr commenced this by talking about strategic planning, and I said it's lacking. There's no linkage between the thought process about "Hey, we're providing training for these doctors" and then using those doctors to provide the medical workforce with highly specialised skills within their own districts.

Mr CLAYTON BARR: I'm befuddled.

Ms TRISH DOYLE: Mind-boggling.

The CHAIR: It also links to a concern we have about the maintenance, say, of obstetrics service in small hospitals. It's just not understandable. We're really concerned that those services are going. We need a pipeline of rural generalists. You would think there would be positions available and a plan to train and provide those—not just GP obstetricians but, of course, midwives and appropriately skilled nurse practitioners in that space, although they would be midwife practitioners. I hope I got the terminology correct there. There isn't a plan for that. I realise you have put your hand up, Ms Sedgman, but do you think there is a resistance from specialist doctors in some hospitals to having GP advanced-skill proceduralists as part of their rosters in some areas?

IAN KAMERMAN: I would agree that, certainly in some areas, there's resistance from non-GP specialists about having GP colleagues working in the same space. I don't think that is necessarily widespread. Considering that these are also the doctors who are heavily involved in providing the training, most of them would obviously be satisfied with the skills and capacity of the doctors that they've trained, so there is that sort of linkage and flow there. I think one of the major problems is that there is this focus within local health districts on budgets and funding. That seems to be what bogs everything down, rather than the provision of patient care, particularly in rural areas, and what can be made available.

If I can give you a very bizarre example that's happening with me, I've been really successful in recruiting. I've got two new rural generalist registrars signed up to work in my practice. Unfortunately, I don't have a practice in a town that has a functioning hospital emergency department, so I've written to the appropriate person in the local health district to say, "Hey, look, I've got some staffing here. Do you need help? Can we take on working in a small-town rural hospital? We'll look after the inpatients. We'll look after the emergency department. Where would you need us most?" I'm still waiting for a reply.

Ms TRISH DOYLE: Oh, my goodness.

The CHAIR: That's very interesting. Ms Sedgman, you've raised your hand.

REBECCA SEDGMAN: There are a few points that you've asked Dr Kamerman around social determinants of health and access to care, and that nurse practitioners in this space don't have access to Medicare health assessment items for that preventative access. Patients who attend a nurse practitioner in these rural and remote communities don't have access to these health assessment items, for instance, that enable the patient to have a full rebate. I'm in a preventative space, so when we talk about health literacy—and maybe the nurse practitioner has built a rapport within that local community and is the only health practitioner who that patient accesses.

That patient's reliance on the MBS to claim a full rebate that isn't accessible because the nurse practitioner has seen them is also a massive gap in these areas where funding is an issue. That also comes into play and needs

to be addressed, and we have addressed that in a previous submission to a review of the MBS in July 2024. So allowing and enabling nurse practitioners to have access to these MBS items—these advanced self-assessment items for your chronic disease management, diabetes or heart conditions—that they otherwise don't have access to.

We also have an issue where we've noted, even for safe driving assessments, nurse practitioners aren't able to fill in the fitness to drive assessment forms. In these rural communities, if the nurse practitioner's the only clinician able to perform that, these drivers are driving around, may be unsafe, because it's a process that just needs to be signed off. The legislation allows it but Austroads doesn't. There are lots of gaps in practice where we can enhance models of care and make the community safer. These are things that the Australian College of Nurse Practitioners really works towards trying to enhance and advocate for, just as another example.

The CHAIR: I thank the witnesses, Adjunct Professor Boase, Mrs Sedgman and Dr Kamerman, for attending today. You'll get a copy of the transcript to check for corrections and so on. There may be some follow-up questions as well, either as part of the hearing today or if the Committee requests some additional information. When you provide answers to that, they will form part of the public evidence. Are you happy to provide those answers?

IAN KAMERMAN: Yes.

LEANNE BOASE: Very happy, yes.

The CHAIR: I note that everyone's nodding. Your evidence has been extremely helpful today for the Committee. I wish you all a happy Christmas and new year.

(The witnesses withdrew.)

(Luncheon adjournment)

Mr MATTHEW CLANCY, Chair, Culcairn Local Health Advisory Committee, before the Committee via videoconference, sworn and examined

Ms JOSH GAYNOR, Member, Culcairn Local Health Advisory Committee, before the Committee via videoconference, sworn and examined

Ms SHARELLE FELLOWS, Community Representative, before the Committee via videoconference, affirmed and examined

The CHAIR: Good afternoon. I welcome our witnesses. Joe McGirr is my name. I wonder if each of you could confirm that you have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

MATTHEW CLANCY: Yes.

JOSH GAYNOR: Yes.

SHARELLE FELLOWS: Yes.

The CHAIR: Would anyone like to make a brief opening statement?

SHARELLE FELLOWS: First of all, thank you very much for the opportunity to address this Committee, Chairperson and Committee members. As you are aware from the multiple submissions from Gulgong, the prevailing sentiment is one of abandonment and frustration that we seem to be worse off than we were three years ago. Due to the sad departure of our doctor due to ill-health, we have been doctorless since March in our MPS and there's no medical practice. People are travelling extensive hours et cetera. No locum has been employed at the MPS by our local health district to plug any sort of a gap. It's a really grim situation with Mudgee medical practices closing their books. The Mudgee emergency department is overrun with low-acuity presentations, and it's a four- to six-week wait, if you're on the books in Mudgee, to see a doctor. This is disappointing. I would like to refer to other previous recommendations. Recommendation 30 from the previous inquiry states:

> That NSW Health:
>
> - Commit to providing continuity of quality care with the aim of a regular on-site doctor in rural, regional and remote communities
> - Commit to a model of care under which virtual care technology is used to supplement, rather than replace, face-to-face services

This is clearly not the case in Gulgong. We're even wondering if a single employer model can be used to fill this gap. Recommendation 12 states:

> That NSW Health review the working conditions, contracts and incentives of GPs working as Visiting Medical Officers … to ensure that the GP/VMO model remains viable…

This isn't the case. We've had a second VMO position advertised for four years and it has never been filled. Something needs to happen with that model because it's not working for smaller MPSs. Finally, I would really like to talk about recommendation 11, and I want to refer to an article that appeared in *The Sydney Morning Herald* yesterday when referring to that. Recommendation 11 states:

> That NSW Health work with the Australian Government collaboratively to immediately invest in the development and implementation of a 10-Year Rural and Remote Medical and Health Workforce Recruitment and Retention Strategy.

I don't know if this is in place, if it has started or if it has occurred, but it was meant to be immediate from that previous inquiry. Yesterday we had a situation where the New South Wales health Minister, Ryan Park, was blaming the crisis in metropolitan hospitals on the lack of GPs and really shifting that to the Federal Government. Then we had a situation where Mark Butler was saying, "Well, in fact, more GPs have been appointed in the last two years than in the previous 10 years." Basically, I don't think cooperation is occurring with the sense of urgency that is needed in a situation which is still so unacceptable—at least, for us—and it's putting lives at risk. That's all I'd like to say.

MATTHEW CLANCY: I thank the Chair and Committee for hearing us today. It is really appreciated as it's giving a voice to small communities. The four points I have covered in my submission basically relate to the following matters. The transfer of patient details between the New South Wales and Victorian health systems. At present, if a patient is transferred from Culcairn, they will print out the record and send it with the patient to Albury. When they receive that patient in Albury via ambulance, they will then input that information into the Victorian or Albury-Wodonga health system. There is no connectivity between the two systems. The second issue relates to greater use of the Culcairn MPS by Albury Wodonga Health. We've got a fairly stretched system in

Albury Wodonga. Prior to COVID I believe there were some formal agreements in place for the transfer of patients back out to Culcairn, but with COVID I think that has fallen by the wayside and now it happens ad hoc. We probably have a situation where we do have capacity at Culcairn to accept more patients, but there's no formal mechanism to transfer them.

The third point we wanted to raise is that we've got a fantastic new facility in Culcairn. Since the opening and the commissioning of the additional aged-care beds in Culcairn, they have sat empty because they don't have the correct staffing profile to actually meet the needs of additional people coming into the hospital. The fourth one picks up on our fellow attendees' issue around the VMOs. We had a long-serving doctor who retired here four years ago. We've had some relief through a cobbled-together arrangement for about 12 months to get a new VMO in. We currently have a VMO that attends the hospital or the MPS for the aged-care section once a fortnight at best. There's no other coverage. I think it comes back to the point made earlier around the fact that the virtual arrangements were there to complement a VMO, not to replace a VMO. That was a key issue for us. I think that's even stated in the NSW Virtual Care Strategy—it is to complement, not to replace.

The other point—and it's just a general one throughout the report—is we note that there are a lot of recommendations listed as completed in the report. Our concern is that, under those recommendations, there are a number of further actions referenced. There is no way of monitoring what happens with those recommendations. I'll just give you a quick example. For example, in recommendation 1, there is talk about a working group being established to look at the future funding model for small hospitals. Now, how does that get monitored? Where does that go once this report gets completed? Because it's saying that recommendation 1 is completed. It gives no follow-up or capacity to understand what happens next. Thank you very much.

The CHAIR: I'm going to begin with a general question. We are keen as a committee to explore each of your individual circumstances. The Committee's terms of reference include the interaction between health communities and health services. We are keen to get the specifics of your interactions to inform our analysis. We will have some questions that will go specifically to the issues that you've raised, but I want to ask both of you to reflect in general on the extent you believe your communities are involved in decision-making and service planning. Rather than going immediately into too much detail, just offer any observations on the extent you think your communities are involved in decision-making and service planning when it comes to local health issues. Who would like to have a crack at that one first?

SHARELLE FELLOWS: I'm not part of the health council and the health council is very small. I do have to confess that I'm not sure what kind of lobbying is going on there and how successful they are. But I do know that the staff at the MPS—they do a wonderful job, but I'm sure they would like to have a locum or a doctor, because they are, I suppose, copping the brunt of the community's frustration with not having a doctor at the MPS. Individually, I have written to the CEO of western area health and just begged, basically, that a locum be placed at the MPS even two or three days a week. We've got the whole issue of aged care. Dr Nebras actually serviced our aged care at the MPS and Wenonah Lodge and he also serviced Dunedoo MPS. That's all lacking as well. But the only response that I had from the CEO of western area health was it was a different kind of contractual arrangement to put a locum in rather than a VMO and therefore that wasn't really possible.

Individually I've been quite active in this area. I just feel frustrated that there's a community that is—I gather you've received a lot of submissions from people in Gulgong and there's been a lot of media coverage. People just really feel that they're entitled to have a doctor. My neighbour is making a four-hour, 470-kilometre trip to Orange to access a GP because they both need continuity of care and that doesn't happen with the virtual care system. They were advised that by the virtual care doctor: "You need a GP." What do you do when there is no GP because Mudgee books are closed? There is no other alternative. Some people can't afford to do that in a cost-of-living crisis and some people can't afford to take a whole day off work to see a doctor, which is what it amounts to. It's just a terrible sense of abandonment.

At one stage I received a letter saying that western area health had attempted to get a locum into the medical practice. Over this whole period since March there's only been a two-week period where there was a locum at the medical practice. There's been nothing in the hospital. We've been given vague assurances that Dr Nebras may return but that's very uncertain. The local real estate agent contacted me last week and said that actually the physical building where the medical practice is is now going to be listed for sale. We're not hopeful that we're going to get anything at this point to serve the medical needs for an expanding population. We're the centre of the renewable energy zone, we've got three new subdivisions going up and we have no doctor.

The CHAIR: We'll come back to those specifics in a moment. Just to Culcairn, in a general sense what is your involvement with decision-making or service planning with the local health district?

MATTHEW CLANCY: Given our role as LHAC we're advocacy for the community. When the doctor retired and we had a situation where the company that bought the doctor's practice decided, for his own reasons—

I don't know them fully. He decided not to provide the VMO service at the hospital. As a consequence, the MPS has been without a VMO. On the back of that the community rallied and, under the previous chair of our LHAC, we lodged a submission to State Parliament. I think we have to have X number of signatures on that submission to be able to lodge it into State Parliament to promote the cause of the VMO here in Culcairn.

On the back of that there was a lot of work done between the Murrumbidgee LHD, the PHN and the local council to get appraisal for a doctor to come in and set up a GP arrangement and provide that VMO service. Due to various reasons, that fell over here about six months ago and we're back to the drawing board. The issue that we have is getting all three of those parties on the same page so we can then drive an outcome that's acceptable to the community, which is restoring VMO services at the hospital. Our biggest stumbling block at the moment—and this is a circular argument. The infrastructure to support an arrangement under the existing model, where you have a VMO but they support their income through GP services in the town—that really can't work unless you've got the right infrastructure around that arrangement to move it forward. That's been our stumbling block at this point—is that we can't, as a community, offer a package if we don't have all those three players on the same page trying to address the agenda.

The way we see it is that, while the PHN may be responsible for the GP practices, that doesn't extend to the State Government requirements of the LHD, which look at the VMO requirements. You need additional qualifications to be able to be the VMO, and that's where we're falling over. You might get a doctor that's willing to provide the GP part, but you don't get that level of expertise to be the VMO. The added complication for us is that, if we were able to attract that, we've got nowhere to put that person to operate from, and the expectation is that that person turns up with sufficient money to buy themselves a house and a practice to operate from.

The CHAIR: We might just dig into your situation a bit, then. I think you said that a GP arrived but didn't want to provide VMO services at the hospital. What were the circumstances around that?

MATTHEW CLANCY: When Dr Reddy retired, he put his practice up for sale and Sarkon, which is a medical practice in Albury, decided to buy the Culcairn GP practice. When they bought the GP practice, the LHD approached Sarkon to see whether they were willing to provide the VMO role at the hospital, and they chose not to provide that role. It's my understanding that that's their commercial arrangement decision. They don't have to offer that as a service to the community. I don't know the commercial arrangements that sit behind that as to what were the blockers, just that you do have to have a certain level of qualification to operate the VMO role. I don't believe the GPs that were servicing Sarkon in their new arrangement had sufficient qualifications to take up that role.

The CHAIR: Mrs Williams, you have your hand up. Did you want to ask a question now?

Mrs LESLIE WILLIAMS: No, I can wait. My questions were really about—it has kind of been answered by the witnesses—why nothing has been done about getting a locum. It seems like the LHD, for some reason—it sounds very complex—is not really open to that.

The CHAIR: It's not clear to me why the doctor in the practice didn't want to practise at the hospital. As you say, it might be a question that they didn't feel qualified to do that. But that does mean that the LHD then has to pick up the funding for a hospital doctor. I can see that, in that circumstance, it would be quite difficult to find someone and, I have to say, very expensive if they're not doing primary care at the same time. I'm interested in the discussions you've had or the information you've had from the local health district around their thinking on that. What have been the discussions and involvement?

Mr CLAYTON BARR: Was it an overseas-trained doctor, maybe?

MATTHEW CLANCY: Murrumbidgee Local Health District has been engaged with us for a period of time. We have a commitment from them to try to pull together a meeting with ourselves and the PHN and local government to look at the issue in the new year and move it forward. They are aware and are willing to look at the issue again. The issue of the VMO presence at the hospital—there is also a similar circumstance playing out in two other local towns near us that fall within the local government area. We've been in touch with the local government. Since the elections, they've picked up this issue and are wanting to take it forward as a collective for the local government area. So it hasn't come to a halt. The last arrangement fell over in about September this year, so this is an attempt to look at where we've landed and how we can address the issue more broadly, with the other two towns involved as well.

The CHAIR: What are the other two towns?

MATTHEW CLANCY: Henty and Holbrook.

The CHAIR: Are they also without doctors?

MATTHEW CLANCY: I can't speak to the specific arrangements there. It's more about the VMO. I think they have GP practices in both towns.

The CHAIR: So they may not have hospital services. They're quite close, aren't they, in the scheme of things?

MATTHEW CLANCY: Yes.

The CHAIR: Henty is, what, 10 minutes, 15 minutes?

MATTHEW CLANCY: It's about 15 to 20 minutes from MPS to MPS, and I'd say it would be about 20 to 25 minutes between Culcairn and Holbrook MPSs.

The CHAIR: How long has this been going on? You said that September was the last arrangement.

MATTHEW CLANCY: That's when it fell over, yes. That was in place for approximately 18 months to two years. Before that, there was a period of about 18 months where there was no VMO at the hospital.

The CHAIR: Can you describe the arrangement that was in place for 18 months, up until September?

MATTHEW CLANCY: Yes. Without going into the commercial arrangements, because I don't believe they're public knowledge, a lot of work went in with the local government and the local health district to secure a doctor to come to Culcairn to provide GP practice and VMO support to the hospital. Originally, they managed to recruit a doctor to do that full time. However, once that doctor left after about an eight- to 12-month period—I can't remember the exact timing—it fell back to a five days a fortnight arrangement where that was in place. There was a lot of negotiation between those parties to get that doctor in place.

JOSH GAYNOR: The building which that doctor was in was a private commercial arrangement. Now that has fallen apart, so now there is no physical place for a doctor.

The CHAIR: What I'm hearing, though, is that we are in a situation where, for a whole lot of reasons, recruitment of doctors is difficult—made worse in your situation because you have actually got someone in town but they're not providing care to the hospital. That creates a whole new dynamic. But it does sound to me, from what you've said, that the LHD and the PHN and the local government have been trying to work together to solve this.

MATTHEW CLANCY: A lot of work has gone into the previous arrangement, but the issue we always seem to face is that when Dr Reddy sold his practice and when this last one fell over, there was just no infrastructure available to take a new arrangement forward. And you fall right back to the discussion of where we find somewhere to enable—under the existing arrangement or the historical model of a GP/VMO arrangement, where can they operate in Culcairn?

The CHAIR: I'm doing too much questioning here. Clay, perhaps you could go through in detail with Ms Fellows the situation at Gulgong.

Mr CLAYTON BARR: Thank you all for the contributions you're making to health in your own local areas and districts. Ms Fellows, you have been very active over a number of years. At a broader level, does your community feel like they have pathways and a means by which they can engage with Health to put forward the claim that you need better?

SHARELLE FELLOWS: At the moment, they have been engaged in a very active social media campaign. They've been involved with the media. A process that they've tried—and it seems to have worked—is writing reasonable letters. They've been writing letters to politicians. I think Federal politicians have raised it at the Federal level. I think the local member has raised it in State Parliament. People feel that they have lobbied and expressed their views and things still haven't changed. This arrangement fell through in September. We've had nothing since March. We have no primary care. We have no doctor at our MPS.

I understand that if it's a sole doctor, which it was for Dr Nebras, running his own private medical practice and then also having responsibility for the MPS—and that wasn't 24/7; some of it was covered by virtual care—the contractual arrangement he was on was not a fee-for-service model. I think in smaller centres, when you may only have one doctor, it's very difficult. And maybe attracting new doctors who are inexperienced—our doctor was an overseas doctor. He had worked in London emergency. He was fully qualified to be a VMO. He was a valuable asset to our town, and he is greatly missed. But we are just in limbo. People do not feel that their voices have been heard and that their desperate need for access to medical care has been met.

Mr CLAYTON BARR: I realise, of course, that you had a *60 Minutes* episode and you had a story in the SMH. You have this very active Facebook page. How old is the Doctors for Gulgong Facebook page? Second to

that, has interaction with the local district health or the primary network increased and improved because you're leveraging into the social media space?

SHARELLE FELLOWS: We're not the only—I don't administrate that page. I'm not very tech savvy. I do provide information but someone else administers it. There's a really big group. I should point out that there's also a group in Mudgee—and I've been part of that group—called Mudgee 4 Doctors. Mudgee, as you know, has closed its books. They're lobbying, again—well, they actually had the Federal regional health Minister out recently to address that meeting. Apparently she said she would take up their concerns. There is lobbying going on at a very high level.

I refer to the previous gentleman—our council has been very late to this issue. It really is only after the most recent elections that they've decided that in fact they need to lobby for incentive packages to somehow attract doctors to the region, because they are facing massive retirement and they're not retaining the doctors that they're training. Doctors come out and train and they're leaving. They're not staying in the regional areas. The old days of a doctor coming and serving for 30, 40 years just seems to go. That's part of the problem in Mudgee; that's why they've closed their books. The Mudgee ED is overrun with people with low-acuity presentations because people literally have nowhere else to go, unless you can drive four hours.

Mr CLAYTON BARR: Here in Cessnock, where I'm based, we have a lot of overseas-trained doctors that come to our area. They've got a requirement to be in the area for five years. But almost once that fifth-year day comes around on the calendar, they move on.

SHARELLE FELLOWS: They're done.

Mr CLAYTON BARR: Do you have similar experiences? That's probably a question for both groups.

SHARELLE FELLOWS: I can answer that one straightaway. We had another doctor, who was also overseas-trained, who was working with Dr Nebras. But when the Monash model—and there was that announcement earlier from the Federal Government, she just went back to one of the isolated areas on the outskirts of Sydney. So we lost her due to that, as well, after her training was up.

Mr CLAYTON BARR: You got rezoned in the Monash model?

SHARELLE FELLOWS: No. Remember, under the Federal Government, they actually did take some doctors who'd been serving in rural communities and sent them to other areas of need which were closer to cities, and doctors did actually take that up. I do note that only in November the Federal health Minister said that all overseas doctors will have to serve 10 years in rural and regional communities, which I think is a step forward, so credit where credit is due. But I guess I'm just being incredibly selfish here. We're desperate in Gulgong. We just have no access to anything—and we're losing people from the town because of that.

Mr CLAYTON BARR: Thank you again, Ms Fellows, for your long advocacy. Culcairn, do you have overseas doctors under the Monash model?

MATTHEW CLANCY: I can only speak to what I know. I'm unaware of them being under the Monash model. The doctor that was historically at Culcairn was here for about 35 to 40 years running that service. That wrapped up in 2020. Since then, the arrangement with the other doctor that was put together was also—he happened to have another practice in another nearby town, Wagga. I don't believe they came in under that model. I can't speak for the GPs currently servicing Culcairn through the same model.

Ms TRISH DOYLE: I want to thank you all for speaking truth to power. I think it is really important, all of the examples that you've given. I am particularly interested, and Dr Joe would also be interested, in hearing the examples from the Culcairn group about lack of transfer of medical records over the border. I think this is an important point that we need to highlight in our deliberations in this Committee and in the inquiry, that this is a problem throughout New South Wales, let alone across the border—the sharing of important medical information between local health districts and different areas across the border. As someone who grew up between Tarcutta and Tumbarumba, I do hear you when you talk about not just the tyranny of distance but the sharing of resources. To Matthew and Josh, thank you for pointing that out.

Sharelle, whilst you've been speaking I've had a message from Sarah Elliott, who calls you an absolute champion in the local area and says that you have been for quite some time. Besides the local health district and the community—further to the points that the member for Cessnock pointed out, with social media playing a role here—the tiers of government, with Coleman, Toole and Gee: Has there been any formal submission or working with those tiers of government and the local health districts on these needs? We hear you loudly and clearly about your desperation.

SHARELLE FELLOWS: There's Andrew Gee, obviously, and Dugald Saunders is the local member. There has been. I have individually written to the health Minister, and he has also been liaising with our duty MLC, Stephen Lawrence. There has been communication through that. But basically the advice, I understand, and the communication from Stephen Lawrence that Ryan Park received was from the health district—initially, before the books were closed, in fairness—that Gulgong really only is 20 minutes from Mudgee and it really wasn't a problem. But the problem is now, of course, that Mudgee doctors are not coping. There was no recognition in that that there's no public transport from Gulgong to Mudgee. There is now; there's one bus that runs one day a week. I know Andrew Gee has—I don't know if they have formally contacted the local health district. I'm just being honest. I don't know whether they've just done that or made speeches in Parliament and a lot of noise. I do know that there are members of the local health district—in fact, the manager of the whole entire local health district, which includes Mudgee and Gulgong, is part of the community group that calls itself Doctors for Mudgee Region, which was started up in recognition. I know that he is actually part of that group. What is actually happening is still very uncertain for us and still very desperate.

Ms TRISH DOYLE: It sounds like—and this isn't a question; maybe it's just a point—there can often be siloed health services in different parts of our State, especially in regional, rural and remote areas. There is that siloed activity and advocacy. There are lots of good people speaking out. Thank you for your work, Sharelle. I think it's important to acknowledge that we hear you. I hope you're doing well.

SHARELLE FELLOWS: Thank you very much. I am.

The CHAIR: My observation would be that no-one thinks it's their job to get a doctor for Gulgong. The LHD doesn't think it's their job. The PHN doesn't think it's their job. Often local government will step in. We've seen that.

SHARELLE FELLOWS: Very late to the party.

The CHAIR: But they haven't so far. I think that's a story you hear frequently. We don't really have mechanisms or pools of funds that local councils or community groups can access if a group in the community says, "We need a doctor. We need to find some facilities." It sort of falls between all of them.

SHARELLE FELLOWS: Actually, I'm sorry to interrupt, but we probably do have an avenue that has been really underutilised. Because Gulgong is the centre of a renewable energy zone, we have 26 projects on our boundary. If you look at the EnergyCo grants, which are up to $1 million each, you can apply for grants that are for social infrastructure. If you look at the documentation—and I have closely—health services were identified in the whole Central West region as the number one priority and they are defined as social infrastructure.

The disappointing thing for me is that our council, to date, has not applied for one of those social infrastructure grants, which could be used to provide incentives or, indeed, subsidise a doctor for Gulgong. EnergyCo was set up in recognition that the Central West communities were bearing the brunt of the renewable energy infrastructure. In fact, some of that money is meant to be spent within 26 kilometres of Gulgong because we're surrounded by it. That is what is putting pressure on our housing, as well, because we have all these workers and workers have medical needs as well. In our unique situation, I think there is an avenue that our local council needs to explore. I'm desperately hoping that they will choose to do so in the future. But that's going to be a long process with a recruitment and incentive package, and we need help now.

The CHAIR: There are two issues here. You're lucky because you've got some access to some funds through EnergyCo.

SHARELLE FELLOWS: If that happens.

The CHAIR: I'll just take the opportunity to point out that I live in a community that has Transgrid renewable energy infrastructure, and we don't have access to those funds. In fact, the renewable energy zone that was set up with EnergyCo was a result of the situation we're in, but we still don't have access to those funds. I just want to make that point. There are two issues. One is access to funds. Sharelle, you've pointed out that you might have a pool.

SHARELLE FELLOWS: Yes.

The CHAIR: But other communities won't have that.

SHARELLE FELLOWS: That's right.

The CHAIR: And these things do take time in terms of recruiting a doctor. The second issue, which is probably more profound, is that it needs to be someone's role if you're going to have a GP in your community. I get the sense that neither the LHD nor the PHN see it as their role to do it. If local councils don't step in and there isn't a community group—and we have come across situations, for example in Parkes, where a community

group has formed—then it's no-one's job. Until someone takes it on, you don't get anywhere. It will take months or years, but it will go nowhere unless someone takes it on. That's just a comment. Did the gentleman from Culcairn want to add some commentary?

MATTHEW CLANCY: I think the summation there is very accurate for our situation. There are two real issues for us around the VMO role. The obligations of the PHN just relate to a GP and those of the LHD relate specifically to the VMO. But the actual historical model of how you put those two together is that they both rely on both activities for that doctor. Yes, that's a big issue for us in terms of getting that balance right. The second part is the infrastructure. When you don't have the infrastructure to start with, you can't even have the conversation about what it is that you can offer an in-clinic person willing to provide that service other than, "By the way, you've got to buy yourself a practice and a house to live in."

The CHAIR: That's true, but I think one thing the Committee can do is crystalise this issue. It just gets repeated and repeated.

Ms JANELLE SAFFIN: No-one's in charge.

The CHAIR: No-one's in charge, and it relates to the recruitment of the rural doctor. I actually think once someone is in charge, getting funds for infrastructure might not be as complicated as you think. For example, you've got a hospital, haven't you? How hard would it be to create a clinic linked to your hospital? Okay, it might require a bit of funding, but once you've set it up, it's there in perpetuity. But someone has to own and take responsibility for the issue. That's my sense of it. I'm talking a bit too much at the moment; I'm conscious of that. Sharelle, did you want to make a comment?

SHARELLE FELLOWS: I think I've said quite a lot also. I guess we can advocate and we can get someone to take this on. But I guess there's a basic sentiment that these two agencies should be taking care of our health and should be talking to each other. So much onus is placed on what is basically a pretty disadvantaged community—Gulgong. I don't know; I just felt that was one of the key—and there were 44 recommendations in the inquiry. I thank you because you actually said that addressing the workforce shortage was your first priority, and those incentives that you put out were good. But I still think there needs to be a solution to the VMO model that doesn't just rely on the individual advocacy of communities. I think the responsibility to ensure that there is a doctor in a rural community has to be placed with those two arms of NSW Health.

The CHAIR: That's absolutely right. Here we are saying there should be someone taking responsibility, but there are two bodies there that we all keep saying should be working together.

SHARELLE FELLOWS: That's exactly right.

Ms JANELLE SAFFIN: My question goes to process. Both of you are doing all of this advocacy. For Gulgong, it's a citizen and then the local advisory committee. Is the health service—the LHD, the PHN or both—engaged with you constantly, reporting on what they're doing to try to work it out?

SHARELLE FELLOWS: Not to me personally. I haven't written to them recently after I received those initial responses. I know that health Minister Ryan Park was in contact with them and we then communicated through Stephen Lawrence. But since that initial letter some time ago, there hasn't been any more communication.

Ms JANELLE SAFFIN: How do they communicate with the community on this?

SHARELLE FELLOWS: I don't think there has been communication with the community on this. I can only judge that by the reaction that people are having on social media, which I know can go into a vacuum. People are really angry and, as I said, feeling really abandoned. Surely the New South Wales Government in some way has to address this issue.

Ms JANELLE SAFFIN: So there's that. Mr Clancy and Mr Gaynor, you engaged in a constant dialogue advising you on how to resolve these things. Does that happen as a standard practice?

MATTHEW CLANCY: We probably talk to both organisations at least once a month to work out how to actually move the issue forward. They have been very cooperative in being available. I think the bigger issue comes back to what their role and responsibilities are and where they see them starting and stopping. There are things that have fallen through those roles that no-one's picking up.

Ms JANELLE SAFFIN: So all of these gaps are not being addressed?

MATTHEW CLANCY: That's where we're having to do the advocacy to try to fill those gaps.

Ms JANELLE SAFFIN: Sorry, that was probably a leading question. But all of the gaps are not being fulfilled?

MATTHEW CLANCY: Yes.

The CHAIR: They're there and they're taking your calls and they're listening to you and they're very sympathetic.

MATTHEW CLANCY: Yes.

The CHAIR: But the idea that they might actually meet themselves and say, "This community has a problem and we need to fix it", hasn't happened?

MATTHEW CLANCY: They have committed to take that forward since the last arrangement has fallen over. We're just trying to get everyone wound up to have that conversation. But I think the bigger issue we face is that those gaps where they think responsibilities end and things fall through those gaps is where we have the issues.

The CHAIR: Yes, I think that's right.

MATTHEW CLANCY: Who owns the issue of infrastructure, for example? That's key to resolving the bigger issue.

The CHAIR: I think it's a very good example of an issue across the State.

Mr CLAYTON BARR: Obviously, Matthew and Josh belong to a Local Health Advisory Committee. Sharelle, do you have access? Is there a Local Health Advisory Committee somewhere around you?

SHARELLE FELLOWS: There is. There actually is one in Gulgong. Basically, because we had our doctor, I thought that I could step back from advocacy. We were very fortunate to regain our Dr Nebras. But I also read the code, and you can't necessarily speak in the community and publicly about—there is that sort of code of conduct issue. I'm quite outspoken, so I decided that perhaps that code of conduct may not be appropriate for me and I could do more actively on the outside than within that. But listening to you, perhaps that is an area. We do have some very good people on that health council, but that communication going out to the community is probably something that we need to address.

Mr CLAYTON BARR: Thanks, Sharelle. Stay wild!

Ms LIZA BUTLER: This question is regarding the Local Health Advisory Committees and leads on from the last question. We heard this morning in a submission from Murrumbidgee PHN that they have a healthy and active network of local health advisory panels. Do you think, since the recommendations of Portfolio Committee No. 2, that this has improved? Do you think you could be better supported?

MATTHEW CLANCY: We've always had a fairly open relationship with the PHN. It's not so much the relationship; it's where they draw the boundaries around where their obligations start and end. That's where we find ourselves, the issue—not so much the ability to speak to someone there. Okay, if we get to this point, they've got a GP. But if that GP can't do the VMO role, they think they've fulfilled their obligations with the GP role being filled. It's that cross-entity relationship and trying to bring parties together to get the whole package sorted, not just one element of the package. It's not so much the dialogue. I spoke to my PHN four times on Friday and Monday, so they're listening. They hear us. It's where they believe their obligations stop and how does that then impact the next part of the puzzle.

Ms LIZA BUTLER: And that aspect hasn't changed in the past two years?

MATTHEW CLANCY: They've been helpful in finding a resolution last time. I believe they will be helpful in trying to find a resolution going forward, but it's where those boundaries are that cause the friction.

Mrs LESLIE WILLIAMS: I thank all of you for sharing insights on some obviously complex issues in your communities. This question is to all of you. What do you think is the next critical first step in getting to a resolution for your issue? As small or large as you think it is, what is the next step you think needs to start you on the right path?

MATTHEW CLANCY: I think the Chair in his summary about five minutes ago articulated the two key issues. If we can move through those issues, we're well on our way. The PHN, the LHD and the local council are all looking to have a joint meeting to see whether this issue can be worked through in some sort of fashion. The second thing that really holds us up, though, is the infrastructure support that sits behind it. I keep coming back to this. Basically, if we get the right person to come in and fill this role, we're asking them to not only come and fill the role, but to put a fair bit of investment into a community to undertake that role, and that's where we're falling over every time.

Mrs LESLIE WILLIAMS: Are you confident, though, that one of those three levels—local government, PHN, LHD—is actually going to take responsibility to make sure that that meeting happens? Often it's very easy—

MATTHEW CLANCY: That's what I'm saying. At the moment, that's where the gaps are, and it's who takes the ownership of the issue moving forward for those gap areas.

JOSH GAYNOR: Moving forward, it's definitely up to us to formalise that meeting.

Mrs LESLIE WILLIAMS: Actually, even before you know who takes responsibility, someone's got to get the three groups together. Are you confident that someone will actually do that first step?

MATTHEW CLANCY: There's a commitment to us to actually hold that meeting, so I believe those parties will come together with the LHACs. It's a question of how do you get the right puzzle pieces on the table so you can put it together, and that's the issue around whether the boundary is wide in terms of obligations for the types of people that are engaged, and also how do you support that person going forward.

SHARELLE FELLOWS: Can I speak very briefly?

Mrs LESLIE WILLIAMS: Thank you, Sharelle. I'd love to hear what you have to say.

SHARELLE FELLOWS: I don't have the same level of confidence because we obviously don't have that prior discussion with council. I'm just going to return to my previous point. The issue between the LHD and the primary health network should be resolved at a governmental level to ensure that these things happen. I just think that's very, very clear. I'm going to keep repeating myself about the VMO model. It was identified as not working for smaller communities. I think it's a huge ask to ask a sole doctor—who is inexperienced, perhaps—to set up and run and have all the expenses of a private medical practice and also have the expertise to be a VMO—to leave his or her medical practice to go down to the hospital.

I can't understand why we perhaps don't move—and that's something for the medical experts. I know that Queensland had a single employer model and senior medical officers appointed to their small hospitals. I don't know how successful that has been over time, but I think the VMO model isn't working for smaller centres. We are hearing that repeatedly. There are so many without VMOs, without doctors, that it needs a solution, basically. The other thing I'd add is that there are 44 recommendations. I agree with Matthew's previous comments. I don't know if there's a timeline or milestones on which of those 44 recommendations are being dealt with and over how long, but that needs to be really clear. I know Ryan Park's made a commitment to implementing all of those, but we really need a clear time frame and they need to be prioritised.

The CHAIR: Thank you Sharelle, Mr Clancy and Mr Gaynor. We really appreciate that. That has crystallised issues very clearly for us, so thank you very much for that. I thank you all for appearing before the Committee today. You will be provided with a copy of the transcript of evidence for corrections, and also any questions that you've taken on notice from today. We may send you some questions in writing. Your replies will form part of the evidence and be made public. Would you be happy to provide written replies to any further questions?

SHARELLE FELLOWS: Yes.

MATTHEW CLANCY: Yes.

JOSH GAYNOR: Yes.

The CHAIR: Thank you very much.

(The witnesses withdrew.)

Mr DAMIAN THOMAS, Directory Advocacy, Local Government NSW, before the Committee via videoconference, affirmed and examined

Councillor PHYLLIS MILLER, OAM, Vice-President, Local Government NSW, before the Committee via videoconference, sworn and examined

The CHAIR: I welcome our witnesses from Local Government NSW. Can you each confirm that you've been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

PHYLLIS MILLER: Yes, we have.

DAMIAN THOMAS: Yes.

The CHAIR: Would either of you like to make a brief opening statement before we begin questioning?

PHYLLIS MILLER: I'd like to thank you for the opportunity to give evidence today on behalf of Local Government NSW. I'm a councillor from a rural council, the mayor of Forbes Shire Council in the Central West. Local government is truly embedded in rural and regional communities and plays a role in helping to maintain and improve the health and wellbeing of our residents. Access to health services in rural, regional and remote areas remains a significant issue for councils and their communities. Councils' submissions to the inquiry note the significant investment made by councils to support their communities in accessing health services in rural, regional and remote areas, despite it not being within councils' remit to do. Investment to maintain health services continue to rise and are diverting funds away from other community infrastructure and services.

The recent release of the report by the parliamentary inquiry into the ability of local government to fund infrastructure and services notes that councils are facing major cost pressures in meeting the needs of their communities. The report recognises that the financial sustainability of councils is being persistently eroded and that, without improvements, all communities will suffer. Local Government NSW's pre-budget submissions in recent years have all continued to call for a local government rural and regional health reimbursement scheme to prevent costs shifting onto councils, and ensure that the limited funds available to councils can be used to invest in the community infrastructure and services. In this regard, in August of this year Local Government NSW was so pleased to see recommendation 19 of the Select Committee on Remote, Rural and Regional Health inquiry into the implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health.

That inquiry report recommended that the New South Wales Government work with the Australian Government to improve and support local councils, including ensuring that more funding be provided to local governments. We have not seen any of that at this stage, and it's long overdue. Many councils have noted the challenges regional and remote councils and their communities face consulting and collaborating with NSW Health local health districts, Local Health Advisory Committees and primary health networks in assessing health care and many community needs. Our submission always references examples where these relationships are working well. I will give you a little brief on Forbes Shire Council. We decided back in 2000 that we would become a partner with NSW Health and our local health district. Of course, we have realised in 2024 that, in those years, we have spent $15 million on delivering our health services.

We have made sure that we have housing for our doctors when they come to town. We have built medical centres. We not only have a walk-in walk-out medical centre, but we'll be having four new doctors in February of this coming year. We also have one of the best and largest Aboriginal medical centres, and we own that building as well. It also has accommodation attached to it to assist any health professionals who are coming to work in Forbes, that they will have somewhere to stay. We've incentivised nurses and doctors to come to Forbes. That's one example. Moree Plains Shire Council reported that they're having great collaboration and consultation in doing their redevelopment of their hospital. They're having multiple consultations with the council and with the communities, so they're very excited about that collaboration that they've got with NSW Health.

Albury City has noted a collaboration with a range of community health service providers by providing affordable meeting spaces for its community drug action team, Red Cross and a primary health provider. Inverell Shire Council has also noted the success of its longitudinal integrated clerkships program where medical students come out to live and work in rural and regional areas for an extended period of time. Learning activities are integrated within the health service of the rural area and, on graduation, the new doctors are better equipped to come out and cope in rural health settings. However, with all of those good stories, the feedback from our members notes that the closure of health services, dated facilities and infrastructure, or the promise of new hospitals that have not eventuated are devastating for our communities. The Local Government NSW submission made a number of recommendations.

These include establishing a joint health taskforce between all levels of government, including local government; expanding the single employer model to more local health districts; adequately funding health workforce incentives—we as councils are doing that, but that would be great if we had a partnership with State and Commonwealth governments to increase those incentives; and working closely with councils and communities via local health districts and primary health networks to improve the quality of health services. These have been lip-service to date. Some work and some are just nothing. Nothing happens out of those local health district meetings. Furthermore, revising the Local Health Advisory Committee model to give it some teeth and have a greater say in what's being delivered in that area. That's really important. We are not all the same. We are in different parts of the State and have different needs. I thank the Committee for your continued efforts to improve the planning and delivery of our health care in regional and rural New South Wales. I look forward to answering any questions, with Damian's help, that you may have.

The CHAIR: Thank you, Councillor Miller and Mr Thomas. I thank Local Government NSW for your submissions to previous inquiries and for your continued engagement in this space. I also compliment Forbes council on the work it has done in terms of health services. We want to explore the role of local government in this space because it's clear that in certain parts of the State there is a gap between what the PHN thinks it's doing and what the LHD thinks it's doing—and often, but not always, local government steps up. In communities where local government steps up, you maintain and build services in those communities. Of course, it means the LHD and the PHN often step away. That's my impression or that's a possible consequence.

In other communities the local government doesn't play such a role, and for a whole lot of reasons. But I want to begin, though, with my first question. This may vary across the State, but what is your view of the communication mechanisms that local government has with both PHNs and LHDs? Are there good examples and are there examples where challenges exist? First of all, on communication, and then how does that relate to planning for health services? I hope that's clear enough.

PHYLLIS MILLER: That's very clear, Chair. I think it varies right across the State. Unless you are a mayor or a council that's going to put themselves out there to talk to NSW Health or their local health district—I think we get emails which don't mean very much. I've been fortunate enough to make sure that I keep a good relationship with both NSW Health and the local health district, but that is not broadly across the State. There is minimal consultation. When we rebuilt our hospitals, the bureaucrats assumed where the health services would be delivered from. They made their mark on the redevelopment of two hospitals—my hospital and another one. They decided which was going to be the biggest and the best, and they were very wrong.

Our hospital services 65,000 people. That infrastructure that has been built in that other hospital is not used at all. These types of things—when we are not getting listened to on what you need to do on a local level. It's not about being parochial; it's about trying to cover off all services in an area. I think that unless we get something really formal, where we are talking to NSW Health and our health districts, we are just going to keep getting these mistakes made when we are having redevelopments.

The CHAIR: Sorry, where's the other infrastructure where it's not being used?

PHYLLIS MILLER: Forbes and Parkes.

DAMIAN THOMAS: If I can add to that briefly, Mr Chair. We've heard some feedback from Albury City Council that they've got significant community concern regarding the lack of transparent consultation for the development of their proposed new Albury Wodonga hospital. Cootamundra-Gundagai is another example where they say that obviously in the health space there are various State agencies and Federal agencies that are seeking to engage with the community, but they are not doing it in a holistic, collaborative way. So multiple agencies are proposing different changes to their services of a health nature, and that has created a lot of confusion and misunderstanding in the community.

But there have been some really good examples, too. Uralla Shire Council notes a mechanism set up by their previous local State member, Adam Marshall, who initiated a regular forum. Hunter New England Health and the local government mayors from across the Northern Tablelands have all come together to discuss rural health matters in the region. This has really improved dialogue and opportunities for mayors to share concerns from their communities and seek advice on potential action from Hunter New England Health.

The CHAIR: Just on the Uralla forum, do Hunter New England Health attend that?

DAMIAN THOMAS: They do, yes.

Ms JANELLE SAFFIN: Yes, they do.

The CHAIR: How long has that been running?

DAMIAN THOMAS: That's attended by senior health executives, including the chief executive and the executive director of the rural and regional health services from Hunter New England Health.

Ms JANELLE SAFFIN: It led from Adam's frustration.

The CHAIR: That's one example of a solution that has almost been developed from the grassroots up, rather than a systemwide approach to ensuring that there is that involvement.

DAMIAN THOMAS: Yes, I think that's fair to say.

PHYLLIS MILLER: Chair, having gone through the development of a new hospital as a mayor, there were bureaucrats from Sydney who thought they knew more than us, and they didn't. We knew the services that we were delivering at this stage. We were prepared to share them between the two campuses. We were up at midnight one night when we landed on a space where we could both live with what was going to happen. It's such hard work when you're not being heard. Even the health staff are not being consulted—the people that are on the ground running these health services. We were not getting consulted when we were doing the rebuild on our hospitals. Those kinds of things have to change.

Ms TRISH DOYLE: Hello, everyone. Thank you for joining us today and for your insight and for sharing what's happening on the ground. I think it has been said by many different people from different organisations and areas today that there is talk about collaboration with local health districts and communities. I'm interested in your view—what needs to happen with local health districts working with local councils? If you were able to write the textbook here—Phyllis, you said very clearly, and I am sure many people would agree with you, that you don't need someone who is a bureaucrat, who is not from the area, making decisions. In light of that comment, what do we need to do to give local councils, local leaders and residents a greater say in the delivery of services in their communities? What are the top three things that we need to do?

PHYLLIS MILLER: I think we have to have an advisory committee made up of all stakeholders—local government, community, health professionals and, of course, our local health district bureaucrats because we need them with us—and I think it should have teeth, and it should have some say in how things are running. I think they need to listen to what is going on out in the community. If we know what's going on and we find out early enough, we can fix it. Local government doesn't not want to be a partner, but we are struggling with the financial side of it. I think if we had advisory committees and if we had a funding regime that was for health for that area—like we do with our Roads to Recovery funds that we get from the Federal Government—so that we could make sure that our health service had really good direction, making sure we have the doctors and the nurses, I think we could be a lot better in delivering in a more sustainable way than we are now.

Ms TRISH DOYLE: To both of you, what would a revised Local Health Advisory Committee look like? What do we need to change about the model that exists? I'll put that question to both of you.

PHYLLIS MILLER: I don't believe we should be—I went to them for years and they were so bad. I just felt like another councillor. They were terrible, and my time is precious. We should know about the financial capacity of our health districts. When you know that, we know that everyone is on a budget—State, Federal, us and the health districts. We should have some knowledge of all of that. We should know that our x-ray department is making good dollars for our hospital or "This is costing us something" so we can try, as a group, to make that work as some form of business, with community-minded care attached to it.

DAMIAN THOMAS: If I could add to that, I think that the transparency of the financial information that Ms Miller has just spoken about—that's something that's come through in feedback from Moree Plains Shire Council as well. They've worked with NSW Health to develop a collaborative relationship in terms of their participation on the Local Health Advisory Committee and they meet with senior representatives of their rural and regional health services on a regular basis too. The purpose of that is to really build the trust and transparency in health-based decision-making and Moree Plains are saying it's working really well there, enabling an increased effectiveness in the council's advocacy on behalf of the community, and that has flowed through to the Moree hospital redevelopment, which that council is really pleased with in terms of how the consultation has gone there. But in terms of a best practice model for a Local Health Advisory Committee, I suppose the point of these advisory committees being local is that there's no one-size-fits-all approach and every council will be different and every region will be different, which is why that local advice needs to come through.

Mrs TANYA THOMPSON: This is a really interesting segment and I'm lost in all of it because I have my own redevelopment happening at the Manning. Phyllis, I share your sentiments and I'm not going to go too much into that because we're short on time and Dr Joe will shoot me if I waffle on. To the same conversation that we're already having, in terms of the advisory committee, my concern would be more that—are all councils as proactive as yours and as you, Phyllis? Would they all have good control over—if you start putting financial

responsibility into local government for health outcomes, do you muddy the waters more? Sometimes you've got councils even for road networks that aren't great at managing road networks. Does that make sense?

I would feel somewhat concerned then that there's financial control in there for some councils. Particularly when you've got large health districts like Hunter New England, for example, which is enormous—it's a huge health district—to have advisory committees set up all the way throughout that health district would be difficult to manage and maintain, so that's quite a beast. I suppose you'd have to look at chopping that up quite a bit. I'm not sure. Maybe that's another hearing day. That's all. I wanted to also know if you could elaborate on what a revised local health action committee model would look like—if you want to talk further to that. I'm very interested in this segment. I think it's wonderful. Thank you for your contribution more than anything else.

PHYLLIS MILLER: I don't think it's about local government taking responsibility over the finances of their local health facility. But having the knowledge of it and understanding is terribly important.

Mrs TANYA THOMPSON: I agree.

PHYLLIS MILLER: I think, unless you know that—I've been abused by particular mayors because I've contributed and become a partner with NSW Health and my local health district. You know what? If people don't want to come to the table, they're going to have to be compelled to come to the table. Because you can sit back and whinge about our health services but, if you're not going to get in and put your money where your mouth is and help out, help the other two tiers of government to deliver it, you're not doing your job at local government level. And I assure you I would help lead local government along those lines. It is now time we did it.

Mrs TANYA THOMPSON: I think a key word, "transparency", shines through in the majority of those conversations, right?

PHYLLIS MILLER: Yes. And as far as what the committee looks like, don't have it look like anything it has been to date. Just try something new.

The CHAIR: Transparency—but can I also add into that accountability. We've just had a session around a couple of communities where neither the LHD nor the PHN seem to want to take responsibility for getting a doctor for the community. That gets repeated all the time because the LHD is happy to employ a doctor who is already in the community but they don't want to recruit one for the community. The PHN says, "Well, our job is not to get doctors for the hospital." So when the community is without a doctor—unless local government steps in, to be honest, or you have a local group that somehow gets active, and that doesn't happen that often, then no-one does the job.

Transparency is part of it, but I think we've also got an issue around resolving accountability for some key issues and where it sits. Part of that, I think, is a discussion that involves local government. Frankly, I think it involves local universities as well. I think the PHN and the LHD have to be there, and probably a range of non-government organisations that provide health services. It probably does need some additional funding if only to do the planning and accountability work. But I'll leave that comment there. It has been really helpful, Mr Thomas and Councillor Miller. Thank you very much. We'll send you a transcript and you'll get to check that. I don't think there were any questions taken on notice, but there may be questions from the Committee that are sent to you and we would like you to write a reply to those questions. That will be part of your public evidence. I presume that you would be happy to do that if we did have supplementary questions. Yes?

PHYLLIS MILLER: Absolutely. No worries at all.

The CHAIR: Thank you for your time. That was terrific.

(The witnesses withdrew.)

(Short adjournment)

Mr CRAIG GROSS, Professional Officer, NSW Nurses and Midwives' Association, affirmed and examined

Ms FRANCES USHERWOOD, Primary Care Sector Coordinator, NSW Nurses and Midwives' Association, affirmed and examined

Ms FIONA DAVIES, Chief Executive Officer, Australian Medical Association NSW, affirmed and examined

Mr TIM McEWEN, Delegate, Australian Paramedics Association (NSW), sworn and examined

Dr CHRIS SELVARAJ, SET5 Accredited General Surgical Trainee, Murrumbidgee Local Health District, and State Councillor, Australian Salaried Medical Officers' Federation NSW, affirmed and examined

Dr KATHRYN DREW, Director of Medical Services, Mental Health, Alcohol and Other Drugs Services, Northern NSW Local Health District, Australian Salaried Medical Officers' Federation NSW, before the Committee via videoconference, affirmed and examined

Dr LESLEY BARRON, General Surgeon and Medical Director of Surgical Services, John Hunter Hospital, Australian Salaried Medical Officers' Federation NSW, before the Committee via videoconference, affirmed and examined

Mr CODA DANU-ASMARA, Industrial Officer, Australian Paramedics Association (NSW), before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome our witnesses from the Australian Paramedics Association, the Australian Salaried Medical Officers' Federation, the NSW Nurses and Midwives' Association and the Australian Medical Association. There are a number of witnesses online as well in as person. For those witnesses appearing in person, please be aware that staff will be taking photos throughout the hearing. If you have any concerns, let us know. Could everyone please confirm that you have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

CRAIG GROSS: Yes.

FRANCES USHERWOOD: Yes.

FIONA DAVIES: Yes.

TIM McEWEN: Yes.

CHRIS SELVARAJ: Yes.

KATHRYN DREW: Yes.

LESLEY BARRON: Yes.

CODA DANU-ASMARA: Yes.

The CHAIR: I ask witnesses who are appearing by videoconference to state their name before answering a question. It will assist Hansard with the recording of today's evidence. The panel will have questions from different members. Before we start, would organisations like to make a brief opening statement, perhaps of two minutes? We will start with the AMA.

FIONA DAVIES: The Australian Medical Association would like to thank the Select Committee for the opportunity to prepare a submission to this inquiry and to appear today. I would like to acknowledge the traditional owners of the lands on which we meet today and pay my respects to Elders past, present and emerging. My name is Fiona Davies. I'm the Chief Executive Officer of the Australian Medical Association NSW. It has been my privilege to appear before this Committee a number of times.

Cross-border and funding arrangements are a very significant issue for rural and regional health. The most obvious issue identified—and it will be raised, I am sure, by all of my colleagues today—is the impact of the disparity in remuneration arrangements between New South Wales and other States. This disparity impacts on regional and rural health services because services close to the border are generally rural and regional. The disparity is also felt because where there are healthcare shortages, doctors, nurses and other healthcare workers may choose to remain in metropolitan hospitals.

Increasingly, as metropolitan and outer metropolitan hospitals need to pay additional rates to fill vacancies, regional areas find it harder to compete. An obvious example of this—which actually doesn't relate to doctors but relates to midwives—is Tamworth Hospital, which is a service that is currently on the brink of collapse, despite being an incredibly critical hospital for a large part of the community. They are struggling to retain their midwife

staff due to the issues with pay. This is an issue that we see needs to be addressed as a matter of urgency. There are numerous other related doctor examples.

I'm really pleased to say that AMA NSW will be filing tomorrow for an arbitration, thanks, in large part, to Dr McGirr for his support. That arbitration will be to address the visiting medical officer arrangement, which is the arrangement that the AMA is responsible for. We're very proud of the fact that the visiting medical officer determination currently includes a differential for regional and rural doctors. It is not enough, and a key part of the arbitration that we will be pursuing will be to strengthen the determination to make it even more attractive to be a doctor in rural and regional areas. We're very confident in that case. While AMA NSW is not responsible for other medical awards, we believe that arbitration in these awards should be undertaken and that the Government should consider more urgent interventions for communities at risk, such as Tamworth.

Cross-border issues also impact regional health services, with many New South Wales hospitals needing to outflow complex patients to interstate hospitals. This has significant impacts on those State budgets. It impacts on access to training, and it impacts on the care that patients are able to access based on their geography. Commonwealth-State funding has a massive impact on general practice, and we have identified that as a critical issue. While there are many solutions being considered, often those are bandaid solutions that are not really addressing, in an innovative way, the way we need to attract, retain and support GPs. For instance, we could be exploring options such as allowing regional GPs to access public hospital radiology and diagnostic services under the Commonwealth Medicare Benefits Scheme—innovative ideas that would improve access to health care.

Obviously the National Health Reform Agreement is set to expire in 2025, and Commonwealth-State health funding arrangements have a profound impact on our public hospital system, particularly our regional and rural hospitals. Activity-based funding was seen as a way to address some of the unfairness and issues facing our healthcare system. It was identified that, for many rural hospitals, that wasn't an appropriate funding arrangement. But it is something where we do need to see funding arrangements from the Commonwealth and the State that fairly address the service and health needs of very disadvantaged communities in rural and regional New South Wales. I'm very happy to take any questions.

The CHAIR: Thank you very much. We might go to the Nurses and Midwives' Association. Did you want to make a brief opening statement?

CRAIG GROSS: Sure, thank you so much. The NSW Nurses and Midwives' Association is the registered union for all nurses and midwives and assistants in nursing and care workers in New South Wales. The NSW NMA membership comprises all of those who perform nursing and midwifery-related work at all levels, including management, education, advocacy and research. The NSW NMA now has over 80,000 members across our State. We are affiliated to Unions NSW and the Australian Council of Trade Unions. Eligible members of the NSW NMA are also members of the New South Wales branch of the Australian Nursing and Midwifery Federation. The NSW NMA strives to be innovative in our advocacy to promote a high-quality, well-funded and integrated health and care system. We are led and predominantly staffed by nurses and midwives who recognise that it is our professional obligation to advocate for a healthcare system that is well staffed, accessible and equitable to meet the healthcare needs of our communities across New South Wales.

The NSW NMA and our members are committed to improving standards of patient care and the quality of services through advocating for competitive pay, evidence-based excellent working conditions and improved government funding of universally accessible, high-quality health services through a fair and just taxation system. I must reiterate sentiments expressed by our assistant general secretary Michael Whaite in a previous hearing of this inquiry that we see the efforts that local health districts within regional, rural and remote facilities are making to improve the recruitment and retention of nursing and midwifery staff through incentives and the like. The concern remains that without significant improvements to pay, working conditions and workplace culture for our members, we won't see genuine improvements that retain skilled workers and serve the needs of our rural communities.

A lack of adequate funding means that progress towards an equitable, accessible and high-quality comprehensive health care system is limited or non-existent. We have heard suggestions that the health budget was overspent and that LHDs continue to invent novel methods of cost cutting to meet inadequate budgets. Some examples of this are the systemic actions being taken by local health districts to undermine the ability of our members to achieve professional recognition and a modest increase in pay through grading as a clinical nurse or midwife specialist. We are seeing reductions in the coverage of administrative staff, with their duties effectively being pushed onto clinical staff. Unless the Government funds the staffing levels required for change, workplace culture will not significantly improve and will most likely continue to deteriorate as we see more people leave our State to work across borders where they're getting better pay and better conditions.

The NSW NMA believes in open, honest and transparent dialogue with the New South Wales Government and the Ministry of Health as to how we will progress improvements for our members to their pay and work conditions that will allow them the financial sustainability and professional respect to continue working within their communities in New South Wales.

The CHAIR: Thank you. Now, the Paramedics Association?

CODA DANU-ASMARA: Thank you. The Australian Paramedics Association is a registered trade union representing on-road paramedics who are employed by NSW Ambulance. We'd like to thank the Committee for giving us multiple opportunities to state our piece as part of this ongoing process. Obviously, rural and regional health is the future of New South Wales, and paramedics play a vital role outside of metro areas and Sydney. However, as this inquiry has gone on, we've noticed a regression in the quality of service, the amount of funding and also the ability to skill as a specialist in these rural and regional areas. Rather than a progression, as the two-year Committee has gone forward, we have noticed instead a regression. We're happy to take questions about that. Thank you, Chair.

The CHAIR: Dr Selvaraj from the Australian Salaried Medical Officers' Federation, do you have an opening statement?

CHRIS SELVARAJ: I am here to represent both ASMOF and my own personal experience. The Australian Salaried Medical Officers' Federation is a registered trade union and they represent all salaried medical officers within the system. In terms of the New South Wales branch, I have been a councillor for four years. I am a doctor-in-training councillor. To give a bit of context as to what that is, I represent over 3,400 doctors in training across New South Wales. Over that time on the union I have had myriad experiences listening to members, hearing stories of doctors in training around the State, whether they are metropolitan, regional or rural. I was born in Sydney, grew up in Sydney and trained in Sydney. In my final year of medical school I rotated out to Lismore. I was there for a year. I fell in love with it. I absolutely love the rural lifestyle, the practice, the patients and the community. I always endeavoured to return. Over the course of my surgical training, I spent 18 months in Port Macquarie, 18 months in Wagga Wagga and 12 months in the Shoalhaven. Whilst most of the position of ASMOF is contained within the submission, I can speak to my personal experiences as well.

The CHAIR: Thank you all for appearing. I am going to begin with a question for all of you. We will then have specific questions for the different groups. In the context of this Committee, workforce has been a major focus and continues to be a major focus. We're clearly today looking at cross-jurisdictional issues and interactions with the community in terms of this inquiry, but workforce keeps recurring. I am interested to know, at this point, whether the New South Wales Government has consulted with any of your organisations about long-term rural and remote medical and heath workforce recruitment and retention strategies? Has there been consultation by NSW Health with any of your organisations about a long-term recruitment and retention strategy for rural and remote?

FIONA DAVIES: The main interactions we have had with NSW Health arising from the original inquiry were related to arrangements for GP Visting Medical Officers (VMOs). But I would not characterise those as discussions about long-term strategic workforce planning.

The CHAIR: Members of ASMOF?

CHRIS SELVARAJ: ASMOF is currently amidst negotiations and a bargaining process with NSW Health. We have, over the past year or so, been discussing issues that we have brought to the forefront regarding recruitment, retention, relocation, accommodation and cultural issues within NSW Health. That's leading to an attrition of the doctor-in-training workforce and, essentially, a slow bleed or exodus to other States.

CRAIG GROSS: From the perspective of our association, our members haven't made any secret of what they see as being required to improve the pay and working conditions here in New South Wales. It's been very public and very loud. Beyond that, our leadership have been in intense negotiations and consultation with the Government to progress the case of our members. Unfortunately, we still see outflows of our members moving to States where we have better pay and conditions. The solutions are there and they're evidence based. We presented a consultancy report prepared by Deloitte that showed how savings could be made to afford to do what needs to be done for our members' pay and conditions to keep them in New South Wales. There has been consultation there. But that seems to have come to a bit of a standstill at this point.

The CHAIR: Any comments from the Paramedics Association?

TIM McEWEN: The biggest one for us is that since the Committee first convened, we've had our major wage case go through, which was successful in securing payment that we see as being commensurate with our skills. That hasn't stopped the flow of paramedics going to other States for better pay and conditions. The other

thing as far as retention goes is that Ambulance defaults to the Health strategies for bonuses for going remote, rural and regional. In my experience, they have been largely ineffective, with very low take-up.

The CHAIR: That is a complex question in the sense that there are ongoing industrial negotiations. I can appreciate the Government would be dealing with those issues as well. It was a recommendation of the original inquiry that there is a workforce recruitment and retention strategy for rural and remote communities. I think the Committee still has a view that that is important to achieve. Part of that is clearly related to pay and conditions. You would imagine that a strategic approach might be valuable, even in that context. I might leave it at that. Is there a question from Coda?

CODA DANU-ASMARA: I was just going to add on to my colleague's answer more specifically to say that while there has been an injection under the Rural 500 system for 500 new paramedics, how to maintain those 500 new paramedics in rural and regional areas has not particularly been consulted on with us via NSW Health. I can even say that the bleed has happened so much that, actually, one of our delegates who previously testified at one of these hearings has moved to Queensland since the beginning of this process, just due to better pay and better conditions. It's a large issue among the paramedic cohort.

The CHAIR: I suppose it goes to the heart of an issue. Part of what is critical in recruiting and retaining health practitioners does relate to pay and conditions, but it also relates to career pathways, to culture and to supporting and valuing the workforce. I think it is part of a strategic approach and goes to more than pay and conditions. I think that you have highlighted that by making that statement. Mr McEwen, I think you indicated the same—that there was still an outflow of your members despite there being a pay settlement in your case. I might commence some questions, with the permission of the Committee, and then I am going to defer to other members. I will start with the AMA. Your submission provides your four-point plan for hospital reform. Would you like to elaborate on that, particularly in terms of the need for cross-jurisdictional health reform?

FIONA DAVIES: There is nothing new about the difficulties between the State and Federal funding of health, and this Committee is not going to fix those issues. We do think that we need to see much better funding arrangements and cross-jurisdictional cooperation to ensure that patients are able to get access to care, even if it is outside their region. That requires transparency, it requires communication and it requires funding. We also see that we need to focus on ensuring access to training as part of those strategies. Obviously, we have touched on workforce. Finally, the key aspect is sufficient budget to be offered, particularly with the current budget for the New South Wales health system. We are seeing it is woefully inadequate. It is our understanding that every local health district is currently significantly over budget, and that needs to be addressed as a matter of priority. I'm happy to talk to more specifics.

The CHAIR: What is the impact for rural and regional health services of that constraint on funding?

FIONA DAVIES: What we are hearing is that because rural and regional health services often have fixed costs in terms of higher locum costs and higher wages costs, we are hearing from most regional local health districts that services are currently being constrained. Many districts have been directed to return to activity levels of 2018-19 despite huge increases in demand for services. We've got many doctors across rural and regional areas—procedural doctors—who are not actually currently able to access operating time because activity has been constrained. For rural and regional patients, where access in other areas is not a matter of simply finding another hospital or another district, those impacts are becoming more profound.

We are also seeing that as metropolitan districts are more and more budget constrained, many districts will no longer accept patient transfers. For instance, it has been well-established that places like RPA used to accept a lot of work in from places like Orange. Many of those districts are indicating that they're not going to support those sorts of arrangements. We are seeing similar tensions in the Albury area and up north into the Lismore border areas. That is why, for regional communities, those budget constraints really have a much more profound impact. It's also an issue for the doctors who work in those areas. They often maintain very significant on-call loads in regional areas but are otherwise not able to have their patients' elective surgery needs met. In terms of your points, Dr McGirr—and I could not say that enough—remuneration is only one part of the issue in attracting and retaining healthcare workers and doctors to regional areas. It is also the sense of satisfaction. It is ensuring your patients are able to get the care they need, and that that care should be comparable to the care that is available to a patient in a metropolitan area.

The CHAIR: If I can be permitted to explore your plan a bit further, you referred to the fact that there should be some funding for performance improvement outside of activity-based funding.

FIONA DAVIES: Yes.

The CHAIR: You also talk about funding for primary care, I think, or out-of-hospital care. I am interested in that idea of funding for performance, separate to activity-based funding.

FIONA DAVIES: The AMA has gone on the full evolutionary journey around activity-based funding. We used to be opposed; we have come around to seeing its value. But the challenge with activity-based funding is that if you have a community with significant social need or health need, and you may not be able to maintain the activity levels, then activity-based funding actually becomes a disincentive. Small rural hospitals are, for that reason, block funded. We think we actually need an injection of payment that is not just linked to activity but that is actually linked to building capacity within hospitals in regional and rural areas. If you are simply relying on activity, if you're not able to have the workforce meet the activity, it is actually perpetuating a problem. It also means it is harder to build and develop your workforce.

The CHAIR: That funding might include funding for teaching, supervision, research and professional development.

FIONA DAVIES: Yes. To give you a really simple answer, if you're trying to attract a doctor to a regional area, particularly a surgeon, you will usually have to give up your time. If you happen to have a great person who could come in, you'll often have to give up your operating time. There is no capacity to develop and support an increased workforce—so, exactly. Look, it would be ideal that it also supported research. We should be aiming that our regional communities not just get good enough health care but that they get as good health care as anybody could get sitting in any part of Sydney. It should be research, it should be training, it should be teaching, it should be supervision and it should address the fact that the needs and demands on doctors and healthcare workers in rural areas and communities are going to be different to those in metro areas.

Ms JANELLE SAFFIN: I have a couple of questions. They are for everyone to answer, or one or two, as you wish. They're general and they do relate specifically to the Legislative Council inquiry and its recommendations. How does the New South Wales Government consult with you as stakeholders, and your members in the remote, rural and regional areas, in relation to improving communication between communities and health services and also developing place-based health plans? Have you got any comments you could make on that?

TIM McEWEN: If I may speak, in my experience, NSW Ambulance doesn't consult with local communities in any way. I have been in the job for 24 years, mainly in rural and regional, and the consultation with local communities is non-existent, in spite of there being a number of measures that change either the workforce or the way that service is delivered. That has significant impact on the community, and the communities are not consulted about that.

Ms JANELLE SAFFIN: Does anyone else want to comment, or not particularly?

CRAIG GROSS: I think, from our perspective, we do see community consultation occurring. It hasn't been a focus for us in this tranche of the inquiry, which is something that we spoke to in our submission. It does occur but obviously our members, especially in rural, regional and remote areas, often access the health services in those areas as well. Where we can, we encourage our members to be actively involved in any consultation that occurs. We have been very conscious as an organisation of attending forums like local health district annual meetings and the like and encourage our members to do the same. I would say probably the strongest suggestion from me would be that, when these forums are coming up, there needs to be greater effort to notify people that they're occurring. I live in a regional area, and my local health district had their annual meeting. It happened like a whisper. It was like it was a State secret for it to occur. As community members, we learnt about it after the fact. So I think make an effort to promote them and encourage people to attend and speak to what they need within their communities.

Ms JANELLE SAFFIN: If there are no other comments, the next question I wanted to ask is whether you have seen any progress in terms of the New South Wales Government investigating ways and means to develop the primary health sector. Again, it speaks to a specific recommendation of the LC inquiry.

FIONA DAVIES: I'm happy to comment. Obviously NSW Health is working with the AMA and the Rural Doctors Association on some of the VMO arrangements that apply to rural GPs. I'd have to say that has been a very slow process. I think sometimes it's because complexities have been the enemy of a solution in that instance. But the process has happened. The Government has, both at a State and Federal level, otherwise focused on the creation of urgent care centres. I understand the political imperative for that, but I think that has been, firstly, fairly metro-centric. It has also been very hard for private general practice to tender for and run those arrangements—some have—partially because of barriers such as you are supposed to offer radiology and pathology. While I would have to say that is honoured in name only, that's a tender requirement. A focus on that strategy has actually taken away from the building of capacity in general practice.

I do commend the Government on the single employer model. NSW Health has taken that really seriously and are working very hard with practices on that model. It is obviously based on a pilot that was established in

the Murrumbidgee. But, again, that should only be one part of a solution, because we also want to ensure that the New South Wales Government does not inadvertently make it really hard to run general practice out of hospitals. If we do that, then suddenly the NSW Health budget will be responsible for not only running hospitals but also running primary care. We've seen in Queensland that well-intentioned salaried models often just build up capacity in hospitals and actually don't build up capacity in general practice. So I would say that there has been some work, but not deep enough work, and I think there is a real need to also bring the Commonwealth to the table, and a need to be much more creative with options such as—I know many GPs who believe that they could provide a broader range of services if they could simply access some diagnostic services out of hours. I realise that's a very hard thing to do at every level, but those are the sorts of creative solutions we should be looking towards.

FRANCES USHERWOOD: As a quick background to myself, I am the primary care coordinator for the NSW Nurses and Midwives' Association, but I'm also a nurse practitioner. I've been a nurse practitioner for a number of years in paediatrics and worked as a nurse since 2005. From a nurse practitioner perspective, I know this morning this Committee touched on the Rural Nurse Practitioners Framework for NSW Health. That is a framework that has been designed to improve primary care in rural and remote areas from nurse practitioners. The framework exists in that it trains nurse practitioners through LHDs in something called a metaspecialty, which is quite new to nurse practitioners—we used to be very specialised—and the metaspecialities are specifically around primary care. The idea is that you train in the hospital or in the LHD and you get GP supervision as well through the university system and you come out as a nurse practitioner working in the community. It's been successful in that the directors of nursing and the nurse practitioner coordinators meet online monthly, I think it is, to check how they're all going. I don't know the numbers, but they've had quite a few nurses take up the opportunity in this program. It came in response to the medical shortages that existed.

It does take a while. It is a long-term vision and it does need sustainability in funding to continue it. From our perspective, to keep those nurses and nurse practitioners working in New South Wales and not moving across the border, there obviously needs to be fair pay and access to that for them. Touching on your point, too, about improving workplace conditions beyond pay would be the scope of practice review that was published last month, Unleashing the Potential of our Health Workforce. That talks about the nursing scope of practice and expanding the nursing scope of practice to the full extent of what a registered nurse can do, not then moving into the nurse practitioner remit. We know that increasing nurses' scope of practice will increase access to healthcare services, but it also shows that nurses working to their full scope is demonstrated in evidence to bring joy to their workplace and make it a more sustainable workplace as well—something that we highly endorse and support.

LESLEY BARRON: I'm a surgeon. I currently work at a large academic tertiary care hospital at the John Hunter, but I have previously worked in Alice Springs and in a small community-based hospital in Canada. Moving here, I was actually extremely dismayed, as a student of healthcare policy, to see the Federal Government bringing in urgent care centres. High-functioning healthcare systems are based in longitudinal, high-quality, universal access to primary care. It's the best money that the healthcare system spends. I say that as somebody who works in a level 6 trauma centre. It's incredibly dismaying to see the lack of interaction because of the funding streams between primary care and acute hospital care. I think there's a lot that could be done to incentivise that through the budget. I actually don't think we can have a healthcare system that functions properly. Canada has had a very long experiment with increasing numbers of walk-in clinics and increasing numbers of urgent care centres, and it does not improve quality or access to care.

Ms TRISH DOYLE: Thank you all for representing your union workforce here today. In doing so, I acknowledge that we're dealing with systemic problems that have landed us at this point for quite some time. Thank you for speaking truth to power and thank you for your patience. It's important for us to hear the brutal truth. Pass my thanks onto your members. I have a question for the APA. Paramedics have a special place in my heart. NSW Health notes that paramedics have been the first workforce to test that integrated workforce model. I understand that has been delivered jointly—the Ministry of Health, local health districts and NSW Ambulance—and it has been delivered at a number of pilot sites. Currently it is in the process of evaluation. Within that process, has consultation occurred with you?

TIM McEWEN: There are probably two pilots that I would refer to. One is at Mudgee Hospital, where they are integrating paramedics into the emergency department there. Another one is the extended care paramedics that are being taken on by the Northern NSW Local Health District, based in the Tweed Valley Hospital catchment. I think there have been three extended care paramedics that have been based up there since July, when I think they started. There was consultation on both of those. I didn't sit on either of those. Very early on I did the extended care paramedic model, but since then I haven't. Mr Danu-Asmara may be able to elaborate on that. Yes, there has been some consultation. I'm not aware of where the evaluation stage is up to.

Ms TRISH DOYLE: My question was really around the consultation through yourselves, and with the paramedic workforce's voice being heard in the process. Did you want to comment on that, Coda?

CODA DANU-ASMARA: Thank you, yes. There was a consultation process with both of those things. The northern New South Wales one was before my time, but I can speak a little bit to the one that is happening currently in Mudgee and I believe Wagga Wagga is another place where it's happening. We did receive some consultation and we have had some member feedback about it, but I don't know, at the moment, where the current data has come from. We haven't been given a lot of updates about how the process is going. We are a little bit in the dark about whether or not it's going to be rolled out elsewhere, whether or not it has been a success or how it has been going. All we know is vague statements on the ground that some people like it and some people don't. That's not really enough to get a great picture of how things are going. What we can also do is we are happy to ask some of those people on the ground and take this question on notice to give you back a more detailed response about this as well.

Ms TRISH DOYLE: It's more about whether you were approached and consulted, because it's premature to comment if the evaluation process is now underway, but I was interested in the consultation. I'm sure that our nurses and midwives have got something to say about this as well.

CRAIG ROSS: We were consulted on the trial that is currently occurring in Wagga and Mudgee. Especially for the trial in Mudgee, with the implementation of paramedics into emergency, we raised questions around that and the utility of that. There was some basis on previous trials or some work that had been done in Canada in a similar vein to this. We questioned why you would be putting another category of worker into an emergency department when you already have skilled and talented nurses with a broad range of abilities that can provide the holistic care, from triage to ward admission or discharge. That was our perspective. We also haven't heard any further about what's actually going on on the ground, other than what we hear back from our members.

Ms TRISH DOYLE: It will be interesting to see what the evaluation turns up. In terms of the different scope of skills and testing the integrated workforce model, I am interested in each of your views.

FRANCES USHERWOOD: To add to that, I think it's a really interesting point to raise—in the context of remote, regional and rural health care—the idea of task shifting and task sharing and roles being available to the clinician that's around at the time. That's something that's quite complex because, from the patient perspective, having someone available is very important. But from our perspective—representing nurses, midwives, doctors, paramedics or pharmacists; whoever we are representing—it's really important that we are thinking about the holistic team and having the right people providing the right care at the right time, depending on their skills, experience and clinical support as well.

The CHAIR: I'm going to ask some questions of ASMOF, particularly, because we haven't asked much of you so far. Your report—I hope I've got this right—made the point that recruitment and retention wasn't any better and, in fact, it referenced a couple of situations with psychiatry and I think obstetrics on the Central Coast where there had been some pretty significant downgrading of services, threats to services or difficulty with recruiting. You referenced both the extensive amount of money spent on locums to keep services going and the issues around culture as being a factor in terms of recruitment and retention. I wonder if any one of you might expand on those issues.

CHRIS SELVARAJ: I can't speak to the Central Coast example in particular, but I can take that part of the question on notice. Speaking from my personal experience and the member sentiment that has been communicated to the council, the general feeling is that since the time of the pandemic until now, the health system is really struggling in terms of maintaining a stable workforce. I'm sure this is replicated across all the different health professions, but particularly within the subset of doctors, we are finding that there are a lot of vacancies and that these positions are being filled predominantly by fly-in fly-out interstate locums. I believe I saw submitted to the inquiry somewhere that the locum budget had doubled from somewhere in the order of $130 million to $260 million since the onset of the pandemic.

What we are seeing here, particularly in rural and regional areas, is that the trainees and doctors that would like to move to these areas, spend time there and invest in the communities aren't really getting those same opportunities to rotate out to these regions. That is coming down to a couple of different factors, which are addressed in the submission, but the holes are being plugged or covered by interstate locums. These interstate locums come and they communicate with the doctors on the ground. They tell them how good the conditions are in other States and how much they are getting paid, which is sometimes in the order of three or four times more than local doctors are being paid, and that affects morale.

In terms of culture, I can say that the perceived lack of oversight or central governance creates an opinion that every local health district is very different—the training is different and the conditions are different. Some are better than others. Some perform really well. I was in Wagga Wagga, and it was an outstanding model of having students that are trained there, junior doctors that are trained there, and having people that desire to return to the area. My daughter was born in Wagga Wagga. They provided accommodation for us in Wagga Wagga. My

family was happy in Wagga Wagga. But that wasn't replicated in every LHD. In fact, some were almost antagonistic.

The CHAIR: Would any other members of ASMOF like to make a reflection on those issues around culture, recruitment, retention and so on? The point you've made around the locums coming from interstate relates to the interjurisdictional nature. We are dealing with pay rates that differ between States. The point that you've made about locums coming in and almost exacerbating those issues is very relevant to what we're looking at here. Thank you for that. I will go to Dr Barron first.

LESLEY BARRON: As a surgeon, on-call matters to surgeons, and how much on-call you're doing is very important.

The entire patient population, but particularly in regional and rural areas, is sicker. They're more complex. You are likely to have to get out of bed in the middle of the night. The days where you could stay at home and let the registrar do the case are long, long over. When you have a system where you're paid a flat salary that does not acknowledge that your call frequency is much, much higher than somebody working in a metro area, it is a problem for the award for staff specialists. Then you have this additional issue that, in spite of the fact that you might have moved there, bought a house there, you're sending your kids to school there and you're invested in the community, you have locums coming who are earning many, many times per hour what you are earning. It does seem unfair. Locums are necessary to give people who work early and are on high-volume on-call schedules a break, but they are certainly needing to be used far too much. For the income differential with private and public work, that's a big problem because there is less private work in rural areas, and that's where most proceduralists make most of their money. That's a big difference when you're looking at this pay scale that does not take into account those differences for surgeons and proceduralists.

KATHRYN DREW: I am the director of medical services for mental health, alcohol and other drugs in northern New South Wales, so I'm well versed in the workforce difficulties in psychiatry in the State, really. It's not just in rural and remote areas, but it is much more the case in rural and regional areas. Psychiatry has a workforce shortage across the State. Some 30 per cent of the staff specialist positions are vacant across the State. In my own district, we have funding for 25 staff specialist positions and we have about five FTE of that filled. Half of the vacancies are filled by VMOs—some quinquennial, some short-term—and the rest are filled by locums. At any time, we would have nine or 10 locums in our service, which is both incredibly expensive but, more significantly, incredibly disruptive and does not provide the best care. In psychiatry, continuity of care is everything. We just have a rotating roster of locums coming and going who are of highly variable quality, not aware of our processes and not aware of how we work. It's incredibly difficult.

In the time that I've been in northern New South Wales, which is a bit over two years, what we have done is that we've worked really, really hard to invest in our junior medical workforce, following through on the evidence that if you live and train and work in an area, that's the key to recruitment in junior medical workforce. That's been a very successful process, in line with registrar positions actually becoming—there have been more applicants for registrar for psychiatry training across the State, so we've been able to boost that workforce. But what is really disappointing in that is that we're not able to provide our trainees with the best supervision because we don't have the senior medical staff to be supervising them.

The other point about that is that the training in New South Wales in psychiatry, as is true for most specialities, has been organised historically, since 2006, as being basically metro-centric and then you rotate out to the regions. That isn't in keeping with the best evidence of growing your own. We would be running with people being rotated from the city. They didn't want to come; they got paid at a higher grade to come. Then we had our own registrars, making up some of the rest of the workforce, getting paid less than the trainees that were being rotated up and with nothing incentivised to keep them there. The accommodations were also subsidised for people coming from the city but not for the people that were working in the region and living in the region.

I don't think that the structure of training is actually there to support local trainees growing, and I really think that that needs to be altered. Until we can get senior medical staff it is almost a moot point, because it's very hard to train people when we don't have the psychiatrists there to train them. I note also that I'm probably the only ASMOF member able to talk to psychiatry. I think there's about the five of us in northern New South Wales, and I don't think any of the other regions have salaried positions for their psychiatry workforce.

The CHAIR: Just on that last point, has that changed recently because of the industrial issues or has that always been the pattern?

KATHRYN DREW: I think that's a very worthwhile point. The industrial issues have arisen essentially as the whole psychiatry workforce has been drastically diminished since, possibly, COVID or some time around that. Psychiatrists have multiple options about where to work—both interstate, where generally psychiatrists are

level one, or always level one—all of the interstate awards are far more favourable, but also VMOs are far more favourable. There has been a decrease in the workforce, perhaps since COVID. People have left the public sector. There are lucrative private options as well. What has happened is that these vacancies have affected the metro areas as well. So now, because the metro areas also have gross workforce shortages, that has led to the industrial processes. Even though this is what the country has been sitting with all the time, it only became something that people would fight for once it happened in the metro area. I hope that makes sense.

The CHAIR: Can I pick up on another point that you've made with regard to the importance of retaining workforce? Dr Selvaraj, I think you described a pipeline of support in Wagga Wagga that seemed to impress you, from junior trainees through. Dr Drew, you pointed out the differences between metro people who rotate up versus your own homegrown people. We had evidence this morning about the fact that focusing on retention in the general practice workforce has been neglected. There is a lot of focus on recruitment, "How do you recruit? How do you get doctors?" But for the doctors who are there already in communities, it almost would be as important to pay a bit of attention to their conditions and support them, yet that seems to be neglected. Perhaps the AMA, or anyone from ASMOF, might comment on the importance of retaining staff that you have in rural and remote areas.

FIONA DAVIES: As I mentioned in my statement, the most profound impact of the wages cap and then the subsequent delay in addressing the wages cap is that local health districts are very constrained in being able to offer arrangements to retain existing staff. I gave the example of the midwives of Tamworth, where the Government has been able to announce—and we welcome this—$20,000 of incentive payments but, for lots of reasons that we understand, cannot offer a similar arrangement to those people who are already there. But we see across rural and regional New South Wales that you cannot get non-standard arrangements for those doctors, nurses, midwives and others, and then they're competing with the locum arrangements. So yes, there's a huge focus on incentives to get people into areas, but there needs to be an urgent focus on flexibility to retain people in areas. I'm sure the Committee is very well aware that local health districts are very constrained about the extent to which they can go beyond existing arrangements.

The CHAIR: Clearly the impact of other States and their funding arrangements is also having an impact on New South Wales. Are there any other questions that members of the Committee want to raise?

CRAIG GROSS: Just regarding the example from ASMOF and the obstetricians and gynaecologists and maternity services on the Central Coast, the Central Coast is my home—I was born there. I still work at Gosford Hospital, which will be the only maternity service to exist from March next year when our private hospital will close its maternity services. Despite having the beautiful facilities at Wyong Hospital, there are no maternity services there. But none of our members work in a vacuum; we are all interdependent on each other. We have wonderful obstetricians and gynaecologists who work at Gosford. I have worked alongside them attending to rapid responses in our maternity wards. They do a great job, but if we see them walk away because they are working in intolerable conditions, that is also going to push our midwives to walk away as well. Our midwives are beside themselves because they are so overworked because of the lack of resources and because of the lack of funding. It becomes a vicious cycle.

I think that we've all written something to the effect of this in our submissions, that this is a vicious cycle or a death spiral when the conditions and the culture are so poor that more people go, which incentivises more people to go. This is what needs to be addressed. When we look at the crux of it, the incentives are great. We are glad that the incentives were introduced to try to draw people to regional and remote areas, but if the structural issues around pay and conditions are addressed, we probably wouldn't need to have incentives because people would be willing to go there.

The CHAIR: I thank everybody for appearing today. There be will a transcript of the evidence supplied to you for checking and also any questions that have been taken on notice today. Dr Selvaraj, I think you were going to come back us to about the situation on the Central Coast, for example. We may have further questions as well. It would be great if you could provide us with a written reply. That written reply will form part of your public evidence, and I presume that you would be happy to do that if you replied. I thank you all very much for appearing.

(The witnesses withdrew.)

Associate Professor SARAH WAYLAND, Senior Researcher, Manna Institute, affirmed and examined

Professor SALLY HALL DYKGRAAF, Head of the Rural Clinical School, Australian National University, before the Committee via videoconference, affirmed and examined

Associate Professor MICHAEL CURTIN, Head of the School of Allied Health, Exercise and Sports Science, Faculty of Science and Health, Charles Sturt University, before the Committee via videoconference, affirmed and examined

Professor MEGAN SMITH, Executive Dean, Faculty of Science and Health, Charles Sturt University, before the Committee via videoconference, affirmed and examined

Ms LEANNE NISBET, PhD Candidate, Faculty of Medicine and Health, University of New England, before the Committee via videoconference, affirmed and examined

The CHAIR: I now welcome our next witnesses. We have one witness appearing in person, Associate Professor Sarah Wayland. Just be aware that there might be photos being taken. If you have a concern with that, please let us know.

SARAH WAYLAND: Not a problem.

The CHAIR: Can everybody please confirm that you have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses? Yes, everyone?

MEGAN SMITH: Yes.

The CHAIR: Very good. Would each of you like to make a brief opening statement?

SARAH WAYLAND: It's a real honour to be here today, and I just wanted to provide a lens in terms of the evidence I will be providing. Manna Institute is a virtual research institute, focusing on regional mental health. The initiative is led by the University of New England, which is where I'm employed as a social work academic, with six other universities collaborating to ensure a place-based focus that challenges those metro-centric approaches to the support of people experiencing poor mental health in the regions. We work alongside our three industry partners, as well as making sure that everything that we do in terms of regional, rural and remote mental health needs are underpinned by a First Nations advisory group. I would also like to acknowledge the lived and living experiences of people with complex mental health conditions.

The CHAIR: I'll begin the questioning, and this is to each of the universities. A big feature of the review has been the workforce, as you're probably aware, and universities have a critical role in that. Workforce, of course, is very cross-jurisdictional. Universities may be established on a State Act but you're funded essentially through the Commonwealth, and so you have a critical role in the rural health workforce and you are funded through the Australian government. What I'd like each of you to do is just to take us through the role of the Australian and State governments in supporting rural student placements and any issues that arise from that and any opportunities for improvement. Is that clear? In other words, how does the system work just as a rural and remote focus?

We know how important the work of universities is in the rural and remote workforce. We know there have been some good models, and Charles Sturt University has been doing some work with the Grow Your Own initiative, for example, in the Murrumbidgee. But we have also heard through submissions of issues with coordinating placements, access to placements and postgraduate training pathways, and the whole remit of that. I'd like the universities to begin that discussion around what the good things are and where the opportunities to improve that are in a way that will ensure that we have a rural health workforce that's growing into the future. That was a bit of a comment, a bit of a speech from the pulpit, I understand, but you get where I'm coming from. Who would like to start?

SARAH WAYLAND: I'm happy to start, considering I'm in the room. I touched on it in my opening in terms of my discipline background as a social worker, and social work provides a really strong connection to the health workforce. From a regional university perspective, we also utilise, as the University of New England, a grow your own perspective where we are focused on connecting with community to ensure that those regional students come to regional universities and then return to their regional homes to bolster the workforce.

Whilst we can spend a lot of time talking about the significant challenges of work-integrated learning and supporting our students, particularly in a post-COVID world, through that learning there have been some really great opportunities to collaborate with communities for community to ensure that we're delivering what we can back to regional communities. The particular example that has been a significant focus of UNE for the past 10 years is the Social Work in Schools program where we identified a need for our social work students to be able

to connect back in with regional communities and to place them within schools to provide that assistance from a social work perspective, not a school counselling or a school psychology perspective, but to place those students within schools to ensure that there was support beyond the school gate.

It meant that we were able to place students there. Some of those were regional students who were going back to regional communities, low SES communities, where social workers were able to consider what the connection point was between students who were experiencing disadvantage in school and think about those connection points in the community. We've been able to not only consider the placement of those students so that they can complete their social work degrees but also then go on to partner with the Department of Education to create the Social Workers in Schools project so that there have been ongoing opportunities in workforce for students after graduating to be able to go and work in those communities.

The significant challenge is that, whilst there is a need for social workers in communities, the retention issues remain the same as any other health workforce, where students are pushed beyond their limits, where they're dealing with a number of psychosocial needs as well as those social determinants of health, and they need that continued support in community to address those health needs for young people. From a wellbeing perspective, we've been able to demonstrate by evaluating that program, but we need that continued connection where universities can assist in solving the wicked problems in regional communities by partnering early and often in those work-integrated learning perspectives.

The CHAIR: Work-integrated learning perspectives—excellent. Thank you for that; that's quite a helpful perspective. Who would like to speak next?

MEGAN SMITH: Joe, I'm happy to. It could be a long answer to this question, but I wanted to make three key points about how Federal and State interact together for us in terms of placement. From Charles Sturt University's point of view, we run placements across a wide range of disciplines, and I would say there are some interdisciplinary differences, but it depends on what discipline you come from as to what impact that has. I would probably cluster that into three groups, which are medicine, nursing—and midwifery related to that—and then allied health because they are treated differently in the placement landscape and quite differently in terms of the impact that subsequently has on workforce. I probably won't pick that up as much, but I'm happy to come back and talk about that if there's a question on it.

One of the main things for us from a Federal-State point of view is, yes, we are funded federally, I would say, across all of those disciplines, though it is the public health facilities in the State that take the bulk of responsibility for placement load for us. Even though there are other parts of the healthcare system that are funded federally, it is State-based facilities that are taking the bulk of the work and, therefore, the workforce that sits in those public facilities that are by and large taking the bulk of the supervision for us. There is opportunity in the private sector. There's opportunity in the primary healthcare network sector, there's opportunity, as Sarah said, in the educational sector, and there's opportunity in the aged-care sectors, which are all publicly funded, but the system to support placements is not as well developed in those types of environments, and that's harder for us to negotiate.

I think that is something—as an observation—of an opportunity there about how to coordinate those pieces, and that hasn't changed a lot. There has certainly been a drive to increase the amount of support for aged care particularly, but we haven't seen as much of that placement—but not the same infrastructure that's so well developed in the public system. The Commonwealth-funded RHMT program—the Rural Health Multidisciplinary Training program and the regional clinical schools, which are the medicine-based components, are really important things supporting us to be able to do regional placements and to grow the health workforce in regional areas. That additional funding support, that funding for accommodation that's sitting at the back end of that and the support that is for students that we can offer through those programs are critical. I've been at Charles Sturt long enough to know when we didn't have that support versus when we did, and access to that has been really important.

Unfortunately, it's very geographically based but I think, if you currently look at the State, there are boundaries around which that support can be provided. We have a physical boundary around which we can't support. We can support places that are inside that boundary. We can't go outside of that, so there are some gaps in that of where there is support. It is certainly better and there's been an expansion of that program, but it's still geographically based. The other challenge for us with placements, of course, is the workforce itself and the circular nature of that.

Some of the things around us that we've tried to do is actually provide—we actually have on-campus clinics that we provide services to the community through in order to augment the placement support. Michael is probably better to answer further questions on this, but one of those is an allied health clinic where we provide podiatry services. That's a great model. We provide dental services into clinics, but some of the anomalies between the

charging systems where, if it is not covered by Medicare for a service—or a service provided by a student cannot be covered by Medicare. There are actually real deficits for us being able to be good contributors to the healthcare system through some of those models by some of those anomalies that exist. That's probably enough from me, but it gives you some real examples of us negotiating what is a complex State-Federal landscape to try to get an outcome. It is certainly better, but there are still lots of opportunities for us to improve that.

The CHAIR: I might come back to Charles Sturt. I might move on to ANU.

SALLY HALL DYKGRAAF: I am the professor of rural health and the head of our Rural Clinical School at the ANU which, as was just pointed out, is part of the network funded by the Rural Health Multidisciplinary Training program. We offer health professional training at ANU only in two disciplines—in medicine and in psychology—and our rural program operates exclusively in south-eastern New South Wales, so in the geographic area that sits to the north-east and south of the ACT. That area almost completely overlaps with the Southern NSW Local Health District, and we operate in a couple of corners of both the western and Murrumbidgee LHDs as well, in our north-western zone. But all of our clinical placement activity is, at the moment, constructed around medical training. We don't offer rural placements in psychology. The only placements that we offer rurally are in medicine, and most of that is, as I said, inside Southern NSW LHD. We also operate a separately funded regional training hub, which is also part of the RHMT and focuses specifically on the postgraduate training pathways in medicine and opportunities for rural and regional training.

The issues that I would say we encounter most in the space where we are working with New South Wales Government-funded entities are much more granular than some of the things that people have talked about so far but, I guess, flesh out some of those concerns, and that's around placement capacity. The capacity is affected by a number of things. It's affected by the supervision workforce and their availability, their credentials and their willingness to supervise. One of the very specific problems that has been an issue in southern New South Wales for some time is that it has been heavily dependent on a locum medical workforce, and the enthusiasm of many of those people for supervising students and taking on that role is not the same as for people who might be a resident in a community and thinking about how they want to invest in their future workforce.

There are issues around the integration between primary care and State-funded health services and what that means for how placements can operate. We are running placements both in general practice and also in the hospitals across the different years of our program, and sometimes those things don't always line up terribly well. There are huge issues around accommodation in terms of where students might live when they're in rural communities on placement but also around what kind of training facilities we have to accommodate their learning and how we work to deliver good teaching in rural sites.

For us, in our footprint, there are some quite specific issues around the fact that the ACT sits in the middle of it. There is a jurisdictional boundary, and we are working across New South Wales, the ACT and the Federal Government. There are some historical arrangements that have been set up to solve particular problems which, over time, have contributed to new problems. For example, the hospitals in the southern New South Wales network are not visible within the HETI networks in New South Wales because all of our junior doctors in that region come out of the ACT. That's a system that in many ways works very well. It was set up for particular reasons, but it has these unanticipated effects then around the visibility to junior doctors who might have done their medical training in Sydney or in Newcastle or somewhere else in New South Wales or even interstate. Even if they wanted to come to our region, it's not self-evident that they would have to go and get a job in Canberra to come there. There are some curious idiosyncrasies around our particular geography that have been problematic for us.

In terms of areas for improvement, there are lots. But I think there are many things that are starting to happen. There have been some really useful collaborations with the LHD in the last couple of years around building new employment models. It's been a bit of a slow burn, if I'm honest, but we have some collaborative work starting to happen around the single employer model in a couple of sites. There has been a really concerted effort this year at the South East Regional Hospital in the far south-eastern corner to start looking at how we can leverage some of the John Flynn funding to procure some new senior RMO positions moving forward next year. That's very exciting. There are lots of things starting to take shape. But I think it's been important in doing that to recognise that the pipeline is long and that it needs to be sustained. This is not something that has a quick fix or that we can just implement a few things and walk away and it will all just continue.

The issue of physical boundaries is an interesting one. I think it's both an opportunity and a threat at the same time. One of the issues for us all operating in the placement space is that, as more and more health professional placements come online, we need to find a place for all of those students to be training—often alongside each other. The more we ignore our physical boundaries, then the more we create competition and pressure in other places. It both works as an opportunity and as something that constrains us. We've also been moving to a "grow your own" approach in the region, which is both happening at the local health district level,

where they are really starting to talk to the university about how do we work together around this, but we've had some growing willingness within the university as well to think about how do we adjust our admission and selection processes to look at local students. But, again, there are a lot of minds that we need to change and there is a lot of influence that we need to pedal to get those things to come together.

The other opportunity for improvement—and I don't know what the answer is. It's true to say that a lot of the things that have been made to work are key-person dependent. If there was a way to improve things by making this not so much dependent on key people who really just drive things because of their enthusiasm but making it more integrated into the system and enabling things to happen because the system demands it, then I think that would see better equity around how things happen. I gave you an example earlier of how things are really starting to happen around some workforce and recruitment models in the South East Regional Hospital—in the other regional hospital in our footprint, the same thing is not happening—because there are a couple of key people who have been able to drive things. Working out how we get the kind of equity where we get the same thing happening in other parts of the region is a really key challenge for us at the moment.

The CHAIR: Thank you, Professor Dykgraaf. The University of New England—Ms Nisbet?

LEANNE NISBET: Thank you very much. I just need to explain. With my presence here today, I'm representing NEViHN, the New England Virtual Health Network, so my lens is very restricted and I don't have a purview across what's happening in the entire faculty. But I do know that one of our three projects funded at NEViHN was longitudinal integrated clerkships, which we intended to have with the digitally enabled healthcare clinics that we were going to establish under NEViHN. The longitudinal integrated clerkships have continued on without that digital component, but our major issue is, as Sally said, finding the supervisors out in the New South Wales hospitals that are equipped and prepared to be able to supervise someone when they're out in their placements.

The idea of the longitudinal integrated clerkships is a great one, where teams of students go out and they're embedded to a regional, rural and remote town for an extended period of time so that they get a good feel of what it's like to be involved with a small rural town and to see what regional, rural and remote health care is all about. We've been lucky with the students in that we're able to offer scholarships to help them with their accommodation costs while they're out there. But the biggest problem of all is finding the supervisory people who can supervise them in the hospitals. I spoke to our dean about this earlier in the week and she said that, as a way forward, perhaps an idea might be to be more flexible with the requirements for supervisors and, perhaps in some of the hospitals that don't have GPs but have nurse practitioners overseeing, a nurse practitioner might be able to also supervise those students out there on the practical placements. That's really all I can offer you with respect to that question. I'm happy to take extra questions if you'd like to ask.

The CHAIR: Can I just clarify there, Ms Nisbet, in terms of the longitudinal integrated clerkship program, which I agree is a very powerful model for training people in general practice and retaining them in rural areas, are you saying that at the moment you'd like to do that but you're not able to do it because you don't have supervisors? Is that what you're saying?

LEANNE NISBET: We are doing that, but our locations for being able to do that are limited. I know that we're doing it in Inverell and I know that we're doing it in Moree, but that, as Sally said before, is a little bit key-person dependent too, because the person who has that responsibility within faculty was also a GP in those locations and so has connections to GPs. She has been able to get them on board with the supervising. But, for other areas where there are smaller rural hospitals like Glen Innes and even smaller ones like Emmaville, there are no GPs there or, if they are there, the GP is on a rolling locum rotation. As Sally also mentioned, they're not so keen to pick up the gauntlet and also be supervisors to our students. We do have it operating, but we're just very limited in the locations that we can send the students to.

(Sally Hall Dykgraaf withdrew.)

The CHAIR: Do any of the universities—and you may want to take this on notice. Can you provide us with any data on how many of your medical student trainees return to work in rural areas?

LEANNE NISBET: Yes, I will have to take that on notice, Joe, I'm sorry. But I can absolutely do it. I do know that there are papers that have been written on this because I've reviewed them. But I will go and find the local information for you.

The CHAIR: I think, Charles Sturt, your program hasn't completed yet, so you're not in a position to monitor that. Professor Smith?

MEGAN SMITH: Yes, one year to go. Just a year to go when first graduates come out.

The CHAIR: ANU, do you track how many of your graduates return to rural—we've lost the person from ANU, is that right? She had to leave. We might put that question on notice to her. Professor Wayland, did you want to make a comment?

SARAH WAYLAND: Yes, I just wanted to, in listening to all of the discussions here and being part of UNE as well as Manna—the other piece of the puzzle that's missing from the conversation is the accrediting bodies. In terms of social work and nursing and medicine, some of those discussions around who has capacity to supervise and some of the COVID workarounds that were included over that 2020 to 2022 period were really important to reflect on in terms of making sure that we could offer work-integrated learning or placement opportunities but making sure that we were in partnership with our accrediting bodies so that they could talk about the realities on the ground as well. That's not about diluting the supervision aspects but about understanding those real-world challenges of finding supervisors on the ground and being creative or innovative in terms of some of the ways that we can address those gaps so that the students can get out there and then become part of the workforce. I just wanted to add that into that pipeline discussion.

The CHAIR: Professor Curtin, did you want to make a comment?

MICHAEL CURTIN: I thought I'd better say something, otherwise I won't get my voice heard. I'm coming more from an allied health perspective here. I would say, in answer to your question—I know you were talking about doctors before—but probably about 70 per cent to 75 per cent of our students go back to working in rural and regional areas. There are a couple of things that I think a lot of what everyone has said would affect us, but I would say that public health does a great job of providing opportunities for our students overall, when they've got the staff around and are available to do that. In the NDIS sector and the private sector—aggressive is probably too strong a word, but they are really out there to get students in the last year of training, and presumably so they have long interviews to recruit the students for their positions afterwards.

I would say that a smaller percentage of our students go into public health now than there used to be, and the NDIS is a major factor in that. The thing that I feel for our students at Charles Sturt University is that they are at a disadvantage. Most of them will come from regional and rural areas. But when they are doing placements, if you go to a regional university, you are at a disadvantage because you're going to have to travel for your placements. We don't get enough placements around Albury or Bathurst or Port Macquarie, or wherever, to cater for all our students, compared to a metropolitan area. I'm not saying that it's easier in metropolitan areas, but generally our students will have to travel. And there comes the whole thing about the cost of living, being away from home, accommodation and all that other stuff that happens. That's generally for most of our placements, not just for one or two—it's for the majority of their placements that they have this financial burden.

The other thing that has been a real challenge, and this is partly due to the growth of allied health courses—and I am sure this has happened in nursing, and I know medicine is experiencing it to a degree now—but the growth of allied health courses has meant that there is more competition for placements. That means universities are finding different ways in which they can try to secure their placements. As much as people don't like to talk about it, universities do pay for placements in New South Wales. They do have arrangements where they will pay—and they will pay more than other universities—and that makes it really difficult.

The example—I'm sure I've told you this one before—is that for a long time we could not get physio student placements in Orange, even though our course is in Orange, because we could not compete with another university paying for placements in Orange. I really struggle with that. For me, the way forward is to get rid of that competition and have a more equitable way in which we can allocate placements between the universities in public health, and there are examples of that working. Obviously Queensland is the example everyone pulls out, but I'm sure New South Wales could develop a system which is fairer, so that we are not competing for placements.

The last thing I would say is that the University Departments of Rural Health have been excellent. They have been really good, but they work differently depending on where they are located. My understanding is there are a number of UDRHs which will take students from a lot of different places. We get a lot of student placements in Western Australia. They have some of the UDRHs there. The Three Rivers UDRH, which is in our footprint, will take students from different universities. Us, trying to get a placement in the Newcastle UDRH, we cannot get one, even though we've got Port Macquarie there. I'm sure there are solid reasons for why they do that, but the fact that they operate differently, when they are supposed to be there to support rural placements and rural communities—I struggle with why they have to operate that differently, where they can't take students from wherever. That's a problem for me as well. I'll stop there, because I could go on, but I'm happy to answer questions.

The CHAIR: We just need to explore a couple of those points you've raised. I have not heard this situation of allied health physiotherapy students at Orange that you're training not being able to do a placement at Orange because of another university. Could you just explain? Is that still the case?

MICHAEL CURTIN: Going back to what the professor from ANU was saying, it's a little bit personality directed. I'm not going to name names here, but it was a decision made by somebody at Orange and it was financially related. They could get more money from another university for taking on their students.

The CHAIR: Sorry, who could get more money?

MICHAEL CURTIN: The physio department.

The CHAIR: So this other university, what was their record in terms of their graduates returning to work in rural and regional areas?

MICHAEL CURTIN: I couldn't tell you, but I know that our graduates often got jobs there afterwards, because a lot of our graduates are from the area. Just to give you the other version of this, we work really well with the Western NSW Local Health District. They have set up clinical schools for our physio students, so we have a really good relationship. Orange has now just come on board, but there has been a change of people there which has allowed that possibility to happen. So they are just coming on board in 2025 to the clinical—

The CHAIR: What were they paying them for? How were they paying them?

MICHAEL CURTIN: You pay a rate per day. I don't know what their rate was. We just wouldn't pay that.

The CHAIR: So you have to pay a rate per day to NSW Health for your students?

MEGAN SMITH: Yes, we pay a lot. We pay it across a lot of placements. In fact, we pay nursing placements and we pay for allied health placements. You could say it's a payment or you could say it's a shared expense model, because obviously there are clearly supervision costs, depending on the way you do it.

The CHAIR: Yes, that's true.

MEGAN SMITH: But, to Michael's point, it is not a consistent rate per university. Victoria, as a contrast, has a consistent rate that is agreed across all agreements, and that's a co-contribution model to the costs of clinical education. There are arguments around that, but New South Wales does not have a consistent way, so there is this opportunity for a market system to exist.

The CHAIR: My point is that it's about rural workforce. Rural universities, university departments, rural health, the RHMT Program are about the rural workforce. It seems to me that we shouldn't have nursing, allied health and medical students based at a regional university that then have to travel large distances unnecessarily—let me put it that way. And we shouldn't be preferencing placements from universities where there is a record of people returning to rural and regional areas. It shouldn't be a market system. I'll put that out there as a possible consideration.

Mrs LESLIE WILLIAMS: On that particular issue in relation to the challenges of having a market system in New South Wales, what jurisdictions have a much more uniform and fairer approach for universities and student placements? Where can we look to see a better model?

MICHAEL CURTIN: Queensland probably has the stand-out model, where it is run by Queensland Health. They employ people at Queensland Health and they have a consortia model. You say how many placements you want and it's allocated through Queensland Health. You don't necessarily go to a hospital and say, "I want this many." They try to cater for people. It's a non-competitive system, as far as I can tell. You say how many placements you need and it is sorted out at that level. Megan, is that your understanding of that model as well?

MEGAN SMITH: Yes. Definitely, physiotherapy probably has the best example of that. There is also an agreed common co-contribution, for want of a better term, around that. Students still need to travel. If you talk to James Cook University, for example, their students will need to still access—but it is everyone sitting at the table and discussing the issue together, as opposed to individual negotiations. The Ministry equivalent takes a very active role in that.

MICHAEL CURTIN: The other bit is Victoria do a standard co-contribution; that's the other model. There's still competition for placements, but there's not a competition as in money. We hardly get any placements in Melbourne itself, because there are so many allied health courses in Melbourne. So, yes, they're going to cater for those. Because those universities are probably private first.

The CHAIR: Professor Curtin, you made a point about the university department of rural health at Newcastle, is that right?

MICHAEL CURTIN: Yes, I did. Well, I don't think it's based at Newcastle. They've got outreaches in Port Macquarie, Armidale and Tamworth. I think it's called the Newcastle department of rural health. This is not anything; they just seem to run a different model to the model that I'm used to where it's a bit more ex-students, because the remit is to get students into rural and regional placements.

Ms TRISH DOYLE: Thank you all for speaking with us today and sharing some of your insights and ideas; thank you for your work. Please pass that on to your colleagues. Since you are here, Professor Wayland, I'm interested in hearing from you. In your submission, there's reference to the limited progress in implementing the recommendations from the previous inquiry. The submission notes that we shouldn't rely solely on these remote, regional and rural communities to identify and respond to the health needs of those communities. Did you want to elaborate on that a little bit? That's an important point that our Committee needs to deliberate on.

SARAH WAYLAND: In the last 10 years or so we've talked a lot about co-design and collaboration, and participation. From Manna Institute's perspective, we hear a lot from the regions about levels of exhaustion and fatigue of constantly being consulted on what should be done to fix the issues when, even in today's examples, we hear so much commonality across a number of areas of people that have potentially never been together talking about the same issues. From a regional university's perspective, we hear a lot from students time and time again about wanting to do good work, yet the cost-of-living crisis, from a placement perspective—placement poverty and the concerns of being able to do that—means that when they get to the regions, they're then also met with the layered challenges of what's been happening in places where there hasn't been infrastructure investment and there hasn't been systems that have been resolved. I think it's about making sure that we're not continually going back to communities and asking what can be done to help, but recognising that there's a strong evidence base that provides those solutions, actually doing those and evaluating, and relying on those evaluations rather than more research or—

Ms TRISH DOYLE: Reinventing the wheel.

SARAH WAYLAND: Yes, and constantly going back. At the moment, with Manna, we've started a town hall approach of going into the regions and talking to them, not about what they might actually need in order to thrive, but what's working, what's not working and how can we focus on what is working, rather than constantly trying to challenge those parts that aren't. I think the fatigue is out there. People feel that people come to them and ask for the solutions, and then they never hear the outcome of that, other than another focus on, "Tell us again, because we didn't hear it the first time."

Ms TRISH DOYLE: I think there's a degree of cynicism that you've touched upon there, and it's not just in health. It's across any portfolio area where we need some systemic change—

SARAH WAYLAND: We do.

Ms TRISH DOYLE: —and we do have the answers.

SARAH WAYLAND: We do.

Ms TRISH DOYLE: That's an important point that was made in your submission that we should focus on.

SARAH WAYLAND: That final part, what we're seeing as well is that the funding cycle is not trauma informed. Sometimes those funding cycles are so short, it's very difficult to identify impact and sustain change. We need to trust that the regions, if they're given the opportunity to be able to invest in their solutions, to be left for a period of time, to then be able to come back and say, "This is what we achieved," not "This is what we achieved in one year or three years".

Ms TRISH DOYLE: Excellent point.

LEANNE NISBET: I agree with Sarah and to let you know that, in the collection of data, from where I was talking about the model of healthcare practice that I designed, many times out in the small towns that I was collecting data from, people would say, "Thanks very much. This is really great. What makes what you're doing so different to everybody else, because everybody else comes here and asks us what the problem is. We tell them what the problem is. They go away, they write something and we never hear from them again." I just think it's important to say that.

Ms JANELLE SAFFIN: The last question, and you may want to take it more on notice, is particularly to do with mental health services and accessing them. It's to everybody, but more to Professor Wayland. I will make a comment. When you said trauma informed, my ears pricked up, having lived through the big disaster in the Northern Rivers. I saw a lot of money and a lot of people come in; I didn't see much trauma informed. Besides that, my question is: To what extent have the New South Wales and Australian governments effectively renewed

or improved funding models for regional communities to access mental health services? You may want to take that on notice.

SARAH WAYLAND: I will take it on notice because I don't want to hurriedly respond to something that's incredibly important.

Ms JANELLE SAFFIN: It is. It's important for the Committee. That was recommendation one of the first Committee, the LC one. I haven't seen a lot change. I've seen some good political will.

SARAH WAYLAND: I will say that I have seen some absolutely lovely, on the ground, community embedded work that happens in mental health, particularly in the Northern Rivers region and working a lot with Lifeline Direct and community connectors. I think that having community champions is a significant step forward to providing those connection points in community. But I will come back to you with a more detailed answer.

Ms JANELLE SAFFIN: Our PHN has done some good work on that too.

SARAH WAYLAND: Yes, amazing work.

Ms JANELLE SAFFIN: I was there the other day with them.

The CHAIR: Thank you everybody for appearing. I really appreciate that. You'll be provided with a copy of the transcript for corrections and any questions taken on notice today, so the one we've just had. We may also send you some further questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions? Everyone is nodding; thank you very much.

That concludes our public hearing for today. I thank all the witnesses who appeared before the Committee and thank the witnesses who are currently before the Committee. We will be resuming hearings for this inquiry at 9.00 a.m. tomorrow. I thank Committee members, Committee staff and Hansard for their assistance in the conduct of today's hearing. I look forward to seeing you tomorrow morning at 9 o'clock.

(The witnesses withdrew.)

The Committee adjourned at 16:55.