Submission No 36

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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Implementation of Portfolio Committee No. 2 recommendations specifically relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health.

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Dear Committee

Thank you for taking the time to review this submission. My submission is relating to funding for remote, rural and regional health services and programs. These perspectives are my own and not those of my employers.

I have worked within the NSW Health system since 1995, first as a paramedic, then as a doctor and now as a specialist anaesthetist. I have lived experience of the poor health outcomes of those living in regional, rural and remote NSW and the first hand impact of the consequences of not addressing the social determinants of health in a fair and equitable way.

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

There will always be insufficient resources. Health spending needs to be allocated on needs. Where the needs exceed the available funding the priorities need to be triaged addressing the areas of greatest need first. Rural health funding must not come at the expense of political objectives (i.e. retaining government). The need must be objective, evidence based, and must consider the demographics, socioeconomic status, demand, alternatives and the disadvantage of a community/s. This will be the only fair way to allocate funds. All communities, deserve health services appropriate to their needs.

The recent commitments by this Government with respect to health spending for Western Sydney are disproportionate when compared to the unmet need in regional communities. The commitments to the future Rouse Hill Hospital alone could see another 5-10 regional facilities redeveloped to minimum standards. The size and rate of growth of a community is not the primary predictor of future healthcare needs. The social determinates of health are much more predictive. Regional facilities have current unmet need and these must be addressed first.

I will use the state electorate of Myall Lakes and Manning Base Hospital as examples using publically available and verifiable information. I encourage the committee to undertake a review of funding allocations to rural NSW over the past decade with respect to capital and operational expenditure.

Key statistical facts from the 2021 census for the Myall Lakes electorate:

- Population just over 75,000 population
- Median age 52 years (state median 39) with almost 32% of the population being 65+ years
- Median average household weekly income is $1,061
- The population comprises 7.6% Aboriginal and/or Torres Strait Islander (state average of 3.4%)
- Of those over 15 years, only 12.3% have a bachelor's degree or above compared to the state average of 27.8%.
- Myall Lakes has less people engaged in the workforce and more unemployed persons.
- The median individual income is $569 compared to the state median of $813 with family median incomes lower also ($1,354 vs $2185)

- The total household weekly income is less than $600 for 26% of households and less than 10% have a weekly household income of more than $3000
- Higher rates of all categories of long-term health conditions with a staggering 15.4% having two or more long-term health condition (State average 8.7%)
- For 39% of couple families, both are not working (state average 22.9%)

It should be self-evident to the Committee that Myall Lakes has a population that is older, is socioeconomically disadvantaged and is over represented in chronic health conditions. The community expectation, quite reasonably, is that we should have access to:

- Aged care services to meet demand including end-of-life care
- Access to affordable, quality and safe health services
- Community based services to support people living with chronic diseases
- Acute care services that are provided locally

Unfortunately there is a gross mismatch between community need and available services stemming from systemically inequitable funding models for both operating expenditure, workforce, evidence based models of care and investment in capital infrastructure.

The heartbeat of acute healthcare services in Myall Lakes is Manning Base Hospital. The "new" Manning Base Hospital was built in circa 1954. Today, with the exception of a total of $40 M in total of investment (Stage 1), the hospital is largely unchanged and no longer fit-for-purpose.

I want to outline objectively for the committee the systemic inequity in funding models again using Manning Base Hospital as an example in addition to other rural and regional areas.

Area	Population[1]	Hospital	Hospital Type	ED attendances (Q2)	Episodes of Care
Fairfield	195,172	Fairfield	Major	9,762	7,539
Manning & Great Lakes	99,656	Manning Base	Major	9,116	5,885
Auburn	103,544	Auburn	Major	8,347	4,445
Orange	61,266	Orange	Major	8,242	5,774
Grafton	36,130	Grafton	District Group 1	6,942	3326
Bathurst	49,146	Bathurst	District Group 2	6,607	3705
Cooma & surrounds	9,233	Cooma	District Group 2	2,882	1,028
Macksville-Scott's Head	5,189	Macksville	District Group 2	3,555	1,134
Cowra & surrounds	14,989	Cowra	District Group 2	2,217	992

Manning Base Hospital sees over 36,000 patients in its ED annually, almost as many as Fairfield as and more than Auburn and Orange. One would reasonable expect that Manning Base Hospitals ED would have the same number of beds, the same equipment, the same workforce profile (medical,

[1] SA3 where available, SA2 as an alternative

nursing, allied health, administration, security, support services etc), the same onsite diagnostic services, the same models of care (as described by the Agency for Clinical Innovation).

Additionally, based on the episodes of care, the available beds, specialty services and wards, medical staff (junior and senior), nursing staff and support services one would also expect to be equitable.

Unfortunately for Myall Lakes, there is limited primary care services (many with closed books), almost no bulk-billing primary care providers, and almost no urgent care services (other than ED). The disadvantage in the area precludes people from accessing affordable services other than in the Emergency Department. The lack of transport infrastructure is a barrier to access and provides no way home for many residents.

I urge the committee to undertake or commission a rural health equity audit that compares the staffing profiles, operating budgets, inpatient beds, and outpatient and community services to the community demands. Rural communities are simply missing out on core services.

What really shocks and disappoints me is how funding is allocated for health infrastructure projects. As I mentioned, Manning Base Hospital was rebuilt circa 1954 and most of the hospital remains unchanged. It should have been obvious to any government that Manning Base Hospital would need further investment / redevelopment within the next 50-60 years. This represents systemic failure of multiple governments over many terms of parliament.

Fortunately there has been a staggering uptick in the investment in regional and rural infrastructure over the last 3 terms of government. However, the allocation of funding has been far from equitable.

I use the table below to illustrate the long systemic biases in the allocation of Hospital Funding.

Hospital	Funding	Status
Fairfield	$550 M	Planning
Wagga Wagga	$431 M	Completed (2021)
Orange	$260 M	Completed (2011)
Tumit Hospital	$50 M	Completed (2022)
Macksville District Hospital	$73 M	Completed (2020)
Sutherland Hospital	$62.9 M	Completed
Canterbury	$350 M	Planning
Eurobodalla Regional Hospital	$260 M	Planning
Bathurst District Hospital	$200 M	Planning
Grafton District Hospital	$263.8 M	Planning
Cowra District Hospital	$110.2 M	Planning
Cooma District Hospital	$24 M	Delivery
Forster Public Hospital	Uncertain	Not included as a Health Infrastructure Project

I will focus on a couple of specific examples. I am unable to explain how Manning Base Hospital has been such a low priority for successive governments. What is abundantly clear is that it is not the population, the demographics, the socioeconomic disadvantage, nor the social determinants of health that are determining healthcare spending. If it was about these things then Manning Base Hospital and health services in general within the Myall Lakes electorate would be substantially better than they are today. The unmet healthcare needs of our community are staggering.

Despite more than a decade of lobbying by local action groups, these please continue to fall on deaf ears – our community is fed up with lip service.

I recommend that the Committee closely examine the commitments to health infrastructure projects and the completion of projects and try and find objective evidence to justify that allocation of these funds were based on actual health data rather than polling data.

The first promise of investment into Manning Base Hospital was a mere 20M in 2016 "Just weeks out from the 2015 state election, state politicians vowed, if re-elected, they'd spend $20 million to rebuild Manning Hospital". An additional 20M was promised in the 2018/19 budget resulting a total investment of $40 M. Stage 1 of the Manning Hospital Redevelopment delivered enhanced cancer care services, renal dialysis services, medical imaging services, a hospital carpark reconfiguration, an increased number of consultation spaces and a refurbished hospital main entrance. Stage 1 was completed in 2020 and Manning Base Hospital has not been further redeveloped since then. The community has been promised and promised a further 100 M in redevelopment (Stage 2) which was allegedly going to "provide patients, carers and staff with a modern new hospital building to help meet the health needs of the community now, and into the future". This has not progressed since 2021 but has been promised year after year including re-announcement by the current government. Stage 2 was not going to meet the needs of the Myall Lakes community in 2021 and most certainly will not today.

When one objectively compares the community of Grafton to the Manning Great Lakes community it is difficult to understand how health funding is allocated. Investment into health infrastructure in Grafton District Hospital includes:

- $17.5 M invested in the delivery of the Grafton Ambulatory Care project
- $19.7 M for Grafton Base Hospital – Surgical Services Building and Emergency Department
- $263.8 M further commitment

Bathurst District Hospital is another comparator will a commitment of $200M.

My favourite comparator is Macksville District Hospital. A brand new hospital $73M, delivered in the term of the former coalition government. This is great news for Macksville and it is an amazing facility. It is claimed that "Macksville's community has a set of unique health challenges, including chronic illness and complex health needs due to its significant aged and Aboriginal population". I do not see how these challenges are different to the Manning-Great lakes, Bulahdelah or Forster-Tuncurry communities.

It would have been far more prudent to invest in a hospital for Forster-Tuncurry in 2017-2020 than in Macksville.

It is important that this Committee better understands how allocation of health spending is allocated. There needs to be clear criteria and a regularly updated priority list of investment and a commitment to deliver core services equitably. For example all emergency departments that see 35,000 patients should be funded the same and expected to provide core and evidence based models of care.

Beyond equity we should be striving for equality. The rural facilities that have been neglected the most need more investment not less to catch up.

The government of the day should be able to choose how much money into healthcare the health of regional, rural and remote communities should not be held to ransom by partisan politics and

political promises. Certainty is needed for health services to develop a pipeline to gain, train and retain a sustainable workforce. The list of infrastructure priorities should be publically available and based on expert / evidence informed assessments of the past, present and future needs and the magnitudes of the existing gaps. Should a government or minister choose to overrule this list of priorities for political purposes then whilst this is their prerogative, at least the public could hold them more accountable and this would ultimately lead to greater integrity in politics and provide a net uplift in the health of regional, rural and remote communities.

We resource what we value as a society and there is not much evidence that the Myall Lakes community is valued when it comes to healthcare. We are fed up as a community with undelivered promises and political stunts.

Whilst there is a lot of focus on workforce over infrastructure I put provide this thought to the committee – how many Michelin Star chefs work in rundown neglected food trucks? Build it and they will come if the community is given the certainty. The lack of contemporary facilities is a major barrier to gaining and retaining a workforce to meet current and future needs. Specifically in my area of practice, the lack of operating theatres alone (would only be delivered only if Stage 3 was delivered) prevents us from attracting and retaining specialist surgeons and anaesthetists and limits the services we can provide for our community. The absence of a hybrid operating theatre prevents us from providing interventional cardiology services and vascular surgical services. This often means delays for patients and the burden for patients to travel out of area away from the support of family and community for core services that could be provided locally.

My recommendations to the committee are:

1. Undertake a deep dive into Health Infrastructure projects including
    a. When promised
    b. When budgeted
    c. When commenced
    d. When delivered
    e. Cost
    f. Review of decision making
    g. Analysis of marginality of seat
    h. Analysis of the community need
2. Understand the criteria which informs regional health funding allocation
3. Undertake or commission a regional health equity audit that objectively measures the health of a community, the available services, the gaps, funding, workforce, skill mix to aid in informing health spending priorities
4. Review healthcare worker and support staffing FTE against objective demand data (e.g. BHI) to identify obvious service gaps

I thank you for the opportunity to contribute to the enquiry.

Yours sincerely

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Dr Jason Bendall

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