**Submission No 4**

# THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO WORKFORCE ISSUES, WORKPLACE CULTURE AND FUNDING CONSIDERATIONS FOR REMOTE, RURAL AND REGIONAL HEALTH

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Prior to retiring earlier this year I have worked in the Public Hospital system for 47years.

In this time I have seen the Public Health care emphasis change from quality patient care to expedited service delivery and bed management. Hospitals are now run on spreadsheets, not informed interaction with staff at the coalface.

When I first commenced in the Public Hospital system the top of the administrative tree was a Medical Superintendent, answerable to a local board and of course, government oversight. These medical administrators were often seen on the floor in various areas of the hospital gathering staff feedback and generally observing how well the service was being delivered. Today the Medical Superintendent, or equivalent, is answerable to a number of public service bean counters within administration and most hospital staff would not recognise their medical leader. The administrative machine in my LHD is an essay in its own right and I don't have the space of time to go into it. Possibly this is also not the correct forum to touch on these matters.

In my time in public health the level of patient dependency has increased exponentially while the number of doctors, nurses and allied staff has not. Dementia, obesity and chronic disease take a heavy toll on attending staff who are trying to juggle multiple patients.

The quality of patient care HAS decreased.

The wellbeing and lifestyle of most staff has decreased.

The LHD I was employed by has become toxic.