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Supported by the NSW Ministry of Health

***ABN** 66 085 654 397*

Aboriginal Health and Medical Research Council of NSW

Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025

The AH&MRC Acknowledges the Traditional Owners of the lands on which the AH&MRC stands, the lands of the Bidjigal and Gadigal people of the Eora Nation. The AH&MRC pays respect to Elders past, present and emerging.

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About the AH&MRC

The Aboriginal Health and Medical Research Council of NSW (AH&MRC) is a membership-based organisation and the Peak Body for Aboriginal Health in New South Wales. We represent 51 Aboriginal Community Controlled Health Organisations (ACCHOs) across the state.

The AH&MRC assists ACCHOs to ensure they have access to an adequately resourced and skilled workforce to provide high-quality health care services for Aboriginal communities. The AH&MRC is committed to the delivery of four key priorities:

- Aboriginal Community Control and Innovation
- Education and Workforce
- Research and Data
- Governance and Finance

The AH&MRC would like to thank the Committee for the opportunity to provide a submission for this review. The AH&MRC has consulted the AH&MRC Policy Advisory Group made up of Chief Executive Officers of our 51 Member Services and internal staff with expertise in this area to inform this review.

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AH&MRC Response:

The AH&MRC thanks the committee for the opportunity to provide a response to the proposed Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025.

The AH&MRC wishes to highlight several concerns on the proposed dissolution of the Hunter New England Local Health District (LHD) and its reconstitution as two separate entities – the Hunter LHD and the New England North West LHD.

While the objective of improving health outcomes for communities with limited access to current tertiary services is understood, the proposal in its current form, does not sufficiently consider the regional variations across the existing LHD or the distinct needs of communities based on geography, population and existing service relationships.

As currently presented, the proposal lacks sufficient detail and strategic planning. This creates a high risk for adverse outcomes, including pressure on already limited resources, duplication of services and significant disruption to service delivery.

Before any structural changes are considered, the NSW government must ensure that there is a robust implementation plan, and that significant investment is made in upgrading infrastructure and service capacity (including workforce and specialist pathways) for providers within the health district boundaries. Proceeding without these provisions will jeopardise the quality of health services and access for communities across the current Hunter New England region.

1. **Uneven impact of the proposed split on ACCHOs**

The proposed dissolution of the Hunter New England LHD and reconstitution into two separate entities would have uneven consequences for ACCHOs and Aboriginal communities across the region. For ACCHOs located in the southern and central parts of the current LHD such as Tamworth, parts of Armidale and surrounding areas that maintain established referral relationships with John Hunter Hospital, the split would likely have negative consequences. These ACCHOs rely on direct access to specialist and tertiary services at John Hunter and have developed relationships with hospital-based

care coordinators and clinical specialists in Newcastle. They are likely to face greater administrative and logistical barriers in referring patients across LHD boundaries and risk being excluded from governance and planning structures to better support Aboriginal patients in tertiary care.

Conversely, ACCHOs based in the far north-west of the current LHD, including areas such as Moree, Inverell and Tenterfield, often have weaker functional ties to John Hunter and refer patients to closer tertiary services in Queensland (Toowoomba or Brisbane). These ACCHOs may benefit from a more regionally responsive administrative model. This could enhance local coordination between hospitals and ACCHOs, improve access to outreach specialist services based closer to their communities and enable more targeted investment and service planning.

This disparity underscores the need for any LHD restructuring to be nuanced and tailored rather than a blanket approach. Without a differentiated approach and specific safeguards, the split risks deepening inequities by leaving some ACCHOs isolated from services they depend on, while others continue to face structural barriers despite being "closer" to administrative hubs.

a) Risk of fragmented access to specialist and tertiary health care services to ACCHOs situated in a newly constituted district that lacks a tertiary hospital.

John Hunter Hospital and Tamworth Hospital are both key healthcare facilities within the current Hunter New England LHD. As a tertiary referral and teaching hospital, John Hunter accommodates approximately 796 beds, includes a dedicated children's hospital, and is home to the only trauma centre in NSW outside the Sydney metropolitan area.[1] It functions as a regional hub for complex and specialist care within the Hunter New England LHD. In contrast, Tamworth Hospital is classified as a rural referral hospital with a significantly smaller capacity of around 282 beds.[2] While it is the largest hospital outside the Sydney–Newcastle metropolitan area, Tamworth primarily provides core medical services without the full capabilities of a tertiary centre to the New England region. The proposed restructure of the Hunter New England LHD would see John Hunter remain outside the newly formed

[1] https://www.newcastle.edu.au/joint-medical-program/about-the-jmp/clinical-schools/hunter-clinical-school
[2] https://www.healthdirect.gov.au/australian-health-services/healthcare-service/tamworth-2340-nsw/tamworth-rural-referral-hospital/hospitals/a28a623c-5a52-0174-e34f-595dcc1c4dce

New England North West LHD, leaving the reconstituted district without a tertiary hospital to service its 185,560 residents.[3]

ACCHOs in the New England and North West region that refer into John Hunter would lose direct alignment with the hospital and experience disruption to established referral relationships with specialist units. This could result in delayed access to care for Aboriginal patients. Additionally, the split is likely to cause strain on local ACCHOs who may be required to manage more complex care locally without the necessary funding, infrastructure or workforce support. Without adequate investment, the impacts on the ACCHO workforce would be significant, increasing the risk of burnout and staff turnover.

The absence of a tertiary hospital in the reconstituted district would see patients that require high-level specialist care continue to be referred to John Hunter Hospital. This means there would be more frequent inter-district transitions over long distances, placing additional strain on patient transport services including ambulance and retrieval teams.

The separation of the LHD may also lead to administrative and clinical fragmentation, with patients transitioning between two health districts for their care. Some ACCHOs already operate across two health districts, but there is a need for greater flexibility and more seamless transfer of care. The capacity to access tertiary care should not be dependent on health district boundaries which should be addressed within the current arrangements.

As would be the largest hospital in the newly reconstituted New England North West LHD, Tamworth Hospital is likely to face increased demand to manage higher-acuity and more complex cases that would previously have been referred to John Hunter Hospital. However, without the infrastructure, specialist workforce or critical care capacity of a tertiary facility, this shift could increase clinical risk and place further strain on overburdened staff. The mismatch between patient needs and hospital capacity is likely to widen health disparities and undermine the quality of care for residents across the New England and North West region.

[3] https://abs.gov.au/census/find-census-data/quickstats/2021/110

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b) Exploring partial administrative separation within the Hunter New England LHD

ACCHOs in the North West region, including towns such as Moree, Narrabri, Inverell and Armidale often face unique challenges due to their geographical distance from John Hunter Hospital as the district's only tertiary referral facility.

Currently many of these ACCHOs operate without strong or direct linkages to tertiary and specialist services housed within the Newcastle region. Referring into John Hunter is often not tenable due to the significant distance (more than 400 kilometres away). The physical and administrative distance has historically resulted in limited integration into referral pathways for specialist care, long travel times and delayed access to diagnostic, treatment and follow-up which contributes to poorer health outcomes and service disengagement.

The current proposal fails to adequately consider the regional variations across the Hunter New England LHD and the distinct needs of communities based on their locality. However, there is a potential value in a partial administrative separation within the LHD to improve service delivery in parts of the region that currently experience limited connection to, or support from John Hunter Hospital.

A more regionally responsive governance or administrative model may provide an opportunity to improve health outcomes by enabling more effective resource allocation, targeted service planning and greater accountability. Embedding leadership and decision-making closer to these communities could enhance responsiveness and better reflect local priorities.

However, any support for such a change is conditional upon:

- the establishment of clear structural and funding safeguards to prevent fragmentation of services and care pathways.
- significant investment in local service capacity and workforce development.
- ongoing commitment to culturally safe, community-led care for ACCHOs operating in these regions.

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The underlying structural issues of this region must be comprehensively mapped before any changes are made to the current health district. Recruitment and retention of general practitioners and specialist staff remains a persistent challenge. Although Armidale hospital has the infrastructure to support rural generalist training, the availability of appropriately qualified staff to supervise trainees in advanced skills is insufficient. The current model is over-reliant on locum specialists and non-regular visiting medical officers which undermines continuity of supervision and the quality of training. This results in critical staff relocating to other areas with required capabilities, further compounding service gaps.

Without targeted investment and structural safeguards, the proposed changes risk weakening an already fragile system. Reform needs to be informed by comprehensive regional mapping and sustained workforce development.

This opportunity relies on a well-resourced and co-designed model that maintains critical links to tertiary care while building local infrastructure and capacity. Without these conditions, the risk remains that regional ACCHOs will be left with increase responsibility but insufficient support that would further entrench structural disadvantages rather than alleviating it.

Recommendations:

Given the potential risks to patient care, system coordination and health service efficiencies, the AH&MRC urges the Committee to consider the below recommendations:

1. **The restructure should not be considered viable, unless there is a commitment that:**
    a. it is accompanied by a clearly articulated and fully funded plan to build adequate infrastructure, workforce capacity and specialist services within the reconstituted New England North West LHD
    b. any new health district configuration includes reliable, formalised pathways for Aboriginal patients within the New England North West LHD to access tertiary care at facilities like John Hunter Hospital and others.
    c. Invest in long-term workforce planning across health districts to ensure sustainability and alignment with rural health training needs.
    d. significant and targeted investment in ACCHOs to support increased, long-term funding to manage the additional burden of complex care and service delivery in the absence of local tertiary services
    e. joint governance mechanisms are maintained and preserved to allow ACCHOs to remain active partners in strategic health planning, regardless of LHD boundaries.



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